

Understanding the Effects Of Trauma on Lives of Offenders

By Joan B. Gillece



The prevalence of trauma histories in incarcerated individuals is widely known. Estimates of up to 85 percent of women in the system have early experiences of physical and/or sexual abuse. The number of men who have experienced similar life-changing childhood trauma is also significant. When correctional staff and inmates alike are made aware of the correlation between traumatic experience and self-destructive behavior, facility culture changes. When certain behavior is understood as adaptive rather than attention-seeking or noncompliant, attitudes change.

Defining Trauma

What exactly is meant by the term “trauma,” and why is it so important to recognize trauma responses in both staff and individuals in custody? Trauma can be best understood as the personal experience of interpersonal violence, including sexual abuse, physical abuse, severe neglect, loss and/or the witnessing of violence, terrorism and disasters.¹

The fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* states that a person’s reaction or response to the traumatic event is a significant factor. If the experience involved intense fear, horror and helplessness, and caused extreme stress that overwhelmed the person’s capacity to cope, it is considered traumatic.

Trauma is the experience of situations or events that are shocking, terrifying and/or overwhelming resulting in intense feelings or fear, horror or helplessness. Traumatic events are interpersonal, intentional, repeated and severe, generally occurring in childhood and adolescence but also continuing over time.² When such events occur, it is understandable that trauma can shape a child’s basic belief system, identity, worldview, self-esteem and spirituality.³

Individuals with trauma histories may also become involved in self-destructive behaviors, such as substance abuse or self-harm, as a way to manage unbearable symptoms. When staff are trained to recognize these symptoms as adaptive, they manage situations differently, reducing the likelihood of their own injury and experience of violence.

Often trauma survivors have other responses to trauma that are not as easy to recognize. An individual may dissociate or appear to be “somewhere else,” which is frequently due to traumatic reminder.

Post-traumatic stress disorder, which is heard about more frequently because of the war in Iraq and returning veterans, is another response to overwhelming feelings of fear and helplessness. An individual suffering from post-traumatic stress disorder feels that the trauma is happening again. This may be called a flashback, reliving experience or abreaction. This can occur in the form of nightmares or intrusive thoughts.⁴

Trauma-based Intervention

When one looks at past experiences of individuals in the criminal justice system and understands how trauma affects them, environments can be created that lessen the likelihood of retraumatization and assist individuals in finding the capacities to self-regulate. The traumatic past is not an excuse, but an explanation. Helping officers and inmates understand the excruciating affect of violence only enhances relationships that are respectful and nonharmful.

Although only a recent emerging intervention in corrections, several states have experienced positive results upon implementation of trauma-based principles and interventions. Maryland’s Department of Health and Mental Hygiene, Maryland Correctional Administrators Association, local detention centers and core services agencies have been at the forefront of such innovation. Growing out of a project funded in 1997 by a Substance Abuse Mental Health Services Administration (SAMHSA) grant program, Maryland’s Phoenix Project served women exclusively. The lessons learned from the evaluation completed by the University of Maryland Department of Psychiatry changed the course of direction for partnership across agencies. The following findings moved both mental health and correctional systems to explore the effects of trauma on the lives of women in the criminal justice system.

The participants in the Phoenix program reported the following:

- 68 percent grew up in a household where one or both parents were actively abusing alcohol, drugs or both;
- 24 percent had a parent with a diagnosed serious mental illness;
- 51 percent experienced childhood sexual abuse by a family member or other outside trusted individual prior to age 14;

- 43 percent were victims of physical abuse prior to age 14;
- 59 percent reported using alcohol by age 14 and 44 percent had begun smoking marijuana by this age;
- 57 percent had become pregnant by age 17;
- 74 percent had their first psychiatric diagnoses by age 18;
- 34 percent had made a serious suicide attempt by age 18; and
- 27 percent had been arrested at least once by age 18.

The Phoenix program was designed to bring parity to women’s services, but instead, the need for gender-specific trauma-informed services emerged as a critical next step.

The program, named TAMAR, began in three detention centers across Maryland. The name was selected for several reasons: Tamar was the daughter of King David. She was raped by her half-brother, Amnon. She ripped her clothes following the attack and retreated to her brother Absalom’s house. Tamar was never mentioned in the Bible again. The program proposed a different outcome for the Tamars of today. TAMAR is also an acronym for Trauma, Addiction, Mental health And Recovery.

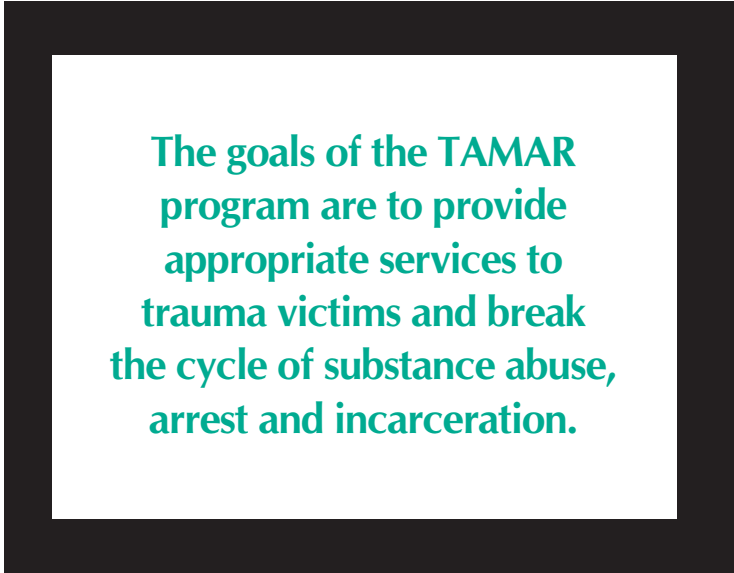
Program Components

In preparing for implementation, Maryland’s Mental Hygiene Administration contracted with the Sidran Institute to develop training for all staff on trauma, and the newly funded program designed to address it. All community providers were trained in trauma, and treatment staff were cross-trained by correctional officers on custody and security issues critical in

the detention setting. The initial three facilities required all staff, including dietary, administration and maintenance staff, to participate in trauma training. Basic training provided by the Sidran Institute included:

- Prevalence of abuse among inmates and probationers;
- Understanding what trauma is and how it affects inmates and staff;
- What behaviors to look for;
- Avoiding burnout; and
- Vicarious traumatization.

The goals of the TAMAR program are to provide appropriate services to trauma victims and break the cycle of substance abuse, arrest and incarceration. The program also was designed to help officers reduce the likelihood of injury. Officers were trained to look for symptoms and to take precautions to not retraumatize. Trauma survivors are



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frequently hypervigilant and in a state of hyperarousal. Telling an individual what is going to happen during the pat-down, for example, and warning where hands will be placed greatly reduces the anxiety and sometimes aggressive response from inmates. Officers also had the opportunity to talk about their own feelings of working in frequently violent situations or feeling disrespected and stressed. The TAMAR program promotes respect in all aspects of facility operations.

In addition to training all staff, the grant dollars provided for the hiring of a trauma specialist for each facility. At intake, the officer provided women with a brief assessment and brochure about the program. Participation in TAMAR is voluntary and no good time is accrued for participation. The initial assessment was carefully developed to avoid self-disclosure. The intent was to offer an evaluation, if desired, and invitation to participate in the program. Upon intake, the following questions are asked:

- Are you haunted by terrible things that happened in your past (distressing dreams or flashbacks)?
- Have you experienced, witnessed or been confronted with events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others?
- Do you have periods of time in your life that you cannot remember that are not because of substance abuse?

The form is confidential and placed in a sealed envelope and forwarded to the trauma specialist, who in turn meets with the individual, conducts a free assessment, explains the TAMAR program and invites her participation.

The TAMAR program provides 15 group sessions that meet for 90 minutes usually twice a week. The program is a compilation of work developed by national trauma experts such as psychologist Maxine Harris and art therapist Anita Rankin as well as the staff training developed by the Sidran Institute. The groups are designed to provide participants with necessary techniques to self-soothe and self-regulate. The 15 TAMAR modules incorporate psychodynamic therapy with expressive art therapy and psycho-educational techniques.

The 15 modules include:

1. **What is trauma?** This module is designed to help inmates become aware of how trauma has impacted their lives.
2. **What is physical abuse?** Many individuals served through TAMAR did not understand that what happened to them was not normal. Frequently, group members reported that they just thought the abuse was normal.
3. **What is sexual abuse?** This session is dedicated to recognizing how sexual abuse has impacted their lives.
4. **Trauma and addiction.** The goal is to start to connect the dots between addictive/compulsive behaviors and coping mechanisms to deal with trauma. The realization that using could be self-medicating

explains a great deal and begins the process of gaining insight.

5. **Facts on HIV/AIDS.** The risky sexual behaviors and the too common assaults and rapes clearly pose a public health concern. Many group members are misinformed or just uninformed about HIV transmission.
6. **Sexual communication and negotiation skills.** This module includes discussion about what constitutes sexual communication, both verbal and nonverbal, as well as role-playing on negotiation skills such as practicing how to refuse unsafe sex.
7. **Containment.** This session helps members understand memory and increase self-awareness.
8. **Containment II – Grounding.** A critical part of self-regulation is the ability to calm oneself when triggers occur. Grounding techniques are practiced.
9. **Tolerating distress.** All of the problems that occur when one is unable to tolerate distress are discussed. Members are encouraged to use grounding techniques when they experience stress.
10. **Self-soothing.** Each group member will be able to identify a healthy replacement for previous self-destructive methods of self-comfort.
11. **Boundaries and safety.** The group discusses how much control they have over what happens to their bodies. Boundary exercises (physical and verbal) are practiced.
12. **Trust and intimacy.** Trauma and inability to trust frequently go hand-in-hand. Barriers that inhibit ability to trust are explored.
13. **Parenting discussion.** How trauma effects attachment as well as how trauma, substance abuse and mental health issues have affected their parenting choices and ability to parent are explored.
14. **Life story.** If desired, members are given the opportunity to share their life story with the group. This session allows members to understand how trauma has impacted so many aspects of their lives.
15. **Closing ritual.** This final session provides members with a sense of completion and healthy closure.

Positive Outcomes

Although TAMAR began as a program for women, it has expanded to serve men in three Maryland facilities, with continuation into the community in some locations. In addition, several detention facilities in Ohio and the women's correctional facility in Rhode Island have trained staff in trauma and all are conducting TAMAR groups.

In Rhode Island, following officer training, a group of officers volunteered and were trained as co-facilitators of the TAMAR groups. A.T. Wall, director of the Rhode Island Department of Corrections, reports, "Staff said trauma training greatly raised their awareness of the role of trauma in offender behavior and provided them with insights to enhance their management of inmates with trauma histories." Carole Dwyer, warden of Rhode Island's women's facility, met with female inmates following graduation of the first TAMAR group in her facility. The women said the program "helped them to identify those behaviors that

were trauma related and to recognize why they act/react as they did. It was their opinion that participation assisted them in de-escalating and controlling their behavior.”

Officer Paula Kane, director of programs for the Dorchester County (Maryland) Department of Corrections, states, “The results of the TAMAR program have made a huge difference in our facility. The take-downs, lockdowns and incidents on the women’s units are nearly nonexistent, which was not the case several years ago.” The benefits to the participants include:

- Physical symptoms of post-traumatic stress disorder are within manageable limits;
- Offenders are able to bear feelings associated with traumatic memories;
- Memories of trauma are linked with feelings;
- Damaged self-esteem is restored; and
- Important relationships have been re-established.

The benefits to the officers have included a calmer work environment, significant reduction in incidents and a feeling of making a difference in peoples’ lives. The program has significantly reduced disciplinary action, reduced recidivism, reduced the use of seclusion and restraints, and promoted connection and trusting relationships. According to Steve Williams, recently retired warden of the Dorchester County Detention Center, “TAMAR was the most important program I ever implemented. I cannot

imagine operating a facility without it. My officers were on board from Day 1 and are firm believers in the benefits of the trauma program. It is the best management tool I have experienced.”

ENDNOTES

¹ NASMHPD. 2004. *NASMHPD/NTAC e-report on recovery*. Available at www.nasmhpd.org/spec_e-report_fall04websites.cfm.

² Giller, E. 2003. What is psychological trauma? *Sidran Institute*. Retrieved May 27, 2005, from www.sidran.org.

³ Pearlman, L. and K. Saakvitne. 1995. *Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors*. New York: W.W. Norton & Co.

⁴ Sidran Institute. 2000. *What is post-traumatic stress disorder?* Available at www.sidran.org/sub.cfm?contentID=76§ionid=4.

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