Annotated Bibliography

Trauma

National Institute of Corrections

Trauma
Annotated Bibliography

Prepared by the NIC Information Center
August 2014
Accession No. 028314

An electronic copy of this document can be found at: *www.nicic.gov/Library/028314*

Contents

Introduction

This bibliography attempts to offer a compilation of information on trauma-informed care by reviewing general information about trauma as well as focusing on the criminal justice system and corrections (women, adults, and younger people), peer support, and screening/assessment for trauma. In addition, definitions of many of these tools are provided. We invite contributions to this list, as well as additions submitted material to the NIC Library, such as articles and training resources.

We are confident you can obtain these resources either through the Internet, the authors, by ordering them, or by contacting the NIC Information Center at *info@nicic.gov*.

Trauma-Informed Care – General

Cain, Laura. *Healing Neen.* Elliott City, MD: In the Hollow Films, 2010.
> "Healing Neen takes viewers on a journey to places and subjects that most find too difficult or uncomfortable to fathom. But it is Tonier "Neen" Cain's joyous spirit and astonishing inner-strength that leaps through the screen directly into viewers hearts, inspiring renewed hope and compassion for those still living on the fringes. For two decades, Neen hustled on the streets of Annapolis, Maryland, desperately feeding an insatiable crack addiction and racking up 83 arrests along the way. Rapes and beatings were a routine part of life; home was underneath a bridge or inside the locked cage of a prison. In 2004, pregnant and incarcerated for violation of parole, she was provided the opportunity to go to a community trauma, mental health and addictions program. Feeling safe for the first time in her life, Neen confronted the haunting childhood memories that she tried to numb with drugs: filth and chronic hunger, sexual assaults by neighborhood men, routine physical and mental abuse dished out by her drunken mother. Realizing for the first time that she had been a victim, she began to heal and reclaim power over her life, embarking on a remarkable "upward spiral," that has no limit. Today, she works for the National Center for Trauma-Informed Care, dedicating her life to being a voice for those still lost and still silent. Traveling the country to give speeches and work one on one with women in prisons and hospitals, Neen continues to transform her own life while helping others to embrace her motto "where there's breath, there's hope"".
> *http://vimeo.com/15851924*

Covington, Stephanie S. *Women and Addiction: A Trauma-Informed Approach***.** La Jolla, CA:
> Stephanie Coveington, 2008.
> '[T]reatment for women's addictions is apt to be ineffective unless it acknowledges the realities of women's lives, which include the high prevalence of violence and other types of abuse. A history of being abused increases the likelihood that a woman will abuse alcohol and other drugs. This article presents the definition of and principles for gender-responsive services and the Women's Integrated Treatment (WIT) model. This model is based on three foundational theories: relational-cultural theory, addiction theory, and trauma theory. It also recommends gender-responsive, trauma-informed curricula to use for women's and girls' treatment services' (p. 377). Topics discussed in this article include: gender-responsive services 'the issue of gender, gender responsive principles, and common themes in the lives of addicted women; Women's Integrated Treatment (WIT); becoming trauma-informed; link between trauma, substance abuse and other health issues; creating programs for women and girls; and providing treatment.
> *http://www.stephaniecovington.com/articles-and-publications.php*

Ferencik, Sonia D., and Rachel Ramirez-Hammond. *Trauma-Informed Care: Best Practices and
Protocols for Ohio's Domestic Violence Programs.* Columbus: Ohio Domestic Violence Network, 2011.
> Best practices and protocols integrating trauma-informed care into domestic violence programs are described. While this manual is designed for domestic violence programs

outside of correctional settings, the content can easily be used in institutional and community based programming. Sections contained in this manual are: introduction; understanding trauma; responding to trauma survivors; trauma-informed care best practices; trauma-informed care protocols; and caring for the caregiver—understanding vicarious trauma. Appendixes provide: Trauma-Informed Care Checklist; Trauma-Informed Best Practices; Suggest Best Practices for Child Victims of Domestic Violence; Trauma-Informed Care and Strengths Based Approach; resources; and a case study.
*http://www.odvn.org/index.php?option=com_content&viewarticle&id=244%3A*trauma-informed-care-*manual*

Jennings, Ann. *Models for Developing Trauma-Informed Behavioral Health Systems and Trauma-Specific Services.* 2008.
This report is an update of the 2004 technical report describing trauma-informed and trauma-specific service models identified by state behavioral health service systems and organizations. All models in this report are designed and used specifically to address trauma in the lives of children, their parents or caregivers, and adults.
http://www.ct.gov/dmhas/lib/dmhas/trauma/TraumaModels.pdf

Mechelfelder, Mollie, and Eileen Swoboda. Trauma 101 [PPT],
http://www.traumainformedcareproject.org/resources/Trauma%20101%20Powerpoint%20Present ationV1.pdf

National Institute of Corrections' Women Offenders Topic Page. Washington, DC: NIC.
This website includes articles, monographs, videos, and links to training classes for addressing the topic of women offenders.
http://nicic.gov/WomenOffenders

Seeking Safety: A Model for Trauma and/or Substance Abuse. Newton Centre: MA: Treatment Innovations, 2013.
Seeking Safety is a therapeutic program for women suffering from trauma, substance abuse, and/or posttraumatic stress disorder (PTSD). This website provides abundant information regarding this program and trauma-informed treatment. Points of entry are: the book "Seeking Safety; outcome results from evaluations of Seeking Safety; a wide range of articles regarding the Seeking Safety model (description and implementation) and empirical studies about it, PTSD and addiction, cognitive-behavioral and other therapies, therapists and therapy, and other related articles; training; frequently asked questions (FAQ); assessment; online forum for questions, ideas, and comments on the use of Seeking Safety; and contact information.
http://www.seekingsafety.org

Stephanie Covington - author and provider of training on the topic of trauma
Dr. Covington offers a variety of trainings and workshops to administrators, clinicians, counselors and other staff who work with women and girls in private, public, and criminal justice settings.

http://www.stephaniecovington.com/t_trauma.php

Transforming Trauma: Implementation of Policies and Promising Practices: Women and Trauma Federal Partners Roundtable II 2010. Washington, DC: Woman and Trauma Federal Partners Committee, 2010.

> "The meeting will catalyze dialogue, strengthen collaboration among federal partners, and increase commitment to support policies and programs which are trauma-informed and promote trauma recovery and resiliency, as well as the health and well-being of women and girls." The objectives of this roundtable are: identify promising practices, gaps, and policy implications that address trauma in the lives of women and girls; expand the dialogue, knowledge base, and opportunities for collaboration among Federal Partners and stakeholders; continue to advance systems change that was initiated by Roundtable I, held in April 2010; and emphasize a multi-systems approach to address awareness, prevention, appropriate assessment, intervention, treatment, education, outreach, and sustainability. This CD contains background material for the participants and some presentation overheads.

Woll, Pamela. *A Strength-based Approach Toward Trauma-informed Treatment and Recovery Support for Women.* Plymouth: Michigan Institute for Prevention and Treatment Education (MI-PTE), 2011.

> "The following notes were compiled by Pam Woll as a post-session handout for this workshop. They were gathered from a number of sources. Wherever a large cluster of information came from the same document, that document is listed. The other elements are synthesized together, so that they can be presented in logical order" (p. 1). This document is a great overview of the issues involved in treating trauma affected women. Its ideas can easily be used in correctional settings to address the needs of female offenders. Sections of these notes are: thought bites; random statistics about women and trauma; post-trauma responses (posttraumatic stress disorder—PTSD)—stages of recovery, women's responses to trauma, and complex trauma; strength-based approaches—resilience and de-stigmatizing post-trauma response; stabilization; trauma-informed care; services for women with co-occurring disorders; and intimate partner violence and substance abuse. *http://www.mi-pte.org/sudppps2011/Woll-HandoutTraumaAndWomen.pdf*

Women and Trauma: A Working Document. Washington, DC: Federal Partners Committee on Women and Trauma, 2011.

> Individuals concerned with violence perpetrated against women and girls in our society need to read this report. A new way to address trauma in any setting, called trauma-informed care, is described, noting that it is "a way for different agencies and groups to come together around a common concern…The report provides an introduction to the key issues facing each participating agency, with statistics documenting the impact of violence against women and girls on their mission and information on how each department is responding" (p. 7-8). Sections following an executive summary include: introduction and

call to action; the importance of listening to first-hand experience; trauma as a cross-cutting issue; getting into action; and new partners and next steps.
http://nicic.gov/Library/025082

Women's Treatment Publications and Reports. Women, Children, & Families: A SAMHSA/CSAT Treatment Improvement Exchange Special Topic.
Includes: Women and Trauma: Report of the Federal Partners Committee on Women and Trauma, A Federal Intergovernmental Partnership on Mental Health Transformation, Substance Abuse Treatment for Women Offenders, Guide to Promising Practices (TAP 23), and Substance Abuse Treatment and Domestic Violence (TIP 25).
http://womenandchildren.treatment.org/more.asp?id=14

Trauma-Informed Care in the Criminal Justice System/Corrections

Addressing Trauma/National Resource Center for Justice Involved Women.
>   This website includes articles, monographs, webinars, and treatment manuals for
>   addressing trauma for justice-involved women.
>   *http://cjinvolvedwomen.org/offender-management-supervision*

Benedict, Alyssa. *Using Trauma-Informed Practices to Enhance Safety and Security in Women's Correctional Facilities.* Silver Spring, MD: National Resource Center on Justice Involved Women, 2014.
>   "In the wake of significant research on trauma and the interventions required to address it,
>   a number of correctional agencies have made efforts to increase the use of trauma-based
>   services and curricula ... This document provides a brief overview of trauma and its effects
>   on women offenders, and specifically defines trauma-informed practices for women's
>   correctional facilities.3 It also provides key actions that facility administrators, managers,
>   and staff can take to better align their operational practices with the research on trauma
>   and to create a more trauma-informed facility culture" (p. 1-2). This publication contains
>   these sections: introduction; what we know about the experience of trauma among women
>   inmates; trauma's impact on brain and body; what the prevalence of trauma among females
>   means for women's correctional institutions; what the benefits of creating a more trauma-
>   informed institutional culture are; creating a trauma-informed culture in women's
>   correctional facilities; opportunities for implementing trauma-informed practices in
>   correctional settings; eight action steps for building a trauma-informed facility culture; and
>   conclusion.
>   *http://cjinvolvedwomen.org/sites/all/documents/Using-Trauma-Informed-Practices-Apr-14.pdf*

Bible, Andrea. *Issues to Consider When Facilitating Groups with Battered Women in Jail or Prison.* Philadelphia, PA: National Clearinghouse for the Defense of Battered Women, 2011
>   "This resource is for advocates in community-based anti-domestic violence organizations
>   who are thinking of starting a group for battered women incarcerated in jail, state prison, or
>   federal prison, and for advocates currently facilitating groups in these setting. The issues
>   and topics explored have emerged from a review of writings by group facilitators, sample
>   curricula, and academic research; conversations with group facilitators; and work with
>   incarcerated women over the years. While many of the issues highlighted in this resource
>   focus on working with women in state prisons, we believe much of this information also is
>   relevant to and important for advocates facilitating groups in jails (and possibly even for
>   those working with incarcerated women in ways other than facilitating groups)" (p. 1).
>   Sections of this guide include: introduction; incarcerated women in the U.S.—a brief
>   overview; purpose and structure of group; group guidelines; jail or prison administration,
>   staff, and rules; group topics; other possible forms of advocacy or support; and conclusion.
>   *http://nicic.gov/Library/027025*

Buell, Maureen. "NIC Services in Managing Justice-Involved Women." *American Jails* 27, no. 6 (January/February 2014): 51-54.

> "Accepted policy and practice in the correctional profession have been established and implemented for the largest population, which is overwhelmingly male. That holds true for programming, facility design, assessment and classification tools, and all operations foundational to the management of an institution. . . Missed are the issues that are either unique to women or that occur with more frequency with female offenders."
> *http://community.nicic.gov/blogs/national_jail_exchange/archive/2014/02/13/nic-services-in-managing-justice-involved-women.aspx*

Creating a Trauma-Informed Criminal Justice System for Women: Why and How. Rockville, MD: GAINS Center for Behavioral Health and Justice Transformation, 2011

> "Why do far too many women keep cycling through the criminal justice system, wrestling with persistent mental health and substance abuse issues, unable to find a footing in the community and reclaim their lives?" This publication answers this question and offers a solution—the "Sequential Intercept Model." This strategy concentrates on five "intercept" points that women could have with the criminal justice system. At each point assistance is offered to these women that enable them to begin their personal restoration. The five intercept points described are: law enforcement and emergency services; arrest and initial court hearing; jails, prisons, and specialty courts; discharge planning—reentry to community from jails or prisons; and community corrections (probation or parole).
> *http://gains.prainc.com/cms-assets/documents/62753-983160.ticjforwmn.pdf*

Fournier, Angela, et al. "Investigating Trauma History and Related Psychosocial Deficits of Women in Prison: Implications for Treatment and Rehabilitation." *Women & Criminal Justice,* 21 (2011): 83-99.

> The present study was an investigation into the needs of women in prison. The purpose was to explore women's rehabilitation needs and assess whether correctional programs and policies are promoting rehabilitation. Both quantitative and qualitative data were collected for descriptive analysis. A total of 17 incarcerated women from a medium-security prison were surveyed; 11 of those inmates also agreed to be interviewed. Results indicated significant history of trauma as well as significant psychosocial deficits typically associated with trauma. Despite an apparent need for programming addressing trauma, qualitative interviews revealed a shortage of services addressing trauma victimization and institutional policies with the potential to further harm trauma survivors.

Health, Justice, Women: Transforming Systems—Changing Lives. [Satellite/Internet Broadcast] Washington, DC: National Institute of Corrections, 2013.

> This national discussion was held on August 15, 2012: Women and girls enter the criminal justice system with distinct and unique health care needs. Most are in their child bearing years, may have children, many are victims of abuse, have a mental health diagnosis, or typically exhibit more misconduct than male offenders. This complex mix of needs affects a

system's ability to work effectively as it draws upon a higher percentage of resources to care for female offenders.
http://nicic.gov/Library/026332

Gilece, Joan B. [National Association of State Mental Health Program Directors]. *Understanding the Effects of Trauma on the Lives of Offenders.*

> 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 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.
> *http://www.aca.org/fileupload/177/ahaidar/Gillece.pdf*

Gunter TD, Chibnall JT, Antoniak SK, Philibert RA, and DW Black. "Childhood Trauma, Traumatic Brain Injury, and Mental Health Disorders Associated with Suicidal Ideation and Suicide-related Behavior in a Community Corrections Sample." *Journal of American Academy of Psychiatry and the Law*, 41, no. 2 (2013): 245-55.

> Suicidal ideation and suicide-related behavior among community-supervised offenders are significant public health problems. In a sample of 418 subjects served by the community corrections office of Iowa's Sixth Judicial District, 56 percent of subjects denied suicidal ideation and suicide-related behavior (control group), 17 percent reported suicidal ideation without suicide-related behavior (ideator group), and 27 percent reported engaging in suicide-related behavior (actor group). A model comprising five independent variables differentiated the ideator and actor groups from the control group: Caucasian race, depressive symptom sum, brain injury, childhood trauma, and avoidant personality. These five factors, combined with the additional variables of PCL:SV Factor 2 (Psychopathy Checklist-Screening Version) score and lifetime anxiety disorder, differentiated the actor group from the control group.

Haugebrook, Sabrina, Kristin M. Zgoba, Tina Maschi, Keith Morgan, and Derek Brown. *"Trauma, Stress, Health, and Mental Health Issues among Ethnically Diverse Older Adult Prisoners." Journal of Correctional Health Care* 16, no. 3 (2010): 220-229.

> The United States' older adult prison population is growing rapidly. This study identifies and describes important psychosocial characteristics, particularly trauma, life-event stressors, health, mental health, and substance abuse, among older adults in prison. Data were collected using case record reviews of 114 prisoners aged 55 or older in the New Jersey Department of Corrections. Findings revealed that the study participants are a diverse group with varied psychosocial issues and needs, including trauma and stress histories, substance use, and health and mental health issues. Most had childhood or adult trauma, such as physical or sexual abuse. Family problems were common in childhood and adulthood. Understanding the problems and needs of older adult prisoners may help

improve practice, promote advocacy, and prompt research that can enhance the quality of life of this population.

Hope Behind Bars: An Advocate's Guide to Helping Survivors of Sexual Abuse in Detention
U.S. Dept. of Justice. Office on Violence Against Women (OVAW) Just Detention International (JDI). 2014

Rape crisis advocates and other victim services providers need to read this publication. It is full of vital information these professionals need in order to address the needs of victims who have been sexually assaulted in a correctional facility. "This manual aims to help advocates take advantage of the unprecedented opportunity created by the PREA [Prison Rape Elimination Act] standards. It also seeks to anticipate some of the challenges that come with helping survivors who are incarcerated. While the core principles that underpin crisis services remain the same in any setting, many advocates have limited experience providing services inside prisons and jails. The manual addresses the ways in which detention facilities are culturally distinctive, how this culture can make it difficult to deliver services to inmates, and what advocates can do to overcome these obstacles" (p. 37). *http://www.justdetention.org/en/SART-Toolkit/Advocates_Manual_FINAL.pdf*

Lewis, Catherine F. "Childhood Antecedents of Adult Violent Offending in a Group of Female Felons."
Behavioral Sciences and the Law 28 (2010): 224–234.

The purpose of this study was to evaluate potential antecedents of violent felony arrest in a sample of female felons. Among male populations, early onset conduct disorder (CD) with progression to adult anti-social personality disorder (ASPD) is associated with increased criminality and aggression. Conduct disorder is associated with a worsened trajectory of alcohol dependence in men. These factors likely have a synergistic contribution to male adult violent offending. Existing work suggests that CD, ASPD, and severe alcohol dependence may represent an externalizing endophenotype, which is, at least in part, genetically conferred. These associations have not been well studied in female populations. The author examined a sample (N¼130) of female mid-sentence felons to determine associations between adult arrest for violent felony with child and young adult antecedents, including CD and alcohol dependence. Data were gathered through administration of the Semi-Structured Assessment for the Genetics of Alcoholism II (SSAGA II). CD had high prevalence (40.8%), as did ASPD (31.4%) and alcohol dependence (43.8%). Women convicted of violent felonies were more likely to have CD with progression to ASPD, and alcohol dependence. Both alcohol dependence and CD were independently associated with violent offending. These data suggest that the most serious female offenders have psychopathology similar to that of males and that the trajectory of disease and etiology of violent behavior may not be as gender specific as previously presumed.

Levenson, Jill. 2014. "Incorporating Trauma-Informed Care into Evidence-Based Sex Offender Treatment." *The Journal of Sexual Aggression* 20 (1): 9.

As we move forward in the field of sex offender treatment, clinicians should consider incorporating principles of trauma-informed care (TIC) into evidence-based sex offender

treatment models. Early adverse experiences are prevalent in the general population and more so in criminal and sex offender populations. Early trauma paves the way for maladaptive coping and interpersonal deficits, which can lead to abusive behaviour. Content-oriented sex offender treatment models emphasising cognitive-behavioural skills should integrate process-oriented components that address the ways in which early trauma shapes adult cognitions and behaviour. Relational approaches to therapy can enhance clients' interpersonal skills and improve general well-being. This type of personal growth would be expected to mitigate future offending as the client adopts and successfully practices healthier, non-destructive strategies for meeting emotional needs. [PUBLICATION ABSTRACT]

Lynch, Shannon. *Pathways Project—Research Factsheet: Mental Health & Trauma among Women in Jails.* Pocatello, ID: Pathways Project, Idaho State University, 2012.

> Findings are presented from a national study showing the prevalence of serious mental illness (SMI), substance use disorders (SUD), and posttraumatic stress disorder (PTSD) in the United States female jail population. Topics discussed include: the majority of females jailed have at least one of the assessed mental health disorders during their lifetime; regional differences exist in the rates of assessed mental health disorders; 25% of these women reported severe functional impairment in the past year; 50% of the women received substance abuse treatment or mental health treatment prior to incarceration; most of the jailed women had multiple types of adversity and interpersonal violence in their lives; trauma and mental health are associated with criminal offenses; women experiencing SMI are more likely to have had trauma in their lives, to be repeat offenders, and to have earlier onset of substance use and running away; and these results show the importance of prevention, rehabilitation, and reentry services.
> *http://nicic.gov/Library/026818*

Lynch, Shannon M., Dana D. DeHart, Joanne Belknap, and Bonnie L. Green. *Women's Pathways to Jail: The Roles and Intersections of Serious Mental Illness and Trauma.* Washington, DC: Bureau of Justice Assistance.

> This multi-site study addressed critical gaps in the literature by assessing the prevalence of serious mental illness (SMI), posttraumatic stress disorder (PTSD), and substance use disorders (SUD) in women in jail and pathways to offending for women with and without SMI... Understanding female offenders' pathways to offending, including both risk for onset and risk for continued offending, helps elucidate the complexity of their experiences and identify key factors and intervening variables that may ameliorate or exacerbate risk. This type of research is critical to development of gender responsive programming, alternatives to incarceration, and problem-solving court initiatives.
> *https://www.bja.gov/Publications/Women_Pathways_to_Jail.pdf*

Maschi, Tina et al. "Trauma and Stress among Older Adults in the Criminal Justice System: A Review of the Literature with Implications for Social Work." *Journal of Gerontological Social Work* 54, no. 4 (2011): 390-424.

Empirical studies addressing the trauma and stress experienced by elderly offenders are reviewed. This should be read by anyone working with this population. This article includes these sections: background; methods; findings—research methods used across studies, ethnicity, history of traumatic and stressful experiences, age specific stressors among older adult prisoners, consequences and correlates of trauma and stress, and coping resources as a protective factor; and discussion. "Overall, the results of this review underscore that trauma among older adults in the criminal justice system involved is a reality and a neglected area in the research, policy, and practice fields" (p. 415).

Masotta, Maria. *Vicarious Traumatization: A Guide to Recognizing, Responding to, and Preventing a Serious Consequence of Providing Mental Health Care in Jails, Prisons, and Community Corrections.*
Clinical staff, correctional officers, administrators, and medical personnel working in correctional mental health settings are at heightened risk for vicarious, or secondary, traumatization. Empathic engagement with inmates' traumatization can threaten one's sense of safety, hope, integrity, competence and purpose. Neither uniforms nor professional degrees provide insulation from this syndrome. Vicarious traumatization is under-recognized. It may result from a one-time encounter with an inmate or a cumulative exposure to inmates' traumas over years of working in correctional facilities. It is more likely to occur and persist when staff work in demanding, high-stress environments and when staff are routinely re-exposed to triggers that may resemble the primary trauma. Jails and prisons are just such environments. Limited resources; physical plant challenges; crowding; the responsibility to maintain safety and security in the face of continuous risks to staff and inmates; and exposure to violent inmate behaviors are among the stressors. Indeed, jails and prisons raise the risk for staff to be affected by both primary and secondary traumatization. Recognizing and addressing signs of vicarious traumatization is key to maintaining professional boundaries and effective treatment with inmates; to providing colleagues with appropriate support to minimize burn-out; and to extending the longevity of a career to which many staff are passionately committed. Prevention and intervention tools to reduce the impact of vicarious traumatization in our workforce are presented and discussed.
http://community.nicic.gov/blogs/mentalhealth/archive/2011/03/11/vicarious-traumatization-a-guide-to-recognizing-responding-to-and-preventing-a-serious-consequence-of-providing-mental-health-care-in-jails-prisons-and-community-corrections.aspx

Matheson, *Flora I.*" Editorial: Implications of Trauma among Male and Female Offenders." *International Journal of Environmental Research and Public Health* 9 (2012): 97-99.
Criminal behaviour is believed to arise from a multiplicity of factors, including unemployment and poverty [1,2], low self-control [3], psychological issues [4,5], early conduct problems [6], childhood physical and sexual abuse disorder [5], and social bonding in child- and adulthood [7]. Social-structural influences like family conflict/disruption, financial resources, child-parent and school/peer attachment and abuse and neglect in childhood have lasting impressions, leading to multiple problems including delinquency and later criminal activity, substance use/abuse, mental illness and poor self-rated health [8-12]. The consequences of such behaviour include financial losses, injury, and death that together have significant personal and societal costs. Society also bears the burden of incarcerating and rehabilitating offenders; a burden that is not trivial. Direct costs of

imprisonment in Canada approach $3.5 billion annually; in the US the cost is substantially higher, approaching $74 billion.
http://www.mdpi.com/1660-4601/9/1/97

Messina, Nena, PhD., Stacy Calhoun M.A., and Jeremy Braithwaite M.A. 2014. "Trauma-Informed Treatment Decreases Posttraumatic Stress Disorder among Women Offenders." *Journal of Trauma & Dissociation* 15, no. 1 (2014): 6.

Traumatic experiences among women offenders can impact their psychological well-being and patterns of substance use and offending. However, rigorous research in this area for women offenders with a history of trauma is sparse. This study combined data from 2 previous studies of women offenders in order to provide greater statistical power in examining the psychological trends found in the individual studies. Specifically, women in gender-responsive treatment (GRT; n = 135) were compared to women in non-GRT (n = 142) in regard to their change in posttraumatic stress disorder (PTSD) and related symptomatology from baseline to follow-up. The pooled sample of women were predominantly White (58%) or Hispanic (22%), and many had never been married (47%); their mean age was 36 years (SD = 8.9), and, on average, they had 12 years (SD = 1.8) of education. Methamphetamine was their primary drug (71%). Moreover, 55% of the women reported histories of sexual abuse and 37% physical abuse. Finally, 31% had a diagnosis of PTSD. Using generalized estimation equations, we detected significant Group x Time interactions in PTSD (odds ratio [OR] = 0.17) and some related symptomatology (reexperiencing: OR = 0.42; and avoidance: OR = 0.24). Given the aggregate impact of trauma in the lives of women offenders, these women, their families, and their communities could benefit from research on how trauma influences their lives and on services that mitigate the negative impact of such histories. [PUBLICATION ABSTRACT]

Messina, Nena, Christine E. Grella, Jerry Cartier, and Stephanie Torres. "A Randomized Experimental Study of Gender-Responsive Substance Abuse Treatment for Women in Prison." *Journal of Substance Abuse Treatment* 38 (2010): 97-107.

The effectiveness of a prison-based gender-responsive substance abuse using manualized curricula treatment (Helping Women Recover and Beyond Trauma) is assessed. 'This study's findings are particularly promising given the severity of addiction and criminal history of the sample. Findings from the pilot study support the beneficial effects of including Helping Women Recover and Beyond Trauma in prison treatment, as well as integrating GRT [gender-responsive treatment] principles oriented toward meeting women's needs within correctional settings' (p. 105). 11 pages. Links: Local Link | *http://www.stephaniecovington.com/pdfs/Messina%20March.pdf*

Miller, Niki. *RSAT [Residential Substance Abuse Treatment] Training Tool: Trauma-Informed Approaches in Correctional Settings*. Bureau of Justice Assistance. Office of Justice Programs. 2011

This curriculum is a cross-disciplinary training curriculum designed to increase knowledge and awareness of the relationship between substance use and trauma among people involved in RSAT jail, prison and aftercare programs. It is directed at program planners and

coordinators, counselors, case managers, behavioral healthcare providers, correctional officials and others. *http://www.rsat-tta.com/Files/Trainings/Trauma_Informed_Manual*

Miller, Niki A., and Lisa M. Najavits. "Creating Trauma-Informed Correctional Care: A Balance of Goals and Environment." *European Journal of Psychotraumatology* 3 (2012).
"This article discusses the centrality of trauma [including posttraumatic stress disorder (PTSD)] 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" (p. 3). Topics covered include: entry into prison—safety for women and danger for men; motives for underreporting of trauma in prisons; "institutional trauma" symptoms in prisons; gender and trauma; how to be heard when training prison staff; why use TICC; group exercises relevant to TICC; incorporating the voice of trauma survivors; relevance of present-focused, cognitive-behavioral approaches; trauma-specific interventions that fir prison settings; and that TICC is possible in prison settings.
http://www.seekingsafety.org/7-11-03%20arts

National Center for Child Traumatic Stress (NCTSN) (Los Angeles, CA). *Think Trauma: A Training for Staff in Juvenile Justice Residential Settings*, 2013, *http://www.nctsn.org/products/think-trauma-training-staff-juvenile-justice-residential-settings*

National Institute of Corrections' Women Offenders Topic Page. Washington, DC: NIC, *http://nicic.gov/WomenOffenders*

The Past, Present, & Future of Federal Government's Commitment to Addressing the Impact of Trauma on Women, hosted by The Women and Trauma Federal Partners Committee .
Webinar presentations include:
- Women and Violence Study: Trauma Services in Public Mental Health – Susan E. Salasin, International Adviser for Development of Trauma Informed Care Public Health Programs
- Adverse Childhood Experiences: Impact on Health & Wellbeing across the Life Course – Melissa Merrick, PhD, National Center for Injury Prevention and Control
- Seeking Safety: An evidence-based model for trauma and/or addition – Lisa M. Najavits, PhD, Boston University School of Medicine, Harvard Medical School
- If it Works I Miami…a Model Program for Serving Traumatized Human Beings – Teresa Descilo, MSW, MCT, The Trauma Resolution Center
You can access the PowerPoint slides and the audio recording of the webinar at:
http://www.nasmhpd.org/TA/Women_and_Trauma_Webinar_Info.aspx

Penney, Darby. *Creating a Place of Healing and Forgiveness: The Trauma-Informed Care Initiative at the Women's Community Correctional Center of Hawaii*. Alexandria, VA: National Center for Trauma-Informed Care (NCTIC), 2013
"Recognizing that most inmates are trauma survivors and many common prison routines can re-traumatize women, the Women's Community Correctional Center of Hawaii, under

the leadership of Warden Mark Kawika Patterson, works to create "a place of healing and forgiveness" [pu'uhonua] through its Trauma-Informed Care Initiative (TICI) ... Reducing the use of restraints and isolation has been a focus of the training and activities of TICI, since these interventions are likely to re-traumatize women who are trauma survivors and cause trauma responses in women who had not previously experienced trauma" (p. 1).
http://www.nasmhpd.org/docs/NCTIC/7014_hawaiian_trauma_brief_2013.pdf

Policy Research Associates (Delmar, NY and CT) University of Connecticut (Storrs. *Trauma-Informed Juvenile Justice and Mental Health Systems: Why We Need Them, How to Move Forward Toward Them*, 2013, *http://www.youtube.com/watch?v=g17Re1Ba604*

Promising Practices Guide Supporting the Recovery of Justice-Involved Consumers. Delmar, NY: Policy Research Associates, Inc.; Arlington, VA: National Alliance on Mental Illness/Support, Technical Assistance and Resources (STAR) Center, 2012

> "The field is gradually recognizing that reduced recidivism and treatment compliance are just two indicators of success. Stable housing and employment are other indicators. Increasingly, programs are integrating evidence-based practices (EBPs) into their program models. However, existing EBPs often need to be adapted or modified to address the "culture of incarceration" and specific issues (e.g., housing, employment and family reunification) germane to justice-involved consumers reentering the community. Because EBP models require adaptations to adequately address the unique needs of justice-involved consumers, many of the practices we review in this guide are characterized as "promising practices." Most have not yet achieved the level of rigorous validation with justice-involved populations needed to elevate them to EBP status. Nevertheless much can be gained by learning about these practices and the programs in which they are utilized. We encourage readers to explore how these promising practices might inform their current or future work with justice-involved consumers. Collectively, the programs highlighted demonstrate how far the field has progressed in its thinking and practice in preparing justice-involved consumers and their families for meaningful lives in their communities" (p. 7). Sections contained in this guide are: background; overview; promising practices—peer support/peer-delivered services, and reentry planning and community reintegration; SPECTRM (Sensitizing Providers to Effects of Incarceration on Treatment and Risk Management); the APIC (Access, Plan, Identify, and Coordinate) model; treatment services; trauma-informed care and trauma-specific services; and conclusion.
> *http://www.consumerstar.org/resources/Justice%20Audio/PromisingPractices.pdf*

Ramirez, Rachelle. "Becoming More Trauma-Informed." *American Jails* 27, no. 6 (Jan/Feb 2014): 25-28.

> Histories of sexual victimization, intimate partner violence, and other maltreatment are much more common among women enter- ing the criminal justice system than for male offenders or women in the general public (Bloom, Owen, & Covington, 2005; Lynch, Fritch, & Heath, 2012). The presence of trauma among female jail populations is important for at least two reasons: * From a safety and security per- spective, trauma-related issues may create additional disciplin- ary challenges for jail staff from women who are more likely to act in negative ways, such as not fol- lowing the rules, getting involved in confrontations

with staff and other inmates, or displaying vio- lent behavior. * Women with untreated trauma histories may require ongo- ing attention from medical and mental health staff, monopolizing these services and making the transition back to the community more difficult.

Saxena, Preeta, Nena P. Messina, and Christine E. Grella. "Who Benefits from Gender-Responsive Treatment?: Accounting for Abuse History on Longitudinal Outcomes for Women in Prison." *Criminal Justice and Behavior* 41, no. 4 (2014): 417-432.

> This study explores outcome variation among women offenders who participated in gender-responsive substance abuse treatment (GRT). To identify subgroups of participants that may differentially benefit from this treatment, secondary analyses examined the interaction between randomization into GRT and a history of abuse (physical/sexual) on depression and number of substances used post treatment. The sample consisted of 115 incarcerated women assessed at baseline and 6 and 12 months post parole. Longitudinal regression showed that women reporting abuse randomized into GRT had significantly reduced odds of depression (odds ratio OR] = .29, p < .05, 95% confidence interval CI] = 0.10, 0.86]) and lowered rates of number of substances used (incidence rate ratio IRR] = .52, p < .05, 95% CI = 0.28, 0.98]), in comparison with those who reported abuse and were randomized to the non-GRT group. Findings suggest that GRT for women offenders who have experienced prior abuse may maximize the benefits of the trauma-informed, gender-sensitive intervention.

Schnavia Smith Hatcher, Brian E. Bride, Hyejung Oh, Dione Moultrie King, and James Franklin Catrett. " An Assessment of Secondary Traumatic Stress in Juvenile Justice Education Workers." Journal of Correctional Health Care 17, no. 3 (2011): 208-217.

> Given the frequency and violent character of the traumas encountered by juvenile offenders, staff members who regularly interact with juveniles in custody are at risk of developing secondary traumatic stress. Juvenile justice teachers and staff (N = 118) were administered a cross-sectional survey, including the Secondary Traumatic Stress Scale. Respondents said the students were moderately traumatized (47%), severely traumatized (27%), and very severely traumatized (7%). Regarding STS, the most frequently reported symptom was intrusive thoughts related to work with the students, mentioned by 61% of respondents. Additionally, 81% met at least one, 55% met two, and 39% met all three core diagnostic criteria for posttraumatic stress disorder. Recommendations for juvenile justice staff members and for the organization are provided to address practice and policy implications.

Stathopoulos, Mary, Antonia Quadara, Bianca Fileborn, and Haley Clark. "Addressing Women's Victimization Histories in Custodial Settings." *ACSSA Issues* 13 (2012). Melbourne: Australian Institute of Family Studies; Australian Centre for the Study of Sexual Assault.

> "This paper explores the prison as a possible site of re-traumatization. The reasoning behind this is that prisons are built on an ethos of power, surveillance and control, yet trauma sufferers require safety in order to begin healing. A trauma-informed approach may

offer an alternative to delivering a less traumatic prison environment and experience for female criminal offenders with a history of sexual abuse and assault" (p. 1). Sections following key messages include: introduction; the profile of women in prison; addressing women's victimization histories in correctional settings, issues and approaches—key challenges in addressing trauma in prison (the prison environment, re-traumatizing practices, and cycling through prison), and whether the provision of trauma support is possible within prison; responses and limitations—supporting women in prison; and conclusion. Two possible strategies for addressing the problem are by utilizing a trauma-informed approach or a gender-responsive framework.
http://www.aifs.gov.au/acssa/pubs/issue/i13/i13.pdf

Substance Abuse and Mental Health Services Administration (SAMHSA). *Creating a Trauma-Informed Criminal Justice System for Women: Why and How.*
An increasing body of evidence tells us that the overwhelming majority of women in jails and prisons have experienced trauma that has scarred their minds and hearts. They may have survived rape, assault, or childhood sexual abuse, or they may have witnessed violence done to others. Trauma can result in physiological changes in the way our brains respond to danger, especially when the trauma is repeated. It has also been linked to depression, suicidal tendencies, chronic anxiety, hostility, impaired ability to relate to others socially, and many other serious consequences in personal life.
http://gains.prainc.com/cms-assets/documents/62753-983160.ticjforwmn.pdf

Van Dieten, Marilyn, Natalie J. Jones, and Monica Rondon. *Working With Women Who Perpetrate Violence: A Practice Guide.* 2014.
"This practice brief was designed to summarize the available research on female perpetrated violence. Information in this area is still quite limited. However, there is a growing body of evidence to suggest that females who engage in violence are not a homogenous group and that there are some important differences in the context and expression of violent behavior across gender. We will examine a host of personal, contextual, cultural, and victimization-related factors among females charged with intimate partner violence and other violent crimes. This information will then be translated into recommendations for assessment and intervention" (p. 1). The monograph includes: a review of the research, prevalence rates, risk factors, and types of perpetrators and motives surround use of violence; implications for Assessment, standardized screening and assessment tools, and conducting a comprehensive interview; implications for intervention approaches and strategies, general considerations for treatment, and treatment programs to address violence.
http://nicic.gov/library/028200

Wallace, Barbara C., Latoya C. Conner, and Priscilla Dass-Brailsford "Integrated Trauma Treatment in Correctional Health Care and Community-Based Treatment Upon Reentry." *Journal of Correctional Health Care* 17, no. 4 (2011): 329-343.
Given the crisis of mass incarceration in the United States and the high prevalence of trauma histories among those incarcerated, it is imperative to improve service delivery to inmates in correctional facilities and to those undergoing reentry in community-based treatment

settings. This article provides trauma definitions and categories, describes the sequelae of trauma, reviews research on the high prevalence of incarceration in this nation, and reviews research on the high prevalence of trauma among the incarcerated. This article also provides a menu of evidence-based and promising treatment approaches to address the overlap among trauma, mental illness, substance abuse, and behavioral problems. A synthesis of research via seven points is meant to guide practitioner and policy responses to the national challenge of meeting the needs of those undergoing reentry.

Wolff, Nancy, and Jing Shi. "Childhood and Adult Trauma Experiences of Incarcerated Persons and Their Relationship to Adult Behavioral Health Problems and Treatment." *International Journal of Environmental Research and Public Health* 9, no. 5 (2012): 1908-1926.

Rates of childhood and adult trauma are high among incarcerated persons. In addition to criminality, childhood trauma is associated with the risk for emotional disorders (e.g., depression and anxiety) and co-morbid conditions such as alcohol and drug abuse and antisocial behaviors in adulthood. This paper develops rates of childhood and adult trauma and examines the impact of age-of-onset and type-specific trauma on emotional problems and behavior for a sample of incarcerated males (N~4,000). Prevalence estimates for types of trauma were constructed by age at time of trauma, race and types of behavioral health treatment received while incarcerated. HLM models were used to explore the association between childhood and adult trauma and depression, anxiety, substance use, interpersonal problems, and aggression problems (each model estimated separately and controlling for age, gender, race, time incarcerated, and index offense). Rates of physical, sexual, and emotional trauma were higher in childhood than adulthood and ranged from 44.7% (physical trauma in childhood) to 4.5% (sexual trauma in adulthood). Trauma exposure was found to be strongly associated with a wide range of behavioral problems and clinical symptoms. Given the sheer numbers of incarcerated men and the strength of these associations, targeted intervention is critical.
http://www.mdpi.com/1660-4601/9/5/1908

See also: NIC Knowledgebase: *https://nic.zendesk.com/entries/27427000-What-are-trauma-informed-practices-with-justice-involved-women-*

Trauma-Informed Care: Youth in the Criminal Justice System

Adams, Erica J. *Healing Invisible Wounds: Why Investing in Trauma-Informed Care for Children Makes Sense.* Washington, DC: Justice Policy Institute 2010.

> The need to fund services for juveniles affected by traumatic events is explained. Topics discussed include traumatic experiences effect on brain development in children; traumatic brain injury and juvenile justice; children are rarely screened for trauma, especially in the juvenile justice system; children who experience trauma have disproportionate contact with the justice system; the current juvenile justice system does not meet the needs of youth who have experienced trauma; incarceration itself can be traumatic; and youth who spend time in juvenile facilities have poorer outcomes than youth who stay in the community.
> *http://www.justicepolicy.org/images/upload*

Buffington, Kristine, Carly B. Dierkhising, and Shawn C. Marsh. "Ten Things Every Juvenile Court Judge should Know about Trauma and Delinquency." *Juvenile Justice Update* 20, no. 1 (2014): 10.

> The majority of youth in the juvenile justice system have experienced traumatic events, and those experiences impact their behavior. When juvenile justice personnel utilize a traum-informed lens, the juvenile court is better able to realize its mission of protecting and rehabilitating traumatized youth while holding them responsible for their actions. The court's efforts to rehabilitate delinquent youth can be maximized by utilizing effective assessment and treatment strategies that reduce or ameliorate the impact of childhood trauma. Here, Buffington et al identify 10 crucial areas about which judges need to be familiar to better assist traumatized youth who enter the juvenile justice system.

Covington, Stephanie S., Angie Wolf, and Callie Long. *Webinar: Girls at Risk: A Trauma-Informed Approach.* National Girls Institute, Washington, DC: National Council on Crime and Delinquency & National Training and Technical Assistance Center, 2013.

> "With the increased awareness of the impact of trauma on girls' lives, juvenile justice and community professionals are beginning to consider what this means in their specific settings. There is a growing evidence base documenting the impact of relationship violence and sexual assault (as well as other forms of trauma) on health, mental health and behavior. This Webinar explores the specifics of becoming trauma-informed, as well as the guiding principles for gender-responsive services. Learning objectives are: define the terms trauma-informed and gender-responsive; discuss the process of trauma; and provide specific examples of effective interventions for girls." This website provides access to the webinar, a transcript, and slides from the overall broadcast and those slides specifically for Dr. Covington's presentation. *88 minutes.*
> *https://www.nttac.org/index.cfm?event=trainingCenter.traininginfo&eventID=100*

Espinosa, Erin M., Jon R. Sorensen, and Molly A. Lopez. "Youth Pathways to Placement: The Influence of Gender, Mental Health Need and Trauma on Confinement in the Juvenile Justice System." *Journal of Youth and Adolescence* 42, no. 12 (12, 2013): 1824-36.

  Although the juvenile crime rate has generally declined, the involvement of girls in the juvenile justice system has been increasing. Possible explanations for this gender difference include the impact of exposure to trauma and mental health needs on developmental pathways and the resulting influence of youth's involvement in the justice system. This study examined the influence of gender, mental health needs and trauma on the risk ofout-of-home placement for juvenile offenders. The sample included youth referred to three urban juvenile probation departments in Texas between January 1, 2007 and December 31, 2008 and who received state-mandated mental health screening (N = 34,222; 30.1 % female). The analysis revealed that, for both genders, elevated scores on the seven factor-analytically derived subscales of a mental health screening instrument (Alcohol and Drug Use, Depressed-Anxious, Somatic Complaints, Suicidal Ideation, Thought Disturbance, and Traumatic Experiences), especially related to past traumatic experiences, influenced how deeply juveniles penetrated the system. The findings suggest that additional research is needed to determine the effectiveness of trauma interventions and the implementation of trauma informed systems for youth involved with the juvenile justice system.[PUBLICATION ABSTRACT]

Ford, Julian B., John F. Chapman, Josephine Hawk, and Albert David. "Trauma Among Youth in the Juvenile Justice System: Critical Issues and New Directions." *Research and Program Brief.* Delmar, NY: National Center for Mental Health and Juvenile Justice, 2007.

  Issues surrounding the trauma experienced by juvenile offenders are discussed. Sections of this brief are: introduction; scope of the problem; trauma and its impact on youth; addressing trauma among youth in the juvenile justice system -- trauma screening, trauma assessment, treatment and rehabilitation of traumatic stress disorders, pharmacological treatment, and phase-oriented treatment; and summary.
  http://iers.umt.edu/docs/nnctcdocs/Trauma_and_Youth.pdf

Toolkit for Court-Involved Youth and Exposure to Violence. North Bethesda, MD: Safe Start Center, 2013.

  "Research shows that most youth entering the juvenile justice system are estimated to have been exposed to violence and other traumatic events, oftentimes having experienced multiple types of victimizations. Youth in the juvenile justice system already face significant challenges related to their incarceration and justice involvement, including separation from their families, communities, education and other positive social networks. Having a trauma-informed justice system is critical to promoting the well-being of the child, their families and the community." While a cursory look seems to indicate the information on this website is for courts, the trauma-informed strategies imparted can be applied to various correctional settings. Points of entry to this website are: practice innovations--service delivery strategies for children exposed to violence in a variety of settings; research—evidence based practices websites and resources, guidelines for research and evaluation,

incidence and prevalence, and research studies and reports; resources—Safe Start Center publications, families and caregivers, publicaciones en Espanol, teen and young adults, curricula and guides, and infographics; about Safe Start; evidence-based programs—Children Exposed to Violence (CEV) Database; and blog. *http://www.safestartcenter.org/resources/toolkit-court-involved-youth-exposure-violence.php*

Selph, Mykel, Amy L. Ast, and Laura Dolan. 2014. "Female Juvenile Offenders: A Forgotten Population." *Corrections Today* 76 (1): 24-25.

> From 1997 to 2006, the rate of simple assault arrests for girls increased by 19 percent, but for boys, the rate declined by 4 percent.1 Although there are many potential reasons for this disparity, research suggests that girls may be more sensitive to risk factors such as household dysfunction and trauma.2 Gender responsive theory may help explain this difference in that girls are relational and thrive on relationships with others. [...]girls may be more emotionally impacted by unhealthy relationships with caregivers and other loved ones, increasing the likelihood of involvement in the juvenile justice system. [...]girls may resist following the rules during this time of day.

Woodson, Kamilah, Courtney C. Hives, and Kathy Sanders-Phillips. "Violence Exposure and Health-Related Risk Among African American Adolescent Female Detainees: A Strategy for Reducing Recidivism." *Journal of Offender Rehabilitation* 49 (2010): 571-594.

> Juvenile crime and violent victimization continue to be significant social problems, in that adolescents, females in particular, are likely to participate in health-related risk behaviors as a result of having been victimized or exposed to a violent environment. Specifically, abuse, neglect, sexual molestation, poverty, and witnessing violence are well-known risk factors for the development of trauma-related psychopathology and poor outcomes relative to delinquency, drug and alcohol abuse, and HIV risk behaviors. HIV infection is a common public health concern, disproportionately affecting adolescent African American female detainees. This unique population has a serious history of violence exposure, which subsequently tends to lead to engaging in risky sexual behaviors, mental health problems, and substance abuse. Also, as a result of little to no intervention, this population is recidivating at an alarming rate—a problem that may further exacerbate the expression of health-related risk behaviors among African American adolescent female detainees. The authors briefly describe a pilot program to be implemented in the juvenile justice system that is based on the model of accumulated risk, Bronfenbrenner's ecological model, and the positive youth justice model. The program proposes to reduce risky sexual behaviors, teach alternatives to abusing substances, treat mental health concerns, and reduce the rate of recidivism through ''positive youth development.'' Tying elements of wraparound services and reeducation together, this program addresses salient concerns that may have an impact on an adolescent detainee's success following their release from prison.

Trauma-Informed Care: Peer-to-Peer

After the Crisis Initiative Peer Support Training Curriculum: Preparing Peers to Assist Peers in Preparing for and Recovering from Disasters. Delmar, NY: National GAINS Center & Policy Research Associates; Washington: U.S. Dept. of Health and Human Services/Center for Mental Health Services. Bethesda, MD: National Center for Trauma-Informed Care, 2007.

> Participants will be able to: understand the roles that peers can play in both assisting in disaster preparation and providing peer support crisis services following a disaster; understand the goals of peer support crisis services and how to use them to promote recovery; understand the different stages of a disaster/emergency and the different needs of survivors, families, and the community; understand the impact of an emergency or disaster; understand the impact that culture has upon an individual's response to traumatic events and how culture can promote recovery; learn strategies that promote engagement, trust, and resiliency; learn basic assessment and referral techniques; understand the need for documentation; learn strategies for self-care and staff support, leveraging additional opportunities for peer support services in the community, having peer support services included in disaster plans, collaborating with local and national disaster relief agencies; and learn about FEMA Crisis Worker Certification Training.

Blanch, Andrea, Beth Filson, Darby Penney, and Cathy Cave. *Engaging Women in Trauma-Informed Peer Support: A Guidebook.* Falls Church, VA: National Association of State Mental Health Program Directors; Sudbury, MA: Advocates for Human Potential, Inc., 2012.

> The fundamentals, cultural considerations, and actions to be taken to address trauma through peer support are explained. 'This guide was created for a very specific purpose: to help make trauma-informed peer support available to women who are trauma survivors and who receive or have received mental health and/or substance abuse services. It is designed as a resource for peer supporters in these or other settings who want to learn how to integrate trauma-informed principles into their relationships with the women they support or into the peer support groups they are members of. The goal is to provide peer supporters, both male and female, with the understanding, tools, and resources needed to engage in culturally responsive, trauma-informed peer support relationships with women trauma survivors' (p. 1). Thirteen chapters are in this publication: introduction to trauma and trauma-informed practices; whether one is a trauma survivor or not; peer support fundamentals; gender policies and the criminalization of women; culture and trauma; religion, spirituality, and trauma; trauma-informed peer support across the lifespan; trauma and peer support relationships; self-awareness and self-care; organizational context; working in systems; trauma-informed storytelling and other healing practices; self-inflicted violence and peer support; and reclaiming power through social action.
> *http://nicic.gov/Library/026095*
> *http://www.nasmhpd.org/ota/NCTIC/PEG%202012/PEG%20Full%20Document.pdf*

Clawson, Heather J., Amy Salomon, and Lisa Goldblatt Grace. *Treating the Hidden Wounds: Trauma Treatment and Mental Health Recovery for Victims of Human Trafficking.* Washington, DC: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, 2008.

> This is the third in a series of Issue Briefs produced under a contract with the Department of Health and Human Services (HHS), Office of the Assistant Secretary for Planning and Evaluation (ASPE) to conduct a study of HHS programs serving human trafficking victims. Funded in the fall of 2006, the purpose of this exploratory project is to develop information on how HHS programs are currently addressing the needs of victims of human trafficking, including domestic victims, with a priority focus on domestic youth. This project also consists of reviewing relevant literature, and identifying barriers and promising practices for addressing the needs of victims of human trafficking, with a goal of informing current and future program design and improving services to this extremely vulnerable population. *http://aspe.hhs.gov/hsp/07/humantrafficking/Treating/ib.htm*

Trauma

Center for the Study of Traumatic Stress (CSTS) Center for the Study of Traumatic Stress (Bethesda, MD). 2008. *http://www.centerforthestudyoftraumaticstress.org*

> Information is provided at this website by the Center for the Study of Traumatic Stress (CSTS). Points of entry are: about the center; trauma and disaster -- world trauma, disaster, armed conflict and war, terror, and preparedness; about you -- you, military community, military children and families, disaster community, disaster workers, and law enforcement; fact sheets -- disaster and terrorism, military health, law enforcement, and children and families; resources -- interviews (post 9/11 and disaster and military psychiatry), articles and reports -- terrorism preparedness, disaster psychiatry, military psychiatry, treatment guidelines, and workplace; research -- clinical and research tools and "Advancing Research Standards for PTSD interventions"; books; CDS; public education; and conferences.

National Center on Domestic Violence, Trauma & Mental Health, *http://www.nationalcenterdvtraumamh.org/publications-products/creating-trauma-informed-services-tipsheet-series-for-advocates/*

> Domestic violence and other lifetime trauma can have significant mental health consequences. Yet the systems to which survivors and their children turn are frequently unprepared to address the range of issues they face in trying to access safety and heal from the traumatic effects of abuse. The National Center on Domestic Violence, Trauma & Mental Health provides training, support, and consultation to advocates, mental health and substance abuse providers, legal professionals, and policymakers as they work to improve agency and systems-level responses to survivors and their children. Our work is survivor defined and rooted in principles of social justice.   The Center is one of four national Special Issue Resource Centers funded by the U.S. Department of Health and Human Services; Administration on Children, Youth and Families; Family Violence Prevention and Services Program and is a member of the Domestic Violence Resource Network (DVRN).

Substance Abuse and Mental Health Services Administration (SAMHSA)/National Center for Trauma Informed Care.

> NCTIC is a technical assistance center dedicated to building awareness of trauma-informed care and promoting the implementation of trauma-informed practices in programs and services.
> *www.samhsa.gov/nctic*

Substance Abuse and Mental Health Services Administration. *Impact of Trauma on Women and Girls across the Lifespan: What Every Health and Social Service Provider Needs to Know about the Importance of Providing Trauma-informed Services to Women and Girls* [A Webinar Series.]. Washington, DC: Department of Health and Human Services, 2012.

> The impact of violence, abuse, neglect, disaster, war, and other harmful experiences continues long after the traumatic event has ended. Exposure to trauma is a pervasive issue that has significantly impacted the health and well-being of millions of Americans and nearly everyone seeking services in the public health and social services systems.

Understanding how trauma affects the emotional, behavioral, cognitive, social, and physical functioning of the people we care for can improve our services.
https://services.choruscall.com/links/womenshealth.html

Substance Abuse and Mental Health Services Administration (SAMHSA). *Trauma Definition*. 2013.
Interest in the impact of trauma on behavioral health has been steadily increasing since the 1970's. Models for the treatment of trauma have been developed and tested and a growing number of organizations have explored ways to make their services more responsive to people who have experienced trauma. Recently, multiple federal agencies representing varied sectors, including child welfare, primary health care, criminal justice, education, and labor have recognized the impact of trauma on the children, adults, and families they serve, and have requested assistance from SAMHSA in addressing these issues. This has compelled SAMHSA to revisit trauma-related concepts and their applicability not only to behavioral health but to other related fields. This document is divided into three parts: Defining Trauma, A Trauma-Informed Approach, and Suggested Guidelines for Implementing a Trauma-Informed Approach.
http://www.samhsa.gov/traumajustice/traumadefinition/index.aspx

National Institute of Corrections' Webpage, *Justice-Involved Veterans*. *http://nicic.gov/veterans*
On any given day, veterans account for nine of every hundred individuals in U.S. jails and prisons (Noonan & Mumola, 2007; Greenberg & Rosenheck, 2008). Recently, veterans who served in the Middle East (Operations Enduring Freedom (OEF), Iraqi Freedom (OIF), and New Dawn (OND)) appear to be at lower risk of incarceration than veterans of other service eras, but those who were incarcerated had higher rates of PTSD. Alcohol abuse or dependence was also a common diagnosis for OEF/OIF/OND veterans (43%), slightly lower then other veterans (45%). (Tsai, et al., 2013)

Women's Health Assessment Team. *The Concerns of Women Currently Serving in the Afghanistan Theater of Operations White Paper.* Health Service Support Assessment Team, UC, Afghanistan, 2011.
Nearly 275,000 women have deployed in support of Operation Iraqi Freedom, Operation New Dawn, and Operation Enduring Freedom. During our assessment, it was clear that female Service Members are participating, contributing, and excelling at all levels in the Afghanistan Theater of Operations (ATO). Women are serving on female engagement and reconstruction teams, in transportation, logistics, police, and engineering units as well as all of the health service support roles to name just a few. In order for women to be fully integrated and effective members of the team, we must ensure their unique health needs are being considered and met.
http://www.globalsecurity.org/military/library/report/2011/womens-concerns-afghanistan.pdf

Screenings and Assessments – Gender Neutral

Adverse Childhood Experiences (ACE) Study. Centers for Disease Control and Prevention. *http://www.cdc.gov/ace/index.htm*.

> This webpage provides a description of the ACE Study and model, major findings, questionnaires, data and statistics on the prevalence of experiences and participant demographics, future directions, related links and a list of publications involving the study.

Briere, John and Joseph Spinazzola. "Phenomenology and Psychological Assessment of Complex Posttraumatic States." *Journal of Traumatic Stress* 18, no. 5 (2005): 401-412.

> The authors offer a framework for the assessment of psychological responses associated with exposure to early onset, multiple, or extended traumatic stressors. Six prominent and overlapping symptoms clusters are described: altered self-capacities, cognitive symptoms, mood disturbance, overdeveloped avoidance responses, somatoform distress, and posttraumatic stress. A strategy for the structured, psychometrically valid assessment of these outcomes is introduced, and specific recommendations for use of various generic and trauma-specific child and adult measures are provided. Implications of trauma assessment for treatment planning are discussed. [ABSTRACT FROM JOURNAL]

Elhai, Jon D., Matt J. Gray, Todd B. Kashdan, and Laurel C. Franklin. "Which Instruments Are Most Commonly Used to Assess Traumatic Event Exposure and Posttraumatic Effects? A Survey of Traumatic Stress Professionals." *Journal of Traumatic Stress* 18, no. 5 (2005): 541-545.

> We report findings from a Web-based survey of the International Society for Traumatic Stress Studies' members (n = 227) regarding use of trauma exposure and posttraumatic assessment instruments. Across clinical and research settings, the most widely used tests included the Posttraumatic Stress Diagnostic Scale, Trauma Symptom Inventory, Life Events Checklist, Clinician-Administered Post-traumatic Stress Disorder (PTSD) Scale, PTSD Checklist, Impact of Event Scale—Revised, and Trauma Symptom Checklist for Children. Highest professional degree, time since degree award, and student status yielded no differences in extent of reported trauma assessment test use. [ABSTRACT FROM AUTHOR]

Hansen, Maj, Tonny Elmose Anderson, Cherie Armour, Ask Elklit, Sabina Palic, and Thomas Mackrill. "PTSD-8: A Short PTSD Inventory." *Clinical Practice & Epidemiology in Mental Health* 6, (2010): 101-108.

> Traumatic events pose great challenges on mental health services in scarcity of specialist trauma clinicians and services. Simple short screening instruments for detecting adverse psychological responses are needed. Several brief screening instruments have been developed. However, some are limited, especially in relation to reflecting the posttraumatic stress disorder (PTSD) diagnosis. Recently, several studies have challenged pre-existing ideas about PTSD's latent structure. Factor analytic research currently supports two four factor models. One particular model contains a dysphoria factor which has been associated with depression and anxiety. The symptoms in this factor have been hailed as less specific

to PTSD. The scope of this article is therefore to present a short screening instrument, based on this research; Posttraumatic Stress Disorder (PTSD) – 8 items. The PTSD-8 is shown to have good psychometric properties in three independent samples of whiplash patients (n=1710), rape victims (n=305), and disaster victims (n=516). Good test-rest reliability is also shown in a pilot study of young adults from families with alcohol problems (n=56). [ABSTRACT FROM JOURNAL]

Hanson, Rochelle F. and Shannon Self-Brown. "Screening and Assessment of Crime Victimization and Its Effects." *Journal of Traumatic Stress* 23, no.2 (2010): 207-214.
> The authors provide a review of tools used to screen and assess history and mental health consequences of adult crime victimization. These measures can be utilized across a broad range of settings that may serve crime victims, including venues for first response (e.g., law enforcement offices or emergency departments), primary medical care, or mental health treatment facilities, regardless of whether or not the crime was reported. The authors conclude with a discussion on limitations in the field and directions for future research. [ABSTRACT FROM JOURNAL]

Hooper, Lisa M., Patricia Stockton, Janice L. Krupnick, and Bonnie L. Green. "Development, Use, and Psychometric Properties of the Trauma History Questionnaire." *Journal of Loss & Trauma* 16, (2011): 258-283.
> The authors describe the development and psychometric properties of the widely used Trauma History Questionnaire (THQ). Additionally, they describe how the THQ has been used both nationally and internationally in a range of studies conducted in the past 14 years (1996-2010). The reviewed studies provide accumulated, although preliminary, evidence that the THQ is reliable and valid in clinical and nonclinical samples. Finally, the authors describe the strengths and limitations of the THQ and make specific recommendations for researchers and practitioners going forward. [ABSTRACT FROM AUTHOR]

Kelly, Sarah and Lynne Hall. "Measuring Anxiety in Adolescents Exposed to Community Violence: A Review, Comparison, and Analysis of Three Measures." *Issues in Mental Health Nursing* 31, (2010): 28-38.
> Exposure to community violence can influence adolescents' anxiety. Researchers have examined the relationship between exposure to community violence and anxiety. In their pursuit to explore that relationship, researchers have used a variety of instruments. This review of literature provides an overview of the instruments used to measure anxiety in adolescents exposed to community violence and evaluates three of these measures. The Trauma Symptom Checklist for Children, the Child Behavior Checklist, and the State Trait Anxiety Inventory for Children were frequently used to measure anxiety in adolescents exposed to community violence. These instruments have good reliability and construct validity. [ABSTRACT FROM AUTHOR]

Measures. United States Department of Veterans Affairs, National Center for PTSD. Last modified July 7, 2011. *http://www.ptsd.va.gov/professional/pages/assessments/all_measures.asp*.

A list of over 60 PSTD measures is provided, along with a link to a description of the measure and the type of measure. The type of measure can be a screening, evaluation, self-report or interview. The measures cover both children and adults.

Screenings and Assessments – Trauma and/or Gender Informed

Black, Donald W., et al. "Relative Contributions Of Gender And Traumatic Life Experience To The Prediction Of Mental Disorders In A Sample Of Incarcerated Offenders." *Behavioral Sciences & The Law 30*, no. 5 (2012): 615-630.

> The objective of this study was to quantify the relative contributions of gender and traumatic life experience to psychiatric disorders in a sample of 320 offenders entering a state prison. Women were more likely than men to report traumatic events and personal and family mental health treatment histories; and were more likely to meet criteria for posttraumatic stress, borderline personality, and eating disorders. People reporting traumatic life experiences were more likely than those not so reporting to have family mental histories and to meet criteria for mood, anxiety, psychotic, antisocial personality, and borderline personality disorders, as well as elevated suicide risk. With both gender and trauma included in the logistic regression models, only trauma was a significant predictor of mood, anxiety, psychotic, attention deficit hyperactivity, and antisocial personality disorders, as well as suicide risk. Trauma-informed programming, regardless of gender, is important for incarcerated offenders. To the extent that trauma is also criminogenic, these data suggest that women and men share the risk. [ABSTRACT FROM AUTHOR]

Bright, Charlotte L. and Sharon E. Bowland. "Assessing Interpersonal Trauma in Older Adult Women." *Journal of Loss & Trauma* 13, (2008): 373-393.

> Interpersonal traumatic experiences (childhood abuse, sexual assault, and intimate partner violence) are common in older adult women and associated with negative short-term and long-term outcomes. Thus, assessing trauma symptoms is essential to providing adequate services. This article explores challenges of measuring trauma in older women, describes the Posttraumatic Diagnostic Scale (Foa, 1995), and evaluates the appropriateness of this instrument using data from a current study of older adult women. Symptom severity scores did not consistently reflect the experiences of the sample. Eschewing a clinical interview to assess the impact of interpersonal trauma in older adult women may be a mistake. [ABSTRACT FROM AUTHOR]

Brown, Vivian Barnett, Maxine Harris, and Roger Fallot. "Moving Toward Trauma-Informed Practice in Addiction Treatment: A Collaborative Model of Agency Assessment." *Journal of Psychoactive Drugs* 45, no. 5 (2013): 386.

> Clients in substance abuse treatment need, in addition to evidence-based and sensitive treatment services in general, a system of care that takes into account the impact of trauma and violence in so many of their lives. In addition, services need to be delivered in a way that avoids triggering trauma memories or causing unintentional re-traumatization. To that end, this article describes an agency self-assessment process that combines atrauma-informed assessment, a NIATx process of "walking-through" and use of the Institute of Healthcare Improvement's Plan-Do-Study-Act (PDSA) cycles, and a user-friendly format. The trauma-informed assessment is designed to address issues of safetyof clients

and staff members, reduction of re-traumatization, consistency in practice, and client empowerment. It brings a non-judgmental, collaborative approach to process and practice improvement. The article describes how the assessment process can be -- and has been -- used to develop an Action Plan, including trainings and the identification of "trauma champions"; i.e., staff who will continue to spread trauma-informed changes and new evidence-based practices throughout the agency. As we enter a period of healthcare reform, addressing trauma as an integral part of addiction treatment also allows us to better deal with the totality of our clients' health problems. [PUBLICATION ABSTRACT]

Carlozzi, Noelle E. and Patricia J. Long. "Reliability and Validity of the SCL-90-R PTSD Subscale." *Journal of Interpersonal Violence* 23, no. 9 (2008): 1162-1176.

> Two studies examined the psychometric properties of the Posttraumatic Stress Disorder (PTSD) subscale of the SCL-90-R. Study 1 examined SCL-90-R responses from 2,361 college women to determine whether this subscale can appropriately assess the three dimensions of PTSD. Factor analysis and Cronbach's alpha suggest that this subscale is best conceptualized as a unidimensional index of PTSD symptomatology. Study 2 confirmed these results in a sample of 1,044 college men and women. Findings in the second sample also supported the subscale's validity, as it correlates well with the Posttraumatic Diagnostic Scale and with trauma frequency and can discriminate between individuals with and without PTSD diagnoses. Results suggest that the SCL-90-R PTSD subscale is a reliable, but unidimensional, measure for screening for distress associated with PTSD. Although there is some support for the usefulness of this scale, especially with women, it should only be considered a general indicator of distress with limited use for men. [ABSTRACT FROM AUTHOR]

Gender-Responsive Policy & Practice (GRPPA), http://nicic.gov/grppa/
The Gender-Responsive Policy & Practice Assessment (GRPPA) is a process designed to guide assessment of research-based, gender-responsive policies and practices in jails, prisons, and community corrections programs for women.

Ruch, Libby O. and Chang-Hwai Wang. "Validation of the Sexual Assault Symptom Scale II (SASS II) Using a Panel Research Design." *Journal of Interpersonal Violence* 21, no. 11 (2006): 1440-1461.

> To examine the utility of a self-report scale of sexual assault trauma, 223 female victims were interviewed with the 43-item Sexual Assault Symptom Scale II (SASS II) at 1, 3, 7, 11, and 15 months postassault. Factor analyses using principal-components extraction with an oblimin rotation yielded 7 common factors with 31 items. The internal consistency was high for 4 factors and moderate for 2 factors. The multitrait-multimethod matrix, correlating the factor subscale scores of self-reported trauma and clinical assessment ratings, demonstrated both convergent and discriminant validity, indicating that the SASS II has construct validity. Correlations between the SASS II subscales and the intrusion subscale of the Impact of Events Scale also indicated the convergent and discriminant validity of the SASS II. Significant positive correlations between current and prior trauma levels further evidence the validity of the SASS. [ABSTRACT FROM AUTHOR]

Simpson, D. Dwayne, et al. "Brief Trauma and Mental Health Assessments for Female Offenders in Addiction Treatment." Journal of Offender Rehabilitation 51, 1/2 (2012): 57-77.

> Increasing numbers of women in prison raise concerns about gender-specific problems and needs severity. Female offenders report higher trauma as well as mental and medical health complications than males, but large inmate populations and limited resources create challenges in administering proper diagnostic screening and assessments. This study focuses on brief instruments that address specialized trauma and health problems, along with related psychosocial functioning. Women from two prison-based treatment programs for substance abuse were assessed (N = 1,397), including one facility for special needs and one for regular female offenders. Results affirmed that those admitted to the special-needs facility reported more posttraumatic stress symptoms, higher rates of psychological stress and previous hospitalizations, and more health issues than those in the regular treatment facility. Findings supporting use of these short forms and their applications as tools for monitoring needs, progress, and change over time are discussed. [ABSTRACT FROM PUBLISHER]

Testa, Maria, Carol Vanzile-Tamsen, Jennifer A. Livingston, Mary P. Koss. "Assessing Women's Experiences of Sexual Aggression Using the Sexual Experiences Survey: Evidence for Validity and Implications for Research." *Psychology of Women Quarterly* 28, 2004: 256-265.

> In this study we examined the ability of a modified Sexual Experiences Survey (SES;) to assess sexual victimization among a local community sample of women (n= 1,014). Women who reported sexual victimization were interviewed regarding the most recent incident. Those who responded negatively to all SES items were asked whether they had ever feared they would be sexually assaulted but were not, and to describe that incident. Independent coders read a subset of transcripts (n= 137) and classified each incident as reflecting: one of the SES items, a form of unwanted sex not included on the SES, or not unwanted sex. Coders viewed nearly all incidents elicited by the SES as reflecting some type of unwanted sex. Respondent-coder agreement for rape and coercion incidents was high, but low for contact and attempted rape incidents. The SES scoring continuum, reflecting objective severity of acts, was only modestly associated with subjective trauma associated with rape, attempted rape, coercion, and contact. [ABSTRACT FROM AUTHOR]

Ward, Allison, and Dominique Roe-Sepowitz. "Assessing the Effectiveness of a Trauma-Oriented Approach to Treating Prostituted Women in a Prison and a Community Exiting Program." *Journal of Aggression, Maltreatment & Trauma* 18, no.3 (2009): 293-312.

> Women who have been prostitutes are social work clients in many clinical, correctional, and community settings. Unique programming that addresses the high levels of trauma symptoms reported by prostituted women has yet to be explored. The purpose of this study is to explore the effectiveness of a group trauma and abuse intervention for prostituted women from two settings, prison and a community exiting program. A quasi-experimental research design was used. Twenty-nine women participated in a 12-week psychoeducational trauma and abuse intervention program called Esuba. All participants

reported decreases in trauma symptoms, but the prison group showed a greater number of significant changes in trauma symptomology than the community group. Implications for practice and future research implications are discussed. [ABSTRACT FROM AUTHOR]

Tool Definitions

Adverse Childhood Experiences (ACE)

What is the ACE Study? The ACE Study is an ongoing collaboration between the Centers for Disease Control and Prevention and Kaiser Permanente. Led by Co-principal Investigators Robert F. Anda, MD, MS, and Vincent J. Felitti, MD, the ACE Study is perhaps the largest scientific research study of its kind, analyzing the relationship between multiple categories of childhood trauma (ACEs), and health and behavioral outcomes later in life.

What's an ACE? Growing up experiencing any of the following conditions in the household prior to age 18:

1. Recurrent physical abuse
2. Recurrent emotional abuse
3. Contact sexual abuse
4. An alcohol and/or drug abuser in the household
5. An incarcerated household member
6. Someone who is chronically depressed, mentally ill, institutionalized, or suicidal
7. Mother is treated violently
8. One or no parents
9. Emotional or physical neglect[1]

Child Behavior Checklist (CBCL)

The Child Behavior Checklist (CBCL) was a parent-report questionnaire on which the child was rated on various behavioral and emotional problems. It was first developed by Thomas M. Achenbach and has been one of the most widely-used standardized measures in child psychology for evaluating maladaptive behavioral and emotional problems in preschool subjects aged 2 to 3 or in subjects between the ages of 4 and 18. It assessed internalizing (i.e., anxious, depressive, and over-controlled) and externalizing (i.e., aggressive, hyperactive, noncompliant, and under-controlled) behaviors. Several subareas were measured including social withdrawal, somatic complaints, anxiety and depression, destructive behavior, social problems, thought problems, attention problems, aggressive behavior, and delinquent behaviors.[2]

---

[1] "The Adverse Childhood Experiences (ACE) Study: Bridging the gap between childhood trauma and negative consequences later in life," ACE Study, accessed September 19, 2011, http://www.acestudy.org/.
[2] Inter-university Consortium for Political and Social Research, "Child Behavior Checklist," Project on Human Development in Chicago Neighborhoods, accessed September 16, 2011, *http://www.icpsr.umich.edu/icpsrweb/PHDCN/descriptions/cbcl-w1-w2-w3.jsp*.

Clinician-Administered PTSD Scale (CAPS)

The CAPS is the gold standard in PTSD assessment. The CAPS is a 30-item structured interview that corresponds to the DSM-IV criteria for PTSD. The CAPS can be used to make a current (past month) or lifetime diagnosis of PTSD or to assess symptoms over the past week. In addition to assessing the 17 PTSD symptoms, questions target the impact of symptoms on social and occupational functioning, improvement in symptoms since a previous CAPS administration, overall response validity, overall PTSD severity, and frequency and intensity of five associated symptoms (guilt over acts, survivor guilt, gaps in awareness, depersonalization, and derealization). For each item, standardized questions and probes are provided. As part of the trauma assessment (Criterion A), the Life Events Checklist (LEC) is used to identify traumatic stressors experienced. CAPS items are asked in reference to up to three traumatic stressors. The CAPS was designed to be administered by clinicians and clinical researchers who have a working knowledge of PTSD, but can also be administered by appropriately trained paraprofessionals. The full interview takes 45-60 minutes to administer, but it is not necessary to administer all parts (e.g., associated symptoms).[3]

Impact of Events Scale – Revised (IES-R)

The IES-R is a 22-item self-report measure that assesses subjective distress caused by traumatic events. It is a revised version of the older version, the 15-item IES (Horowitz, Wilner, & Alvarez, 1979). The IES-R contains 7 additional items related to the hyperarousal symptoms of PTSD, which were not included in the original IES. Items correspond directly to 14 of the 17 DSM-IV symptoms of PTSD. Respondents are asked to identify a specific stressful life event and then indicate how much they were distressed or bothered during the past seven days by each "difficulty" listed. Items are rated on a 5-point scale ranging from 0 ("not at all") to 4 ("extremely"). The IES-R yields a total score (ranging from 0 to 88) and subscale scores can also be calculated for the Intrusion, Avoidance, and Hyperarousal subscales. The authors recommend using means instead of raw sums for each of these subscales scores to allow comparison with scores from the Symptom Checklist 90 – Revised (SCL-90-R; Derogatis, 1994). In general, the IES-R (and IES) is not used to diagnosis PTSD, however, cutoff scores for a preliminary diagnosis of PTSD have been cited in the literature.[4]

Life Events Checklist (LEC)

The Life Events Checklist (LEC) is a brief, 17-item, self-report measure designed to screen for potentially traumatic events in a respondent's lifetime. The LEC assesses exposure to 16 events known to potentially result in PTSD or distress and includes one item assessing any other extraordinarily stressful event not captured in the first 16 items. For each item, the respondent

---

[3] Blake, Weathers, Nagy, Kaloupek, Charney, and Keane, "Clinician-Administered PTSD Scale (CAPS), United States Department of Veteran Affairs, National Center for PTSD, last modified August 16, 2011, http://www.ptsd.va.gov/PTSD//professional/pages/assessments/caps.asp.

[4] Weiss and Marmar,"Impact of Events Scale – Revised (IES-R)," United States Department of Veteran Affairs, National Center for PTSD, last modified August 3, 2011, http://www.ptsd.va.gov/professional/pages/assessments/ies-r.asp.

checks whether the event (a) happened to them personally, (b) they witnessed the event, (c) they learned about the event, (d) they are not sure if the item applies to them, and (e) the item does not apply to them.

The LEC was developed concurrently with the Clinician Administered PTSD Scale (CAPS) and is administered before the CAPS. The LEC has demonstrated adequate psychometric properties as a stand-alone assessment of traumatic exposure, particularly when evaluating consistency of events that actually happened to a respondent. The LEC has also demonstrated convergent validity with measures assessing varying levels of exposure to potentially traumatic events and psychopathology known to relate to traumatic exposure. However, the LEC does not establish that the respondent has experienced an event with sufficient severity to meet DSM-IV criteria for a traumatic exposure (Criterion A1), and it does not assess peritraumatic emotional experiences (Criterion A2).[5]

Posttraumatic Stress Diagnostic Scale (PDS)

The Post-traumatic Stress Diagnostic Scale (PDS) was developed and validated by Edna Foa to provide a brief but reliable self-report measure of post-traumatic stress disorder (PTSD) for use in both clinical and research settings.

The scale is intended to screen for the presence of PTSD in patients who have identified themselves as victims of a traumatic event or to assess symptom severity and functioning in patients already identified as suffering from PTSD. The test is self-administered and can usually be completed within 10–15 min and requires a reading age of ~13 years. The pencil and paper and computerized scoring versions of the PDS are available from the test distributor.

Test items mirror DSM IV criteria for PTSD and items are framed in accessible language. Questions relate to the frequency of distressing and intrusive thoughts, post-traumatic avoidance and hyperarousal.[6]

PTSD Checklist (PCL)

The PCL is a 17-item self-report measure of the 17 DSM-IV symptoms of PTSD. The PCL has a variety of purposes, including: Screening individuals for PTSD, Diagnosing PTSD, and Monitoring symptom change during and after treatment. There are three versions of the PCL:
1. The PCL-M (military) asks about symptoms in response to "stressful military experiences." It is often used with active service members and Veterans.
2. The PCL-C (civilian) asks about symptoms in relation to "stressful experiences." The PCL-C is useful because it can be used with any population. The symptoms endorsed may not be specific to just one event, which can be helpful when assessing survivors who have

[5] Blake, Weathers, Nagy, Kaloupek, Charney, and Keane, "Life Events Checklist (LEC)," United States Department of Veteran Affairs, National Center for PTSD, last modified August 17, 2011, http://www.ptsd.va.gov/professional/pages/assessments/life_events_checklist.asp.
[6] McCarthy, Stephen. "Post-Traumatic Stress Diagnostic Scale (PDS)." *Occupational Medicine* 58 (2008): 379.

symptoms due to multiple events. Typically, it is optimal to assess traumatic event exposure to ensure that a respondent has experienced at least one Criterion A event.

3. The PCL-S (specific) asks about symptoms in relation to an identified "stressful experience." The PCL-S is useful because the symptoms endorsed are clearly linked to a specified event. Typically, it is optimal to assess traumatic event exposure to ensure that the event meets Criterion A. Respondents also may be instructed to complete the PCL-S in reference to a specific type of event.[7]

Sexual Assault Symptom Scale (SASS)

The SASS is a 32-item (plus two global emotional trauma items) instrument designed to measure trauma in the immediate aftermath of sexual assault. This is one of the few available self-report measures that is relatively brief and is used to assess initial symptom of sexual assault trauma syndrome (i.e., immediately following the assault). The SASS has four subscales discovered through factor analysis: disclosure shame (DS: items 4, 7, 16, 20-22); safety fears (SF: items 1,9,14,18); depression (D: items 23-25); and self-blame (SB: items 5,6, 13, 29). The items are read by the clinician to the client, who then reports her response.[8]

Sexual Experiences Survey (SES)

The Sexual Experiences Survey (SES) is a widely used 14-item instrument used to measure degrees of sexual victimization. Questions are used to assess whether/if victimization occurred as a result of coercion, threats, drugs, authority, or use of force. One example is "Have you ever had sexual intercourse when you didn't want to because a man gave you alcohol or drugs?"[9]

State-Trait Anxiety Inventory for Children (STAIC[TM])

The STAIC consists of two 20-item scales that measure state and trait anxiety in children between the ages of 8 and 14. The A-State scale examines the shorter-term state anxiety that is commonly specific to situations. It prompts the child to rate 20 statements from hardly ever true to often true. The A-Trait scale measures longer-term trait anxiety, which addresses how the child generally feels. A separate score is produced for the State scale and the Trait scale to determine which type of anxiety is dominant and which type of treatment is the most appropriate.[10]

---

[7] Weathers, "PTSD Checklist(PCL)," United States Department of Veterans Affairs, National Center for PTSD, last modified August 17, 2011, http://www.ptsd.va.gov/professional/pages/assessments/ptsd-checklist.asp.
[8] Joel Fischer and Kevin J. Corcoran, *Measures for Clinical Practice: Adults* 2nd ed. (New York: The Free Press, 1987), 562.
[9]M.P. Koss and C.A. Gidycz, "Sexual Experiences Survey: Reliability and Validity," *Journal of Consulting and Clinical Psychology* 53, no. 3 (1985): 422-423.
[10] Speilberger, Edwards, Lushene, Montuori, and Platzek, "STAICTM: State-Trait Anxiety Inventory for Children," Multi-Health Systems Inc., accessed September 16, 2011, http://www.mhs.com/product.aspx?gr=edu&prod=staic&id=overview.

Symptom Checklist-90-Revised (SCL-90-R)

The Symptom Checklist-90-R (SCL-90-R) instrument helps evaluate a broad range of psychological problems and symptoms of psychopathology. The instrument is also useful in measuring patient progress or treatment outcomes.

The SCL-90-R instrument is used by clinical psychologists, psychiatrists, and professionals in mental health, medical, and educational settings as well as for research purposes. It can be useful in:

- Initial evaluation of patients at intake as an objective method for symptom assessment
- Measuring patient progress during and after treatment to monitor change
- Outcomes measurement for treatment programs and providers through aggregated patient information
- Clinical trials to help measure the changes in symptoms such as depression and anxiety[11]

Trauma History Questionnaire (THQ)

The Trauma History Questionnaire (THQ) is a 24-item self report measure that examines experiences with potentially traumatic events such as crime, general disaster, and sexual and physical assault using a yes/no format. For each event endorsed, respondents are asked to provide the frequency of the event as well as their age at the time of the event. The THQ can be used in both clinical and research settings, and is available in English and Spanish.[12]

Trauma Symptom Checklist for Children (TSCC)

The TSCC evaluates posttraumatic symptomatology in children and adolescents (ages 8 to 16, with normative adjustments for 17 year-olds), including the effects of child abuse (sexual, physical, and psychological) and neglect, other interpersonal violence, witnessing trauma to others, major accidents, and disasters. The scale measures not only posttraumatic stress, but also other symptom clusters found in some traumatized children.[13]

Trauma Symptom Inventory (TSI)

The TSI is used in the evaluation of acute and chronic posttraumatic symptomatology, including the effects of rape, spouse abuse, physical assault, combat experiences, major accidents, and natural disasters, as well as the lasting sequelae of childhood abuse and other early traumatic events. The

---

[11] Leonard R. Derogatis PhD, "Symptom Checklist-90-Revised (SCL-90-R)," Pearson Education, Inc., accessed September 16, 2011, *http://psychcorp.pearsonassessments.com/HAIWEB/Cultures/en-us/Productdetail.htm?Pid=PAg514*.

[12] Green, "Trauma History Questionnaire(THQ)," United States Department of Veteran Affairs, National Center for PTSD, last modified August 16, 2011, http://www.ptsd.va.gov/professional/pages/assessments/thq.asp.

[13] "Trauma Symptom Checklist for Children (TSCC)," John Briere, accessed September 16, 2011, http://www.johnbriere.com/tscc.htm.

various scales of the TSI assess a wide range of psychological impacts. These include not only symptoms typically associated with posttraumatic stress disorder (PTSD) or acute stress disorder (ASD), but also those intra- and interpersonal difficulties often associated with more chronic psychological trauma.[14]

---

[14] "Trauma Symptom Inventory (TSI)," John Briere, accessed September 16, 2011, http://www.johnbriere.com/tsi.htm.