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Creating trauma-informed correctional care: a balance of goals and environment

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Background: Rates of Post-traumatic Stress Disorders and exposure to violence among incarcerated males and females in the US are exponentially higher than rates among the general population; yet, abrupt detoxification from substances, the pervasive authoritative presence and sensory and environmental trauma triggers can pose a threat to individual and institutional stability during incarceration.

Objective: The authors explore the unique challenges and promises of trauma-informed correctional care and suggest strategies for administrative support, staff development, programming, and relevant clinical approaches.

Method: A review of literature includes a comparison of gendered responses, implications for men's facilities, and the compatibility of trauma recovery goals and forensic programming goals.

Results: Trauma-informed care demonstrates promise in increasing offender responsivity to evidence-based cognitive behavioral programming that reduces criminal risk factors and in supporting integrated programming for offenders with substance abuse and co-occurring disorders.

Conclusions: Incorporating trauma recovery principles into correctional environments requires an understanding of criminal justice priorities, workforce development, and specific approaches to screening, assessment, and programming that unify the goals of clinical and security staff.

Keywords: *trauma*; *incarceration*; *criminal justice*; *PTSD*; *substance abuse*; *treatment*

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Trauma-informed care is a relatively recent development in the treatment field. It has as primary goals accurate identification of trauma and related symptoms, training all staff to be aware of the impact of trauma, minimizing retraumatization, and a fundamental "do no harm" approach that is sensitive to how institutions may inadvertently reenact traumatic dynamics (Harris & Fallot, 2001; Hodes, 2006).

Prisons are challenging settings for trauma-informed care. Prisons are designed to house perpetrators, not victims. Inmates arrive shackled and are crammed into overcrowded housing units; lights are on all night, loud speakers blare without warning and privacy is severely limited. Security staff is focused on maintaining order and must assume each inmate is potentially violent. The correctional environment is full of unavoidable triggers, such as pat downs and strip searches, frequent discipline from authority figures, and restricted movement. (Owens, Wells, Pollock, Muscat & Torres, 2008). This is likely to increase trauma-related behaviors and symptoms that can be difficult for prison staff to manage (Covington, 2008).

Yet, if trauma-informed principles are introduced, all staff can play a major role in minimizing triggers, stabilizing offenders, reducing critical incidents, de-escalating situations, and avoiding restraint, seclusion or other measures that may repeat aspects of past abuse (Blanch, 2003; CMHS, 2005). In addition to general trauma-informed principles, clinical staff can provide trauma-specific therapies—actual counseling models and curricula that are designed to promote trauma recovery. There is recognition that staff and inmate

relationships are the day-to-day fabric of both trauma recovery and of re-traumatization. Clinical interventions for inmates need to be relevant to the environment, culture and relationships that incarcerated trauma survivors must navigate on a daily basis. The most successful interventions in prisons 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.

This article discusses the centrality of trauma in the lives of inmates and explores components of what we will call *trauma-informed correctional care* (TICC). TICC is the adaptation of trauma-informed care for correctional settings in particular, which have their own unique challenges, strengths, culture, and needs. We will address a variety of themes related to TICC, including institutional and personal safety, staff training, cultural change and relevant clinical approaches. We also focus on gender differences in relation to both trauma and criminal justice.

Entry into prison: safety for women and danger for men

The vast majority of women in prison have experienced some sort of interpersonal or sexual violence in their lives, with estimates as high as 90% (Commonwealth of MA, 2005; Women in Prison Project, 2006). Yet, ironically, women, especially those who were homeless, drug addicted or living with dangerous partners prior to incarceration, are statistically safer from victimization in prison than they were prior to incarceration. For example, the estimated prevalence of sexual assault in US prisons, based on the most recent Bureau of Justice Statistics inmate survey, is about 4.4% (Beck & Harrison, 2010). Yet, for women on college campuses, the estimated prevalence of sexual assault is from 20 to 25% (Bureau of Justice Statistics, 2009; Youth Violence and Suicide Prevention, 2004). Studies have also shown that incarcerated women with posttraumatic stress disorder (PTSD) report a much higher rate of witnessing violence than the female population in general and that many of them designate such witnessing as their most serious trauma (Hackett, 2009; Hodes, 2006).

Some women express a feeling of safety and relief during intake at women's prisons (Loper, 2002). Escaping homelessness, sex work, violent partners, dealers, and pimps may also contribute to a new awareness of the level of danger with which they have lived (Blackburn, Mullings & Marquart, 2008). Perhaps that small moment of relief upon entry provides the requisite psychic safety that allows these women to begin to identify their trauma symptoms and triggers.

"Harmed and harming": trauma histories, crime and institutional risk

Theories of women's pathways to criminal behavior include the "harmed and harming" woman, who has been seriously sexually abused and neglected, and is at high risk for anger and hostility, which is associated with increased rates of institutional difficulty and recidivism (Brennen, 2007). This is also captured in the phrase, "hurt people hurt people," which speaks to the repetitive nature of the trauma experience and how it is transmitted to others (Bloom & Farragher, 2011). A history of sexual abuse is recognized as a risk factor for crime in both males and females. In general, people who have been sexually abused are more likely to be arrested (Hubbard, 2002), and to experience future trauma (Council of State Governments, 2005; Najavits, 1997).

For women offenders, sexual violence, defined as the combined prevalence of adult and child sexual abuse and assault, is by far the most commonly reported type traumatic experience, followed by intimate partner violence (Battle, Zlotnick, Najavits, Gutierrez, & Winsor, 2002; Zlotnick, 1997; Zlotnick, Najavits, Rohsenow & Johnson, 2003). For incarcerated women, rates of sexual victimization across the lifespan are highest in childhood (Blackburn et al., 2008; Clements-Nolle, Wolden & Bargmann-Losche, 2009; Raj et al., 2008).

Research suggests histories of sexual abuse interfere with female inmates' ability to benefit from programs, perhaps in part, due to the disorientation and disconnection that trauma creates (Saakvitne, 2000). If the offender has limited coping skills and cannot control her dissociative symptoms in the face of multiple triggers, it interferes with her engagement in cognitive-behavioral therapy (CBT) interventions (Hubbard, 2002, Van Voohris, 1997). Therefore, the principles of trauma-informed care, along with interventions aimed at trauma stabilization, are a priority for women offenders. This theory is supported by research on women's risk classification and security levels, which has shown that a history of childhood physical and/or sexual abuse is associated with increased institutional difficulty (Gilfus, 2002; Van Voorhis, Salisbury, Wright & Bauman, 2008).

In studies of male prisoners, the most commonly reported trauma is witnessing someone being killed or seriously injured (Sarchiapone, Carlia, Cuomoa, Marchettia & Roy, 2008), followed by physical assault (Johnson et al., 2006), and childhood sexual abuse (Weeks & Widom, 1998). Overall, higher rates of trauma and earlier age of trauma onset is associated with increased violence and victimization in prison (Komarovskaya, 2009). Studies of male veterans in prison (Saxon et al., 2005), inmates in rural prisons and jails (Powell, Holt & Fondacaro, 1998), and men in substance abuse treatment have repeatedly shown high rates of physical and/or sexual abuse histories and PTSD.

For example, an estimated 38% of men in substance abuse treatment have PTSD (Najavits, 2006). Studies of childhood sexual abuse among male inmates vary, but most suggest a much higher rate of childhood sexual abuse than in the general male population (Bureau of Justice Statistics, 1999; Johnson et al., 2006; Fondacaro et al., 1999; Weeks & Widom, 1997).

However, unlike women, men are rarely safer behind prison walls than prior to incarceration. Their risk of sexual assault increases exponentially when they enter a prison, (National PREA Commission, 2009; Testimony of Hennessey, 2005) compared to the risk for males in the general population. They face an increased threat of lethal violence in male facilities that may trigger more externalizing trauma responses (i.e., outward-directed aggression) and high levels of arousal that can endanger staff and inmates (Freedman & Hemenway, 2005).

Motives for underreporting of trauma in prisons

Reporting of trauma is influenced by the culture of mistrust in prison environments. Confidentiality does not fully extend to clinical staff working in prisons. Limits on confidentiality include knowledge of escape plans, contraband or knowledge of the introduction of contraband, and knowledge of intent to commit a crime, in addition to the limits that apply to all clients (Bartol & Bartol, 2008). Inmates may not trust clinical staff with disclosure of their trauma histories (Grella & Greenwell, 2007). They may also consider any disclosure of trauma that was perpetrated by intimate partners or family members as "ratting them out" to the authorities, a violation of social codes both in and outside of prison.

Both males and female may under-report sexual violence and symptoms of sexual trauma, even to researchers, either because they do not consider them to be out of the ordinary (Moses, Reed, Mazelis & Glover, 2003), or because of guilt and self-blame, or, especially for males, a sense of shame and fears about their sexual identity. Male and female inmates also learn not to report troubling psychiatric symptoms and to manage them on their own as a way to maintain a greater degree of autonomy during institutional stays and limiting vulnerability. This is especially true for male inmates with histories of past victimization, who have been shown to be at a significantly greater risk for prison sexual assault than men without such a history (Beck & Harrison, 2010; National Institute of Corrections, 2007; Testimony of Hennessey, 2005).

Inmates with any type of traumatic history may have symptoms of PTSD that increase difficulties within correctional institutions, both for the inmate, other inmates, and for staff responsible for their supervision (Saxon et al., 2001). By taking a trauma-informed approach, correctional staff gain the opportunities to minimize such concentric harm and to reduce mental health and security costs for institutions (Bloom, 2003).

"Institutional trauma" symptoms in prisons

Good correctional practice requires environments that are highly structured and safe, with predictable and consistent limits, incentives and boundaries, as well as swift and certain consequences such that inmates are treated fairly and equally (Council of State Governments, 2010). These same practices can provide the type of stability trauma survivors need to learn new information and skills that promote trauma recovery.

Vicarious trauma (a sense of identification with trauma that may result in staff experiencing trauma-type symptoms) can affect workplace decision making. Boundaries may erode and cynicism and hopelessness can increase (Headington Institute, 2010). In the absence of effective trauma-informed tools, prison systems may develop "institutional trauma," becoming highly reactive and reliant on "management-by-crisis." Inmates begin to re-enact the dynamics of their chaotic and abusive families. The more the system responds with authoritative measures, the more deeply the dynamics are repeated and reinforced. Clinical staff may spend most of their time re-stabilizing symptomatic offenders.

Staff may have experienced direct exposure to trauma from witnessing prison violence, on the job injuries, 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 in numb detachment. They also have important security concerns that may trump the need to focus on trauma, making organizational and cultural change exceedingly slow. For example, there is empirical evidence that criminal sanctions and authoritative and punitive measures, without treatment, are the least effective means of reducing future criminal behavior (Andrews et al., 1990; Landenberger & Lipsey, 2005). Treatment and rehabilitation are more likely to be a successful means of reducing recidivism than surveillance and enforcement (Gendreau, Goggin, Cullen & Andrews, 2000; Latessa, Cullen & Gendreau, 2002). Yet security staff may be reluctant to reduce the use of sanctions and surveillance when they perceive these as critical enforcement tools. Trauma-informed principles such as increasing empathy, compassionate care, grounding, and de-escalation may be perceived as "weak," "pandering," or "ineffective" and risky, even though, ironically, they may be more likely to help to create security and a stable environment.

Even experienced staff who have developed good capacities to respond well to traumatized inmates typically lack formal training, and may be subject to countertransference (emotional reactivity) and burn out. Combined with the challenge of managing a system that

is perpetually under-resourced, the result is staff who may feel as overwhelmed as the inmates in their care.

Correctional staff training is starting to include more information about trauma and techniques to respond to effectively to trauma symptoms. It can be helpful to give security staff information on the nature of the clinical services available, the trauma recovery approach and the structure and goals of trauma-specific interventions (McCown, 2006). When clinical and non-clinical staff members understand their common goals, most offender interactions can focus on safety, supporting good coping skills and reinforcing treatment gains.

Gender and trauma

It is also key to recognize gender differences in how much attention is given to trauma (Gilfus, 2002; Covington, 2008). Trauma is far more likely to be addressed in female than in male inmates. In male facilities, correctional officers must deal with large numbers of violent offenders.

Females and Trauma	Males and Trauma
● Typical trauma: childhood sexual abuse	● Typical trauma: witnessing violence
● More likely to develop PTSD when exposed to violence	● More likely to be exposed to violence, but less likely to develop PTSD
● Repeated exposure to sexual and violent victimization from intimates beginning in childhood	● Exposure to violence from strangers and adversaries; sexual abuse and coercion outside family
● Internalizing: self-harm, eating disorders, addiction, avoidance	● Externalizing: violence, substance abuse, crime and hyper-arousal
● Likely to get mental health treatment rather than substance abuse treatment	● Likely to get substance abuse treatment rather than mental health treatment
● Treatment needs to emphasize empowerment, emotion regulation and safety	● Treatment needs to emphasize feelings, relationships and empathy

Although training on gender specific issues is of critical importance, educating officers on both male and female trauma at the same time has several advantages. Staff may better engage the material and gain a deeper

understanding of both the differences and commonalities of male and female reactions to trauma. When staff is familiar with gendered responses, they are better prepared to deal with a range of reactions, whether an inmate's response is characteristically masculine or feminine. (Battle et al., 2002; Fallot, 2008; Henigsberg, Folnegović-Šmalc & Moro, 2001; Merwin, Rosenthal & Coffey, 2009; Sarchiaponea et al., 2008; Southwick et al., 1995; Wolff et al., 2010). The exploration of male trauma dynamics and trauma recovery can evoke compassion, curiosity and capture the attention of male staff. When examples, exercises and role plays include scenarios that men can relate to, TICC can begin to be understood as a safety issue rather than the "abuse excuse" or something that only applies to female offenders.

How to be heard when training prison staff

Correctional officers tend to respect experience rather than research. The most effective tool for developing in-service training is ensuring that seasoned correctional officers and other staff take a lead role. Despite limited resources, fears for their own safety, vicarious trauma, and conflict between enforcement responsibilities and compassion, many officers have developed effective approaches. It is important to reinforce staff intuition and compassion and to recognize and build on strategies that have been successful before introducing new information and skills. Shift commanders and chiefs of security should assist with training content and be visible as co-trainers and in role plays and demonstrations. Training that highlights stress management, self-care and remedies for burn out tends to engage more experienced staff.

Three essential training elements and examples are listed below (and more resources for training and information appear at the end of this article).

What's in it for me to use TICC?

● Controlling costs of healthcare, close custody and staff turnover
● Controlling the high cost of secure mental health housing units
● Reducing seclusion and restraint and de-escalating critical incidents
● Effective behavior management, safer facilities and job satisfaction

Group exercises relevant to TICC

● Trauma-related symptoms, behaviors, adaptations and their function
● Grounding role plays and demonstrations
● Practicing verbal trauma de-escalation prompts

216 ● Demonstrating talking inmates through pat downs
217 and searches
218 ● Redirecting offenders and inmates who bring up
219 trauma details

Incorporating the voice of trauma survivors

221 ● Panels of veterans in trauma recovery
222 ● Videos and films of stories of trauma healing
223 ● Stories of offenders overcoming victimization
224 ● Signs of vicarious trauma, supporting co-workers

225 The best training approaches include buy-in from security
226 and administration, skill demonstration and rehearsal,
227 and establishing a human connection to trauma.
228 A caveat, however, is that inmate stories and films
229 that speak to healing from the effects of trauma are
230 well-received, but details of extreme and horrifying
231 experiences are not a desirable training tool. The
232 principle, "headlines, not details" is apt (i.e., trauma
233 can be mentioned as a phrase, such as "child abuse,"
234 "rape," etc., but there is no need to ever go into details of
235 trauma). This helps to reduce vicarious trauma and
236 triggering of staff's own personal trauma memories.
237 Also, by modeling this in training, staff can then
238 implement this approach with inmates. Setting ground
239 rules for keeping details of traumatic experiences to a
240 minimum to avoid triggering effects is essential. This can
241 be approached as a means of ensuring safety and
242 supporting self-care for both security staff and inmates,
243 while clinical staff members perfect their skill at redirect-
244 ing group members and reinforcing boundaries.

Relevance of present-focused, cognitive-behavioral approaches

247 The effectiveness of cognitive-behavior interventions, or
248 CBI, in prisons is well documented in the correctional
249 literature (Andrews & Bonta, 2003). Prison systems have
250 developed policy and procedure manuals mandating their
251 use (CBI Standard Operating Procedures, 2001). The
252 National Institute of Corrections supports training in
253 several evidenced-based curricula on restructuring crim-
254 inal thinking and developing pro-social coping skills.
255 Features that make them the approach of choice for
256 working with prisoners are that they can be facilitated by
257 correctional staff and that they target observable beha-
258 viors (Van Voohris, Branwell & Lester, 2009). Moreover,
259 meta-analyses have consistently shown cognitive-
260 behavioral interventions to be effective at reducing not
261 only offender recidivism, but also substance use and
262 mental health problems (Andrews et al., 1990; Clark,
263 2010; Landenberger & Lipsey, 2005).

264 Unlike medical care and mental health services,
265 rehabilitation programming, is driven by a risk assess-
266 ment that measures factors associated with re-offending,

rather than clinical diagnoses. These factors are known as
criminogenic risks (Andrews, Bonta & Hoge, 1990).
Rehabilitation programs are aimed at correcting criminal
thinking, with a focus on changing present-day and
future behavior; hence, increasing public safety.

Substance abuse, criminal thinking and anti-social
personal attitudes and characteristics, such as impulsive-
ness, anger, and hostility are among the major risk factors
for recidivism (Andrews, Bonta & Hoge, 1990). For
women, substance abuse has been identified as a key
driver of increasing rates of incarceration (Grella &
Greenwall, 2007) and substance involvement is the
primary reason they return to prison (MacDonald,
2008). Additional women's recidivism risk factors include
mental health symptoms and past trauma and abuse (Van
Voorhis, Salisbury, Wright & Bauman, 2008).

Although clinical staff may regard prison as an unsafe
environment for clinical work that addresses trauma, the
potential benefits of implementing trauma-specific inter-
ventions may be substantial. Since childhood physical
and sexual abuse is associated both with institutional
difficulties and low program engagement, prisoners may
have difficulty benefiting from even the most effective
cognitive-behavioral rehabilitation programming until
the impact of childhood trauma is addressed (Brennen,
2007; Covington, 2008; Gilfus, 2002; Hubbard, 2002;
Komarovskaya, 2009; Van Voorhis et al., 2008). Prison
can also be a golden "teachable moment" in that the
inmate's incarceration may heighten awareness of needing
new coping skills and addressing trauma impact. It also
provides a time apart from outside life on the streets and
undermining influences that can distract or derail them
from a recovery focus.

Trauma-specific interventions that fit prison settings

As correctional policy shifts its focus to decreasing
recidivism, the advantages of evidenced-based counseling
approaches are becoming more apparent to prison
administrators (Taxman, 1999). The use of present-
focused, cognitive-behavioral, and coping skills treat-
ments with strong educational components have helped
stabilize inmates with PTSD and substance abuse pro-
blems (Zlotnick et al., 2003; Gillece, 2001). These
approaches tend to be compatible with the correctional
culture of responsibility, consistency, accountability and
behavioral change, and are relevant to a range of trauma
impacts (e.g., substance abuse, depression) and a variety
of new coping skills that promote rehabilitation.

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). By addressing
trauma in terms of current impact, symptoms, related

problems (e.g., substance abuse), building psychoeducation, and increasing safe coping skills, such a model can address trauma directly but without requiring the client to explore distressing memories. This ''best of both worlds'' approach (targeting trauma and related impacts, but in present-focused safe ways) can be ideal in prison settings. Past-focused models, such as exposure therapy (Foa, Hembree & Rothbaum, 2007), may be evidence-based models for PTSD, but have a real risk of emotionally destabilizing inmates who are already vulnerable. The security response to such destabilization can set the cycle of re-traumatization in motion. In the current climate, prison environments are likely best suited to present-focused approaches, given the unmet need for more mental health training, staffing limitations, and the typical lack of funding for additional formally trained and supervised staff required for past-focused PTSD treatments such as exposure therapy. Past-focused therapies may never be embraced as safe by staff, nor are all inmates likely to acquire the requisite level of readiness and trust of prison clinical staff to benefit from them. Present-focused approaches such as Seeking Safety can be done by a far broader range of staff, do not necessarily require formal training, are extremely low-cost to implement, and are known to be safe.

TICC is possible in prison settings

There is sometimes great reluctance to open the trauma ''can of worms'' given the prison environment and the limited clinical resources available. Yet, trauma-informed correctional care and staff training can go a long way toward creating an environment conducive to rehabilitation and staff and institutional safety. Trauma-informed principles are helpful regardless of whether the institution chooses to make trauma-specific clinical intervention available to inmates. However, it can be noted that trauma-specific interventions have been found to be more powerful than trauma-informed interventions (Morrissey et al., 2005), and thus ideally making both available will result in greater success in prison settings. It is important to remember that prison staff is legally responsible for medical care for inmates and must provide appropriate treatment, including mental health services. The use of TICC can provide a contextual foundation that strengthens the prison setting to provide effective help in increasing pro-social coping skills, creating a calm and safe prison environment, reducing adverse events, and aiding staff morale, all of which can lead to better offender rehabilitation outcomes.

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References

Andrews, D. A., & Bonta, J. (2003). *The psychology of criminal conduct* (3rd ed.). Cincinnati, OH: Anderson.

Andrews, D. A., Dowden, C., & Gendreau P. (1999). *Clinically relevant and psychologically informed approaches to reduced re-offending: A meta-analytic study of human service, risk, need responsivity and other concerns in justice contexts.* Carelton University, Ottawa, Canada.

Andrews, D. A., Bonta, J., & Hoge, R. D. (1990). Classification for effective rehabilitation: Rediscovering psychology. *Criminal Justice and Behavior, 17,* 19–52.

Andrews, D. A., Zinger, I., Hoge, R. D., Bonta, J., Gendreau, P., & Cullen, F. T. (1990). Does correctional treatment work? A psychologically informed meta-analysis. *Criminology, 28*(3), 369–404.

Bartol, C. R., & Bartol, A. M. (2008). *Current perspectives in forensic psychology and criminal behavior.* Thousand Oaks, CA: Sage Publications.

Battle, C., Zlotnick, C., Najavits, L. M., Gutierrez, M., & Winsor, C. (2002). Posttraumatic stress disorder and substance use disorder among incarcerated women. In P. Ouimette & P. J. Brown (Eds.), *Trauma and substance abuse: Causes, consequences, and treatment of comorbid disorders* (pp. 209–226). Washington, DC: American Psychological Association Press.

Beck, A. J., & Harrison, P. M. (2010). *Sexual victimization ion state and federal prisons, reported by inmates 2009.* Washington, DC: US Department of Justice, Office of Justice Programs, National Institute of Justice, Bureau of Justice Statistics.

Blackburn, A., Mullings, J., & Marquart, J. (2008). Sexual assault in prisons and beyond: Toward and understanding of lifetime sexual assault among incarcerated women. *The Prison Journal, 88*(32), 351–377.

Brennen, T. (2007). *Institutional assessment and classification of women offenders: from robust beauty to person-centered assessment.* Northpointe Institute: Boulder.

Blanche, A. (2003). *Developing trauma-informed behavioral health systems.* Report from NTAC's National Experts Meeting on Trauma and Violence August 5–6, 2002 Alexandria, VA National Technical Assistance Center for State Mental Health Planning, National Association of State Mental Health Program Directors.

Bloom, B. (2003). *Gender-responsive strategies: Research, practice, and guiding principles for women offenders.* Washington, DC: National Institute of Corrections. Sponsored by. Grant no. NIC-99D03GIL4 NIC-00D03GIL4 NIC-01D03GIL4.

Bloom, S., & Farragher, B. (2011). Destroying sanctuary: the crisis in human service delivery systems. New York: Oxford University.

Bureau of Justice Statistics. (1999). *Prior abuse reported by inmates and probationers.* US Department of Justice, Washington, DC.

Bureau of Justice Statistics. (2009). *National crime victimization survey: criminal victimization, 2008.* US Department of Justice, Washington, DC.

Center for Mental Health Services. (2005). *Roadmap to seclusion and restraint free mental health services.* DHHS Pub. No. (SMA) 05-4055. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

Clark, P. (2010). Preventing future crime with cognitive behavioral therapy. *Nation Institute of Justice Journal*, *265*, 22–25 April 2010. Retrieved August 30, 2011 https://www.ncjrs.gov/pdffiles1/nij/229882.pdf

Clements-Nolle, K., Wolden, M., & Bargmann-Losche, J. (2009). Childhood trauma and risk for past and future suicide attempts among women in prison. *Women's Health Issues, 19*(3), 185–192.

Cognitive Behavioral Interventions CBI Standard Operating Procedures. (2001). The North Carolina Department of Corrections. NC DOC OFFICE OF RESEARCH AND PLANNING. Retrieved from: http://www.doc.state.nc.us/rap/CBI_SOP.pdf

Commonwealth of Massachusetts (2005). Executive Office of Public Safety Department of Corrections. Governor's Commission on Corrections Reform (2005). Dedicated External Female Offender Review. Boston, MA. Retrieved August 30, 2011 from: http://www.mass.gov/eopss/docs/doc/research-reports/gccr-13-review-final.pdf

Council of State Governments. (2010). *Understanding the Second Chance Act*. Adult and Juvenile State and Local Reentry Demonstration Project Grants (Section 101). The National Resource and Re-entry Center. Retrieved 1 September, 2010, from: http://www.nationalreentryresourcecenter.org/documents/0000/0491/Understanding_Section_101.pdf

Council of State Governments. (2005). *Violence against women with mental illness*. Consensus Project. Justice Center of the Council of State Governments, Washington DC.

Covington, S. (2008). Women and addiction: A trauma-informed approach. *Journal of Psychoactive Drugs, 165*(1), 187–192.

Fallot, R. (2008). Men and trauma: Paths to recovery. Power Point Presentation. 6th Annual Conference on Co-occurring Disorders. Long Beach, California, February 8, 2008.

Foa, E., Hembree, E., & Rothbaum, B. (2007). Prolonged Exposure Therapy for PTSD: Emotional Processing of Traumatic Experiences, Therapist Guide. New York: Oxford University Press.

Fondacaro, K. M., Holt, J. C., & Powell, T. A. (1999). Psychological impact of childhood sexual abuse on male inmates: The importance of perception. *Child Abuse & Neglect, 23*(4), 361–369.

Freedman, D., & Hemenway, D. (2005). Precursors of lethal violence: A death row sample. In Bruce A. Arrigo & Stacey L. Shipley (Eds.), *Introduction to Forensic psychology*, 2E: *Issues and controversies in law enforcement and corrections* (pp. 423–428). Elsevier: St. Louis, MO.

Gendreau, P., Goggin, C., Cullen, F. T., & Andrews, D. A. (2000). The effects of community sanctions and incarceration on recidivism. *Forum on Corrections Research 12*(2), 10–13.

Gilfus, M. E. (2002, December). Women's experiences of abuse as a risk factor for incarceration. Harrisburg, PA: Pennsylvania Coalition Against Domestic Violence. From National Electronic Network on Violence Against Women, http://www.vawnet.org

Gillece, J. (2001). *Understanding the prevalence and effect of trauma in the lives of those in our care*. Presented to the National Association of State Mental Health Program Directors, National Technical Assistance Center, Washington DC.

Grella, C. E., & Greenwell, L. (2007). Treatment needs and completion of community-based aftercare among substance-abusing women offenders. *Women's Health Issues, 17*(4), 244–255.

Hackett, M. (2009). Commentary: Trauma and female inmates: Why is witnessing more traumatic? *Journal of the American Academy Psychiatry Law, 37*(3), 310–315.

Harris, M., & Fallot, R. D. (2001). *Using trauma theory to design service systems*. San Francisco, CA: Jossey-Bass.

Headington Institiue. (2010). Pearlman, L. A. and Lisa McKay, Understanding and Addressing Vicarious Trauma. Retrieved from: http://www.headington-institute.org/Portals/32/resources/How_to_Cope_with_Vicarious_Trauma_4-11.pdf

Henigsberg, N., Folnegoviæ-Šmalc, V., & Moro, I. (2001). Stressor characteristics and post-traumatic stress disorder symptom dimensions in war victims. *Croatian Medical Journal*, 42, 543–550.

Hubbard, D. J. (2002). Cognitive-behavioral treatment: An analysis of gender and other responsivity characteristics and their effects on success in offender rehabilitation. A dissertation submitted to the Division of Research and Advanced Studies of the University of Cincinnati In partial fulfillment of the requirements for the degree of Doctorate of Philosophy (Ph.D.) in the Division of Criminal Justice of the College of Education.

Hodes, G. R. (2006). *Responding to childhood trauma: The promise and practice of trauma informed care*. Pennsylvania Office of Mental Health and Substance Abuse Services.

Johnson R. J., Ross M. W., Taylor W. C., Williams M. L., Carjaval, R. I., & Peters, R. J. (2006). Prevalence of childhood sexual abuse among incarcerated males in county jail. *Child Abuse and Neglect, 30*, 75–86.

Komarovskaya, I. (2009). Trauma, PTSD, and the cycle of violence among incarcerated men and women. A Dissertation presented to the faculty of the Curry School of Education University of Virginia in partial fulfillment of the requirements for the degree Doctor of Philosophy by M.Ed. August, 2009.

Landenberger, N. A., & Lipsey, M. W. (2005). The positive effects of cognitive–behavioral programs for offenders: A meta-analysis of factors associated with effective treatment. *J. Exp. Criminol, 1*, 451–476.

Latessa, E. J., Cullen, F. T., & Gendreau, P. (2002). Beyond correctional quackery: Professionalism and the possibility of effective treatment. *Federal Probation, 66*, 43–49.

Loper, A. B. (2002). Adjustment to prison of women convicted of possession, trafficking, and non-drug offenses. *Journal of Drug Issues, 32,* 1033–1050.

McCown, A. (2006, April). *After the crisis initiative: healing from trauma after disasters*. In Resource Paper, criminal justice systems issues and response in times of disaster. Presented at the After the crisis: Healing from trauma after disasters, Expert Panel Meeting, Bethesda, MD.

Merwin, R., Rosenthal, M., & Coffey, K. (2009). Experiential Avoidance Mediates the Relationship Between Sexual Victimization and Psychological Symptoms: Replicating Findings with an Ethnically Diverse Sample. *Cognitive Therapy and Research*, *33*(5), 537–542.

Morrissey, J., Jackson, E., Ellis, A., Amaro, H., Brown, V., & Najavits L. (2005). Twelve-month outcomes of trauma-informed interventions for women with co-occurring disorders. *Psychiatric Services* 56: 1213–1222.

Moses, D. J., Reed, B. G., Mazelis R., & D'Ambrosio, B. (2003). *Creating trauma services for women with co-occurring disorders: Experiences from the SAMHSA women with alcohol, drug abuse and mental health disorders who have histories of violence study*. WCDVS, Delmar, New.

Najavits, L. M. (1997). Psychotherapists' implicit theories of psychotherapy. *Journal of Psychotherapy Integration*, 7, 1–16.

Najavits, L. M. (2002). *Seeking safety: A treatment manual for PTSD and substance abuse*. New York: Guilford Press.

Najavits, L. M. (2006). Managing trauma reactions in intensive addiction treatment environments. *Journal of Chemical Dependency Treatment, 8*, 153–161.

National Institute of Corrections. (2007). *Report to the Congress of the United States on activities of the Department of Justice in relation to the Prison Rape Elimination Act (Public Law 108–79)*. Washington, D.C: US Department of Justice.

National Prisons Rape Elimination Act Commission. (2009). *National standards for the detection and reporting of prison sexual assault*. Retrieved 1 September 1, 2010, from http://www.cybercemetery.unt.edu/archive/nprec/20090820154841/http://nprec.us/publication/report/

Owens, B., Wells, J., Pollock., Muscat, B., & Torres, S. (2008). *Gendered violence and safety: A contextual approach to improving*

384 *security in women's facilities*. Washington, DC: US Department
385 of Justice, Office of Justice Programs, National Institute of
386 Justice.

387 Powell, T. A., Holt, J. C., & Fondacaro, K. M. (1998). The
388 prevalence of mental illness among inmates in a rural state.
389 *Law and Human Behavior*, *21*(4), 427–437.

390 Raj, A., Rose, J., Decker, M., Rosengard, C., Hebert, M., et al.
391 (2008). Prevalence and patterns of sexual assault across the life
392 span among incarcerated women. *Violence Against Women*
393 *Volume*, *14*(5), 528–541.

394 Saakvitne, K. W. (2000). Commentary on clinical protocol. In
395 *Psychoanalytic Inquiry, 20*(2000), 249–258. Special Issue:
396 "Multimodal Treatment of Complex Dissociative Disorders."

397 Sarchiapone, M., Carli, V., Cuomo, C., Marchetti, M., & Roy, A.
398 (2009). Association between childhood trauma and aggression
399 in male prisoners. *Psychiatry Research*, *165*(1–2), 187–192.
400 Epub 2008 Oct 30.

401 Southwick, S., Morgan, C., Darnell, A., Bremner, D., Nicolaou, A.,
402 Nagy, L., & Charney, D. (1995). Trauma-related symptoms in
403 veterans of Operation Desert Storm: A 2-year follow-up.
404 *American Journal Of Psychiatry*, *152*(8), 1150–1155.

405 Saxon, A. J., Davis, T. M., Sloan, K. L., McKnight, K. M., McFall,
406 M. E., & Kivlahan, D. R. (2001). Veterans trauma, symptoms
407 of posttraumatic stress disorder, and associated problems
408 among incarcerated. *Psychiatric Services*, *52*(7), 959–964.

409 Taxman, F. S. (1999). "Proactive Supervision: Supervision as Crime
410 Prevention," *Journal of Offender Monitoring 12*(2): 25–26.

411 Testimony of Hennessey, M. (2005). *At Risk: Sexual abuse and
412 vulnerable groups behind prison bars*. (p. 276). San Francisco:
413 National Prison Rape Elimination Act Public Hearings.

414 Van Voorhis, P. (1997). Correctional classification and the respon-
415 sivity principle. *Forum on Corrections Research*, *9*(1), 46–50.

416 Van Voorhis, P., Braswell, M., & Lester, D. (2009). *Correctional
417 counseling and rehabilitation* (7th ed.). New Providence, NJ:
418 Mathew Bender and Company.

Van Voorhis, P., Salisbury, E., Wright, E., & Bauman, A. (2008).
*Achieving accurate pictures of risk and identifying gender
responsive needs: Two new assessments for women offenders*.
University of Cincinnati Center for Criminal Justice Research,
National Institute of Corrections, Washington DC.

Weeks, R., & Widom., C. S. (1999). *Early childhood victimization
among incarcerated adult male felons*. US Department of
Justice, Office of Justice Programs, National Institute of
Justice, Washington DC.

Wolff, N., Epperson, M., & Fay, S. (2010). Mental health probation
officers: Stopping justice-involvement before incarceration.
Center for Behavioral Health Services & Criminal Justice
Research, Policy Brief. Retrieved from http://www.cbhs-cjr.
rutgers.edu/pdfs/Policy_Brief_Oct_2010.pdf

Women in Prison Project. (2006). *Fact sheet: Why focus on women in
prison. Correctional Association of New York*. Retrieved 1
September, 2010, from www.correctionalassiciation.org.

Youth Violence and Suicide Prevention. (2004). *Suicide Prevention
Resource Center: Promoting mental health and preventing
suicide in college and university settings*. Newton, MA: Educa-
tion Development Center, Inc.

Zlotnick, C. (1997). Posttraumatic stress disorder (PTSD), PTSD
comorbidity, and childhood abuse among incarcerated women.
Journal of Nervous and Mental Disease, *185*(12), 761–763.

Zlotnick, C., Najavits, L. M., Rohsenow, D. J., & Johnson, D. M.
(2003). A cognitive-behavioral treatment for incarcerated
women with substance abuse disorder and posttraumatic stress
disorder: Findings from a pilot study. *Journal of Substance
Abuse Treatment, 25*, 99–10

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