

The Brain Behind Bars:

Perspectives on Injury and Aggression

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Although they remain limited in number, scientific studies are beginning to confirm what many correctional practitioners have suspected all along — there are elevated rates of Traumatic Brain Injury (TBI) among offenders when compared to individuals in the community. In general, TBI can range in severity from “mild” to “severe” and typically results from a jolt, blow or penetration of the head that disrupts the function of the brain. Individuals who experience multiple head injuries, even with no alterations in consciousness, may have cognitive deficits as severe as someone who has had only one TBI with an alteration in consciousness. As prison populations across the country grow, there is a need for greater understanding of the health and mental health needs that such injuries create. Offenders often come from poverty situations where health care options are limited. They are likely to have used illegal substances and engaged in activities that put them at risk of injury, both from unintentional and intentional sources. These factors combine to place the offender population at particularly high risk of TBI.

Of particular relevance to correctional administrators, is evidence suggesting that such deficits and injuries may play a role in violent or disruptive behavior by reducing impulse control and increasing aggressive tendencies. TBI may result in hidden and/or obvious, short- and/or long-term behavioral symptoms such as emotional dyscontrol; changes in mood and in cognitive and motor abilities; and difficulties in planning, goal-setting and impulse control. If left unmanaged, these may lead to difficulties in adjustment to prison life and may make successful reintegration into the community less likely. This is an obvious area of concern for correctional systems that are responsible for the safety, security, management and treatment of offenders as well as the safety of staff at their facilities.

In terms of research, the existing literature in the field points to a demand for more targeted studies of neuropsychological impairment and TBI among offender populations. Similar to studies with community samples, TBI and the severity of TBI has been variously defined and measured in offender populations. To date, most offender-based studies of TBI have relied upon self-report that attempts to configure offender recall of injuries and subsequent symptoms onto standard definitions of TBI severity. Unfortunately, most studies of TBI in corrections have not used similar instrumentation and their sample sizes have been small and/or focused on limited offender sub-populations (e.g., domestic violence perpetrators). Recently, however, work

has focused on developing valid and reliable ways to assess TBI in the entire offender population. This should make it possible to enter the next phase of research in the area — documenting the number of individuals in corrections with TBI, pinpointing the core cognitive deficits experienced by this group, and identifying the impact of comorbid conditions, such as substance abuse and serious mental illness, on behavioral and cognitive functions both in and out of prison. This type of knowledge will allow offenders with TBI to be assigned to appropriate treatment and will facilitate the development of targeted management programs and techniques during incarceration.

In terms of correctional practice, it is important to note that several common problems related to TBI (attention and memory deficits, irritability, and anger) often respond well to standard correctional management and communication techniques. For example, being calm and direct in communications, avoiding arguments, and trying to rephrase problems, rules and work-detail instructions by breaking them down into smaller parts and explaining them slowly and step-by-step are all effective TBI management strategies. In addition, helping offenders ask questions when something is not understood and encouraging them to write down steps for a task or the schedule for their day can also be helpful.

Ultimately, training corrections professionals will serve as the bridge between the emerging TBI science and

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operational practices within corrections. This would include raising consciousness of the term TBI and the standard correctional management strategies that can be effective with this type of problem. As the science mounts, training for implementation of routine TBI screening can be developed for health and mental health staff and a more detailed consideration can be given to the co-occurrence of substance abuse disorders and TBI. In all, there remains much work to be done to solidify the working relationship between public health and public safety that the problem of TBI in corrections represents.

FURTHER RESOURCES

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