Proposing a Population-Specific Intervention Approach to Treat Trauma Among Men During and After Incarceration

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Men account for up to 90% of the 1.2 million individuals incarcerated in America and approximately 600,000 men are released from state and federal prisons across the country each year (Carson, 2015). Unfortunately, national studies indicate that recidivism after incarceration is strikingly high for these men with nearly three-quarters of men being re-arrested for a new crime within five years of release from a state or federal prison (Carson, 2015). One of the most ignored, but highly influential factors in post-release outcomes of formerly incarcerated men are unaddressed symptoms resulting from lifetime traumatic experiences (LTEs; Hosser, Raddatz, & Windzio, 2007; Kubiak, 2004; Mumola & Karberg, 2006; Nyamathi et al., 2012). According to the American Psychiatric Association, LTEs are inclusive of the following experiences: direct personal experiences of victimization; threat of serious injury or death; experiencing serious injury; learning of a serious injury or death occurring to a loved one; or personally witnessing an event that involves death or serious injury/threat to another person (American Psychiatric Association, 2013). Thus, LTEs capture both directly experiencing or witnessing a traumatic event and LTEs may occur in childhood or adulthood.

The prevalence of LTEs among current and formerly incarcerated men is striking. Between 62% and 98% of incarcerated men (rates vary based on study methods, such as probability and random sampling) report at least one LTE prior to incarceration (Breslau, 2009; Pettus-Davis, 2014; Wolff, Heuning, Shi, & Frueh, 2014). The rate of LTEs among incarcerated men is much higher than men who have never experienced incarceration. In studies capturing national samples of men in the general population via panel surveying and geographically stratified random sampling find that between 22% and 47% of men report LTEs (Briere & Elliott, 2003; Kilpatrick, Resnick, Milanak, Miller, Keyes, &
Some of the differences between incarcerated and general population samples may be driven by the high proportion of ethnic minorities in correctional settings. While the literature is mixed, multiple studies suggest that African-Americans and Latinos have the highest rates of PTSD among racial groups suggesting that they may experience higher rates of LTEs (Hall, Sawyer, Golik, & Asnaani, 2016).

Addressing LTEs among incarcerated men is important because over 95% of people who become incarcerated eventually get released (Travis, 2005). Trauma symptoms and risks for recidivism (i.e., continued criminal justice involvement after release from incarceration) are correlated. Trauma symptoms include: increased sensitivity to stress, high levels of negative emotionality, sensation seeking (i.e. tendency to pursue novel and highly stimulating experiences), aggression, impulsivity (Clark, Reiland, Thorne & Cropsey, 2013; Najavits & Walsh, 2012; Otto, O’Cleirigh, & Pollack, 2007) dissociation, impaired ability to adequately assess risk, and unrealistic expectations of relationships that can result in unstable social support (Fagan, 2005; Topitzes, Mersky, & Renolds, 2012). Moreover, untreated symptoms of LTEs in studies with adults with criminal histories significantly predict violent and non-violent criminal behaviors (Nyamathi et al., 2012), increased rates of substance abuse (Mumola & Karberg, 2006), destabilizing mental health problems (Hosser et al., 2007) including PTSD (Fagan, 2005; Topitzes et al., 2012), and high treatment drop-out rates from substance abuse treatment (Kubiak, 2004). Indeed, incarceration itself may exacerbate symptoms associated with untreated LTEs (Kubiak, 2004; Moloney, van deh Bergh, & Moller, 2009; Messina, Calhoun, & Braithewaite, 2014). For incarcerated individuals, the number of LTEs is highly correlated with the number of incarcerations (Mersky, Topitzes, & Reynolds,
Trauma increases the odds of engagement in lawbreaking, arrest, incarceration and recidivism, which in turn, contributes to a higher likelihood of additional trauma (Jennings, Piquero, & Reingle, 2012; Sadeh, & McNiel, 2014).

Thus for most, the multiple challenges of stabilizing in the community after incarceration combined with the potential negative impact of unaddressed LTEs create circumstances that increase men’s risk for recidivism and, in turn, threaten public safety. Therefore, understanding how to provide services to respond to LTEs and to treat trauma related symptoms among incarcerated and formerly incarcerated men is an urgent public health issue.

Yet, relatively little research has been conducted on trauma treatment for men or women during and after incarceration (Van Buren, Stocke, Wunderlich, & Thurston-Snoha, 2014). A handful of small trials have been conducted with incarcerated women (Messina, Grella, Cartier, & Torres, 2010; Zlotnick, Johnson & Najavits, 2009). These trials report promising evidence, but are limited by small sample sizes, short or no follow-up data collection, and modest impact on outcomes. Only one randomized controlled trial of a trauma intervention has been conducted with incarcerated men. To our knowledge, no studies have looked at differential responses by gender to trauma treatment among incarcerated samples. Yet, research demonstrates that men are likely to respond to trauma treatment differently than women. Findings from a recent meta-analysis indicates that women have greater reductions than men in clinician-rated PTSD symptoms at post-intervention and short-term follow-up (Wade, Varker, Kartal, Hetrick, O'Donnell, & Forbes, 2016).
Tailoring interventions to men requires situating the interventions within the discourse on masculinity, as well as the interaction between masculinity and trauma. In general, men in the United States are socialized to meet the norms of traditional masculinity (Hopton & Huta, 2013). Levant and colleagues (1992) posited that masculine norms consisted of “avoiding femininity, restrictive emotionality, achievement and status, self-reliance and aggression” (p. 328; see also David & Brannon, 1976). While such social norms evolve over time, there is little doubt that in general, men find it ideal to be viewed as strong and independent. These inculcated norms are thought to be a source of hardship for men (Chan, 2014). In particular, the collision of LTEs with such prevalent norms presents challenges, and some opportunities, for men who experience trauma symptoms.

The widespread acceptance of traditional masculinity by men who experience trauma symptoms has significant implications for intervention. Such men may believe that they should be able to self-heal or otherwise recover from trauma without assistance (Connell, 2005). When they are unable to do so, this can be perceived as a failure to meet traditional gender norms (“Discrepancy Strain”), (Baljon, 2011). Feelings of failure to meet gender norms further leads to guilt, shame, self-stigma, and a reluctance to seek help or self-disclose (Liu, Rochlen, & Mohr (2005). This cascade effect has ramifications for intervention, particularly recruitment, retention, and openness during psychotherapy.

While masculine gender norms exist throughout the population, hypermasculinity is common among incarcerated males. This is a form of exaggerated masculinity, thought to result from a covert hypervulnerability, and frequently stemming from prior abuse (e.g., sexual abuse), which is particularly emasculating (Cassidy & Stevenson, 2005;
Forde & Duvvury, 2017). Importantly, hypermasculinity is associated with violence (Beasley & Maguire, 2007). Of course, by their very nature, prisons are hypermasculine environments. This presents a challenge when incarcerated men are released, as they face the task of modulating their behavior based on a new set of norms where traditional masculinity is largely acceptable but hypermasculine behaviors, such as aggression, are likely to lead to re-incarceration (Evans & Wallace, 2008).

Several studies suggest that traumatized men are at a disadvantage compared to women; they seem to respond less to intervention (e.g., Vishneyisky, Cann, Calhoun, Tedeschi, & Demakis, 2010). Men who adhere to traditional gender roles display lower rates of post-traumatic growth (i.e., Barlow, & Hetzel-Riggin, 2017). In a similar vein, in an often overlapping population with incarcerated and formerly incarcerated men, a study of homeless men found that high gender role conflict was correlated with negative self-appraisal and low confidence (Nguyen, Liu, Hernandez, & Stinson, 2012) which could inhibit post-traumatic growth. These studies underscore the importance of considering differential gender responses in both research and implementation of trauma interventions.

In addition to gender differences, it is important to research which trauma intervention approaches are appropriate within the incarceration and reentry context (i.e., the transitional period immediately following incarceration). Existing empirically supported trauma treatments conducted among the general US population have established effectiveness with recipients who are in stable and safe environments. In fact, stable and safe conditions is often a prerequisite for treatment. Incarceration and the reentry period following incarceration is rarely experienced as safe or stable. Conversely,
incarceration is described as a hyper-masculine (Seymour, 2003) and frequently hostile environment (Haney, 2002) and high proportions of men release from incarceration into volatile communities (Clear, 2009). Regardless of the stability of the community to which a man returns, the pressure of securing housing, obtaining employment, establishing social support, and securing other life necessities during reentry is highly disorienting (Jonson & Cullen, 2015). Thus, it is also important to understand what types of trauma interventions are needed for men during and after they release from incarceration. Focusing only on treatment during incarceration ignores the likelihood that men will need additional and different tools and skills after release from incarceration when the stressors have heightened and relationships and daily living situations need to stabilize. Post-release treatment has the potential to reduce post-incarceration LTE exposure by increasing coping skills, that when weakened, result in men re-engaging in risky situations related to crime, violence, or illicit substances.

We aim to advance the field toward gender specific and incarceration responsive trauma intervention approaches. We build on existing empirically supported trauma treatment models and propose a phased intervention approach to trauma treatment that is responsive to the unique context of incarceration and reentry to communities. We offer an intervention approach to guide trauma treatment research and practice innovations specific to men and masculinity. We build into the model key empirically supported treatment ingredients overtime in a way that we propose is most sensitive to the stages of reentry. We conclude with critical next steps needed to advance the practice and research of implementing transitional trauma treatment for incarcerated men during and after release from incarceration.
Background

Prevalence of LTEs among Current and Formerly Incarcerated Men

LTEs that occurred prior to incarceration for men more than double the rate of LTEs of men in the general population. Previous research has demonstrated that 58% of incarcerated men report childhood physical abuse compared to 14% of males in community based samples, and 17% of incarcerated men report prior sexual abuse compared to 10% of community-based men (Center for Disease Control and Prevention, 2010; Swogger, You, Cashman-Brown, & Conner, 2011; U.S. Department of Veterans Affairs, [VA], 2015). Although incarcerated men and women report similarly high rates of trauma, the types of trauma they experience differs across the lifespan. Incarcerated men report much higher rates of witnessing extreme harm to others in childhood (30.4% vs 15.6%) and adolescence (60% vs 34.8%), and being victims of interpersonal nonsexual trauma in adolescence (63.2% vs 34.8%; Komarovskaya et al., 2011). In contrast, incarcerated females report higher rates of interpersonal sexual trauma, sexual contact without consent, in childhood (31.2% vs 15.2%), adolescence (35.3% vs 6.4%), and adulthood (27.7% vs 4.8%; Komarovskaya, Booker-Loper, Warren, & Jackson, 2011). Additionally, incarcerated men are more likely to report experiencing traumatic events while incarcerated than women (Kubiak, 2004). Even with the similarly high rates of trauma exposure between men and women, most research efforts on trauma treatment delivery to an incarcerated population prioritizes women. However, although the types of LTEs differ, given the high prevalence of LTES among incarcerated men, it logically follows that men could equally benefit from treatment for trauma symptoms.
Histories of LTEs permeate the lives of many men during and after incarceration in addition to the LTEs experienced prior to incarceration. The amount of violence that occurs during incarceration and who perpetrates the violence is a reflection of the unpredictable living conditions found in many incarceration settings. Studies show that incarcerated men are at risk for cumulative LTEs during incarceration (Wolff, Blitz, Shi, Siegel, & Bachman, 2007; Struckman-Johnson & Struckman-Johnson, 2000). Almost one-quarter of incarcerated men report being sexually victimized during incarceration (Struckman-Johnson & Struckman-Johnson, 2000). Nearly 60% of those victimized men indicated that the sexual perpetrator was a correctional staff person. A notably smaller percentage, 26%, reported another prisoner was the assailant, while 15% indicated that both correctional staff and other prisoners had sexually victimized them (Struckman-Johnson & Struckman-Johnson, 2000). Further, data from 13 adult male prisons show a prevalence rate for inmate-on-inmate physical assault to be 252 per 1,000 and a higher rate of 292 per 1,000 for staff-on-inmate physical assaults (Wolff et al., 2007). Even with these exceptionally high rates of violence, researchers suggest that the reports of physical and sexual assaults are grossly underrepresented because of fear of retaliation, stigmatization around male rape, and a prison code of “no-snitching” (Wolff et al., 2007).

Much less is known about LTEs after incarceration, because such little research has been done. Data suggest that LTEs do not cease after release from incarceration. In the single study that reported rates of post-incarceration LTEs, Boxer and colleagues (2011) found that former prisoners reported experiencing up to 3 LTEs, with an average of 1.3 LTEs within the first two to three years of release.

**Impact of LTEs on Current and Formerly Incarcerated Men**
LTEs among current and formerly incarcerated men have implications for individual outcomes as well as public health and public safety. Consistent with research on non-incarcerated groups, for current and formerly incarcerated men, LTEs predict psychological distress (Dube, Felitti, Dong, Chapman, Giles, & Anda, 2003; Medrano, Hatch, Zule, & Desmond, 2002; Porter, 2013) and negative mental health outcomes (Hochstetler, Murphy, & Simons, 2004; Komarovskaya et al., 2011; Wolff, Shi, & Schumann, 2012). Furthermore, as the number of LTEs increase, the degree of mental health and psychosocial impairment requiring treatment increases (Anda et al., 2006; Hosser et al., 2007; Khoury, Tang, Bradley, Cubells, & Ressler, 2010; Messina, Grella, Burdon, & Prendergast, 2007; Porter, 2013) – yet receipt of effective treatment remains rare for incarcerated and formerly incarcerated men (Heckman, Crospey, Olds-Davis, 2007; Wallace, Connor, Das-Bralsford, 2011). In part due to the lack of provision of effective treatment for those who have been exposed to LTEs, posttraumatic stress disorder (PTSD) diagnosis is higher among men with incarceration histories (21%) compared to men in the general population (4%-5%) and male veterans (7%; Breslau, 2009; VA, 2015; Wisco, Marx, Wolf, Miller, Southwick, & Pietrzak, 2014; Wolff et al., 2014). Moreover, PTSD diagnosis is significantly correlated with exposure to violence prior to incarceration (Hochstetlter et al., 2004).

LTEs among men who have experienced incarceration are also associated with high rates of substance use (Komarovskaya et al., 2011; Wolff & Shi, 2012; Wolff et al., 2014) and diagnosable substance use disorders (Fagan, 2005; Fergusson, Boden, & Horwood, 2008; Huang et al., 2011). A recent study found that among a randomly sampled group of incarcerated men with LTEs (n=163), 86% screened positive for a
substance use disorder compared to 68% of those men without trauma histories (Pettus-Davis, 2014). In a similar study that examined the relationship between LTEs and substance use with a national sample of male state prisoners, drug dependent men were more likely to report prior sexual or physical abuse (23%) compared to non-drug dependent men (15%; Mumula & Karberg, 2006). Furthermore, research has demonstrated that incarcerated men with substance use disorders are 80% more likely to have experienced at least two or more LTEs (Messina et al., 2007). Incarcerated men with co-occurring substance use disorders and LTEs are substantially more likely than those without co-occurring disorders to re-engage in substance use after release (Mumola & Karberg, 2006; Schroeder, Giordano, & Cernkovich, 2007; National Center on Addiction and Substance Abuse at Columbia University, 2010) and to be re-arrested (Hosser et al., 2007; Mersky, Topitzes, & Reynolds, 2012; Topitzes, Mersky, & Reynolds, 2012). In addition to crime, increased prevalence of substance use leads to heightened risk for the spread of sexually transmitted diseases (Braithwaite, Stephens, Conerly, Jacob Arriola, & Robillard, 2004).

Men with LTEs who have experienced incarceration have previously engaged in higher rates of violence and have a greater risk of engaging in future violence (Burnette et al., 2008; Hill & Nathan, 2008; Van Buren et al., 2014; Wolff et al., 2014). Some research suggests that the roots of violent behaviors among incarcerated men may be partially attributed to prolonged history of LTEs (Forsman & Långström, 2012; Nyamathi et al., 2012). In a study of 1,526 young incarcerated men (age 14-24), frequent victimization was associated with onset of aggression early in life (Hosser et al., 2007). Moreover, research has demonstrated that men who are incarcerated for committing
lethal violent criminal acts (i.e. murder) are more likely to have experienced victimization at an early age (Burnette et al., 2008; Hill & Nathan, 2008; Nyamathi et al., 2012) and are 4.5 times more likely to have been physically abused than those not incarcerated (Christofferson, Soothill, & Francis, 2007). Violence exposure during incarceration can trigger outward-directed trauma responses such as aggression and heightened arousal, when the body and mind are more alert, that can threaten others (Freedman & Hemenway, 2005). Experiencing violence after incarceration is significantly correlated with beliefs supporting aggression, negative emotional reactivity to violence, antisocial behavior, emotional distress, and financial risk (i.e. food insecurity; Boxer et al., 2011).

Previous research has demonstrated that men with LTEs have greater difficulty with effectively reconnecting with positive social supports after incarceration. This lack of positive social support during reentry, which could promote better behavioral health and desistance from criminal behaviors, occurs as a side effect of the symptoms (i.e. depression and anxiety) associated with history of LTEs (Herman, 1992; Pettus-Davis, 2014; Topitzes et al., 2012; Van Voorhees, et al., 2012). Disruption of positive relationships is problematic in that it removes a protective layer against the negative impact of LTEs such as psychological distress (Haden & Scarpa, 2008; McLewin & Muller, 2006) and violent offending (Maschi, et al., 2010). Moreover, positive support has the ability to promote well-being post-incarceration by reducing social isolation (Havassy, Hall, & Wasserman, 1991); buffering the impact of negative social influences (Thoits, 1986); providing essentials such as housing, clothing, food, transportation, financial assistance, and assistance getting a job (Naser & La Vigne, 2006; Visher & Courtney, 2006); increasing exposure to people who can help manage stress (White,
2009); and promoting self-efficacy and treatment retention (Dobkin, Paraherakis, & Gill, 2002). Therefore, a key to successful reentry is having positive social support in the community after prison and these very relationships can be difficult to establish or maintain in the presence of cumulative and untreated symptoms associated with LTEs (Pettus-Davis, 2014).

**Overview of Empirically Supported Trauma Interventions with Non-Incarcerated Persons**

Substantial research exists on the development of empirically supported trauma interventions for non-incarcerated populations. Because this paper is not intended to provide an extensive review of trauma treatment literature, we focused on four widely used trauma treatment approaches that have undergone at least two randomized controlled trials and established effectiveness with a range of non-incarcerated populations with varied LTEs. These therapies include cognitive processing therapy, eye movement desensitization and reprocessing (EMDR), prolonged exposure therapy, and skills training in affective and interpersonal regulation (STAIR).

Sixteen randomized controlled trials examining the effectiveness of cognitive processing therapy have been conducted with veterans, women who have been sexually assaulted as children or as adults, and individuals who have experienced multiple or complex traumas (Chard, 2005; Falsetti, Resick, Davis, & Gallagher, 2001; Monson et al., 2006; Resick et al., 2008). Cognitive processing therapy is effective at reducing panic attacks \(d = 1.55\), PTSD \(d = 1.55\), trauma symptomatology \(d = .74\), and depression \(d = 1.42\); Chard, 2005; Falsetti, Resick, Davis, & Gallagher, 2001; Monson et al., 2006; Resick et al., 2008). Across 20 randomized controlled trials, EMDR has been found
effective at significantly decreasing PTSD ($d = 1.53$), depression ($d = 1.73$), anxiety ($d = .49$), and subjective distress symptoms ($d = 2.07$; Bisson et al., 2007; Chen et al., 2014). EMDR’s effectiveness has been established with ethnically diverse samples with mixed LTEs in treating male and female children, adolescents, and adults (Ahmad & Sundelin-Wahlsten, 2008; Bisson et al., 2007; Edmond & Lawrence, 2015; Rodenburg, Benjamin, de Roos, Meijer, & Stams, 2009). Prolonged exposure (PE) therapy has been rigorously tested and commonly endorsed as a first line of treatment for PTSD (e.g., Veteran Affairs and American Psychiatric Association). PE is an exposure therapy program that has been found to address multiple types of trauma, from sexual and nonsexual assault to combat and natural disaster across multiple populations (Nacasch, Rachamim, & Foa, 2015; Powers, Halpern, Ferenschak, Gillihan, & Foa, 2010). PE has been shown to outperform control conditions on primary and secondary outcomes at the conclusion of treatment and at later follow-up (Powers et al., 2010). Outcomes have included reduced incidences of PTSD ($d = 1.46$); lowered depression ($d = 1.42$) and anxiety ($d = 1.32$), and higher ratings of quality of life (Hedge’s $g = 0.77$; McLean & Foa, 2011; Nacasch et al., 2015; Powers et al., 2010). Lastly, Skills Training in Affective and Interpersonal Regulation (STAIR) has growing empirical support for improving PTSD recovery ($d = 1.03$), emotion regulation ($d = 1.32$), and interpersonal relationships ($d = .67$; Cloitre et al., 2010; Gudino, Leonard & Clotet, 2014; Trappler & Newville, 2007). Two randomized controlled trials have been conducted with male and female adolescents and adults with single and multiple trauma histories (Cloitre, Koene, Cohen, & Han, 2002; Cloitre, et al., 2010). STAIR is still under development as interventionists combine the original STAIR model with Narrative Storytelling Therapy (NST) – a form of cognitive processing
therapy; and/or test adapted versions of STAIR for adolescent samples that are school based and have tailored content that is developmentally more age appropriate (Gudino, Leonard, & Cloitre, 2016).

**Trauma Interventions for Incarcerated Individuals**

We contacted 50 state departments of corrections in the United States that oversee the state prison system to inquire about their use of trauma interventions (*citation omitted for peer review*). Forty-two state correctional departments responded to requests for information; 32 had implemented trauma interventions; 20 of the states with trauma interventions offered those interventions to both men and women. Although it is encouraging to see that 76% of prison systems implemented some form of trauma treatment, many of the interventions that states identified have limited research on their effectiveness in reducing trauma symptoms among this population.

An intervention entitled Seeking Safety was the most commonly used intervention by state correctional agencies (60% reported its use). Seeking safety is a group-based cognitive behavioral intervention designed for co-occurring PTSD and substance use disorders. The only published RCT of Seeking Safety among an incarcerated sample (*n* = 49 incarcerated women) compared Seeking Safety to a psycho-education, abstinence based substance abuse treatment program for those with substance use disorders and PTSD (Zlotnick, Johnson, & Najavits, 2009). The study found Seeking Safety to have small effects on trauma related outcomes such as PTSD (*d* = .17), alcohol use (*d* = .11), and drug use (*d* = .22; Zlotnick et al., 2009).

Other states implemented a variety of different interventions including Beyond Trauma (25%), Helping Women Recovery (12%), and Trauma Recovery Empowerment
Model (TREM; 13%). Beyond Trauma (paired with Helping Women Recovery) has undergone one RCT ($n = 115$ incarcerated women; Covington, 2008; Messina et al., 2010). Beyond Trauma is a group-based intervention that employs a strengths-based approach to psychoeducation, cognitive behavioral therapy, relational therapy, and mindfulness; while Helping Women Recovery is a group-based substance use treatment that uses cognitive behavioral therapy principles. Compared to a treatment-as-usual control condition, which for this study was a standard prison-based therapeutic community, the trial found the combined Beyond Trauma/Helping Women Recover to have low to moderate effects on re-incarceration ($d = .28$) and substance use ($d = .44$) within 12 months after release from prison. Measures of psychological well-being demonstrated no significant difference between study conditions.

Three other interventions that were not mentioned by state departments in the survey have undergone a RCT with incarcerated women. Trauma Affect Regulation: Guide for Education and Therapy (TARGET) has an established evidence-base in non-incarcerated samples, and has recently been studied in an RCT with 72 incarcerated women (Ford, Chang, Levine, & Zhang, 2013; Ford & Russo, 2006). TARGET, as well as the control condition of supportive group therapy, was found to be efficacious in reductions of PTSD and associated symptom severity ($d = .79$) and increased self-efficacy ($d = .49$). TARGET had significantly higher positive impacts on increasing a sense of forgiveness ($d = .93$) when compared to the control group. Lastly, in a RCT with 123 female prisoners, the effectiveness of Traumatic Incident Reduction Therapy was examined with a waitlist control (Valentine & Smith, 2001). Traumatic Incident Reduction Therapy focuses on being both client-respectful and therapist-directed and is a
brief memory-based therapeutic intervention. Women who received the Traumatic Incident Reduction Therapy had significantly greater improvement in PTSD ($d = .68$), anxiety ($d = .52$), depression ($d = .56$), and expectancy for success (i.e., low self-efficacy; $d = .58$; Valentine & Smith, 2001).

In the only trauma intervention study implemented with incarcerated men, researchers employed a comparative effectiveness trial of two trauma interventions originally designed for women – Seeking Safety (SS) and Trauma Recovery Empowerment Model (adapted to Men’s TREM or M-TREM). TREM assists in trauma recovery through cognitive restructuring, psychoeducation, and coping skills training. In the study of 230 incarcerated men, Wolff and colleagues (2015) found that across the two conditions there were significant improvements in mental health symptoms ($\eta^2 = .52$), PTSD severity ($\eta^2 = .43$), self-esteem ($\eta^2 = .56$), coping ($\eta^2 = .68$), and self-efficacy ($\eta^2 = .36$) outcomes, which were sustained over a six-month prison-based follow-up. Data comparing the effectiveness of M-TREM to Seeking Safety on PTSD symptom severity, revealed no significant differences between treatment groups six months post-intervention. PTSD severity declined by 19 points for men who received Seeking Safety and 21 points for those who received M-TREM (Wolff et al., 2015).

**Proposed Trauma Intervention Approach**

Current empirically supported trauma interventions offer a myriad of options for treating trauma among incarcerated men during and after incarceration. Common treatment elements across the empirically supported and promising treatment approaches with samples regardless of incarceration status include: psychoeducation, emotion regulation, coping skills, managing triggers, interpersonal functioning, social support, and
cognitive processing. We propose a transitional (i.e., spans prison-to-community) trauma intervention approach that aligns with the phases of reentry. We use these existing common treatment elements to form an intervention approach that accommodates individual and group treatment and targets factors associated with increased trauma symptoms. Before describing the proposed intervention approach, it is important to review the circumstances of incarcerated men that demonstrate the need for incarceration and reentry-specific adaptations to trauma treatment approaches.

**Circumstances of Incarcerated Men**

Incarceration is psychologically taxing because it creates an unnatural human environment characterized by a loss of control over activities, deprivation of privacy, rigid institutional routine, and creation of a stigmatized status for prisoners (Haney, 2002). Conditions of confinement can result in social-sensory disorientation, alienation, and institutionalized traits (e.g. paranoia and hampered decision-making; Liem & Kunst, 2013). In addition to formal rules of incarceration, a culture of informal rules and norms is also present in most settings (Haney, 2002; Johnson-Listwan, Colvin, Hanley, & Flannery 2010). This culture often discourages sharing and vulnerability and encourages choosing between isolation or violence (Haney, 2002; Johnson-Listwan et al., 2010). Many who are incarcerated experience feelings of increased vulnerability to harm and limited ability to respond to threats to personal safety (Ireland, 2011). Further, distrust and hesitation to share personal experiences is rampant among prisoners and staff (Wolff & Shi, 2009).

The shifts in thinking about freedom, trust, safety that are required to adjust to incarceration may limit the ability for individuals who are incarcerated to fully benefit
from traditional treatment approaches (Haney, 2002). Positive social interactions and coping behaviors are not consistently rewarded, thus potentially limiting the “uptake” of certain types of coping and cognitive-behavioral intervention targets. The circumstances of incarceration have led some researchers to call for trauma-informed correctional care wherein adaptations are made to existing “trauma-informed” approaches in order to respond to the context of incarceration (Miller & Najavits, 2012). For example, addressing trauma in correctional facilities requires sensitivity to the trauma triggers that occur often, such as strip searches, frequent discipline, and restricted movement – all of which are likely to increase trauma-related behaviors (Covington, 2008).

Experiences during incarceration may exacerbate the impact of LTEs on men’s outcomes as they transition out of incarceration and back to the community. Adaptation to incarceration can create thinking and acting habits such as physical violence to demonstrate power or territory that are maladaptive in prosocial communities post-incarceration (Haney, 2002). Living in the threatening environment of incarceration increases psychological distress, which manifests as posttraumatic stress cognitions for some formerly incarcerated individuals (Johnson-Listwan et al., 2010).

The transition from incarceration to the community is a period of renegotiation and can be volatile (Pettus-Davis, 2014). Men are at greatest risk of problematic behaviors and contact with the law earliest after release from incarceration (Mears, Wang, Hay, & Bales, 2008; Stabler, Mennis, Belenko, Welsh, Hiller, & Zajac, 2013). This occurs because the early months after release are stressful for most as they re-orient to community-based living, new and old relationships, and struggle with unrealistic expectations of immediate self-sufficiency (Arditti & Parkman, 2011; Liem & Kunst,
2013). However, protective factors of stability and social support from loved ones that may have existed prior to incarceration have been disrupted. Complicating matters, men returning to communities after prison often have multifaceted and complex needs, with limited access to formal supports (Taxman, Perdoni, & Caudy, 2013) for public assistance and behavioral or physical health (Mallik-Kane & Visher, 2008; Wheeler & Patterson, 2008; Zajac, Hutchison, & Meyer, 2014). Lack of formal supports are coupled with the fact that high unemployment and homelessness are pervasive among previously incarcerated men (Geller & Curtis, 2011; Hagan & Foster, 2012; Harley, 2014; James, 2015) making it more difficult to stabilize after release from incarceration. Perceived racial discrimination, low socioeconomic status, and poverty-related environmental stress (all common among formerly incarcerated individuals) are also known to contribute to the development of PTSD following LTEs (Cerezo, 2016; Roberts, Gilman, Breslau, Breslau, and Koenen, 2011). Building on our understanding of the experiences of incarcerated and formerly incarcerated individuals, we propose a gender tailored, incarceration and reentry specific trauma intervention approach not previously described in published literature.

**Overview of Proposed Intervention Approach**

The purpose of proposing a tailored intervention approach is to provide a conceptual framework, as well as practical strategies, that can be used to design, implement, and research a trauma intervention for men during and after incarceration. Our trauma intervention approach is comprised of treatment components that aim to help individuals to learn about trauma; become aware of and contextualize their trauma experiences and potential trauma symptoms; develop skills to counter maladaptive
thoughts and behaviors; and process trauma to the extent necessary in order to build and enhance healthy life experiences and reduce risks for recidivism. Our own anecdotal experience delivering services in incarceration and post-incarceration settings, prior research, and prominent psychosocial theories underlying trauma intervention research grounded us in thinking through the proposed intervention approach. We stage the intervention approach across the transitional phase of during and after incarceration we refer to as the reentry context. The reentry context begins approximately three to four months prior to release from incarceration and continues for the first 12 months after release from incarceration.

We propose a multi-phased trauma intervention approach because of the transitional nature of reentry to communities. Individuals’ transition from incarceration to the community is best understood longitudinally, taking into account immediate (e.g., where to live the first day after release from incarceration) and long-term situational circumstances (e.g., livable income and stable housing; Visher & Travis, 2003). It is important to note that our model is specific to trauma treatment and is likely best paired with other reentry services such as assistance with finding employment, housing, and other formal supports.

In our proposed intervention approach, Phase 1 (during incarceration) begins three to four months prior to an individual’s release from incarceration. Phase 2 (referred to as “reentry”) represents the initial days and weeks after release from incarceration and reentry to the community. This “re-orientation” phase spans the first three to four months after release. Phase 3 (referred to post-incarceration) is the community stabilization period that begins around month five or six after release from incarceration.
Key Ingredients of the Intervention Approach by Phase

Phase 1: During Incarceration (3–4 months prior to release). During phase 1, our intervention approach acknowledges that confinement in the hostile environment of incarceration can impede the relief of trauma symptoms because LTEs may continue to occur during incarceration. Perpetual distrust and fear of staff, treatment providers, and other prisoners may exacerbate symptoms because of the inability to access therapy or support for verbal processing of LTEs. The transactional model of stress and coping provides some guidance as to why the incarceration environment may impede the relief of trauma symptoms or even exacerbate symptoms. According to the transactional model of stress and coping, when individuals experience stressors (such as LTEs or incarceration), an individual assesses potential threats, as well as their ability to modify the situation and handle negative emotional reactions. The impact of the stressor is then mediated by the resources at one’s disposal (Glanz, Rimer, & Viswanath, 2008; Lazarus & Cohen, 1977). Incarceration settings are unpredictable due to rapidly changing social composition (new prisoners entering and releasing from the facility daily; high staff turnover; prevalence of violence) and the nearly total lack of control of one’s surroundings (Bonta & Gendreau, 1990; Picken, 2012; Wolff & Shi, 2009). Therefore, an individual is likely to experience the likelihood of a repeat LTE as high during incarceration while also perceiving themselves as having little resources to respond to stress or threats related to LTEs resulting in an increased likelihood that LTE symptoms will be exacerbated. The first phase of our proposed intervention approach accommodates
the incarceration context by focusing on increasing internal resources of incarcerated men for responding to stressors or symptoms related to LTEs.

**Phase I Intervention components.** Phase 1 emphasizes trauma psychoeducation and the initial development of emotion regulation and coping skills. A primary focus on psychoeducation reduces the need to disclose specifics of LTEs and thus does not require men to ignore feelings of distrust, lack of control, or fear engendered in an incarceration environment. Psychoeducation will include definitions of trauma; information about the prevalence and types of trauma experienced by incarcerated men; common reactions to LTEs; potential immediate and long terms impacts of LTEs; and connections between LTEs, PTSD and substance use. Coping skills and emotion regulation strategies effective during incarceration may need to be adjusted after release as new and different stressors surface. Phase 1 will build emotion regulation and coping skills focused on distress reduction strategies that are adaptive enough to be applied during and after incarceration while recognizing that new strategies may need to be adopted post-release. Distress reduction will introduce participants to relaxation strategies such as breath training and visualization that can be revisited throughout treatment to reduce anxiety generated by trauma reminders and the stress of releasing from incarceration.

Self-compassion is also targeted during Phase 1 because it moderates the relationship between gender norm adherence and issues such as the perceived risk of disclosure and self-stigma (Heath, Brenner, Vogel, Lannin, & Strass, 2017; Heath, Brenner, Lannin, & Vogel, 2018). Self-compassion is the ability to be benevolent to one’s self in the face of difficult challenges. Increasing self-compassion has the potential to increase both retention and engagement of men in treatment. While there is limited
research on this topic, there are a range of possible intervention components to address
self-compassion, among them, self-authoring, psychoeducation, and mindfulness
techniques (Heath et al., 2017; Ko, Grace, Chavez, Dalyrmple, & Olson, 2018).

Phase 1 can address LTEs directly and develop safe coping skills without asking
the recipient to delve into distressing memories (Miller & Navajits, 2012). In addition to
providing men with much needed tools they can use during the highly stressful time of
reentry, engaging individuals pre-release increases the likelihood of engaging them in
treatment post-release.

Given the reluctance on the part of traumatized men to seek help, the issue of
initial engagement and recruitment in Phase 1 deserves significant attention. A recent
systematic review concluded that depressed men do seek treatment -- when it is engaging,
appropriate, and accessible (Seidler, Dawes, Rice, Oliffe, & Dhillon (2016). The authors
suggest cognitive behavioral therapy as an intervention that plays to men’s strengths, and
it may be seen as more engaging then some other approaches. Beyond making the
program logistically smooth and appealing, recruitment could be boosted by using
incentives. These could include, for instance, increased exercise time for men who
participate (Ritter, Stover, Levy, Etter, & Elger, 2011). A social marketing approach to
recruitment for a smoking cessation program for incarceration men showed promising
results (MacAskill, Lindridge, Stead, Eadie, Haton, & Braham, 2008), and elements of
this model could be exported to the present intervention. During this engagement phase,
it will likely be important for men to be able to contact intervention deliverers before and
between sessions in order to allow them to further discuss any resistance, hesitancy, or
increased feelings of vulnerabilities related to intervention participation.
Phase 2: Reentry (3-4 months after release). Individuals who have released from incarceration describe the initial weeks and months in the community as disorienting as they work to put back together the pieces of their lives and selves that existed prior to incarceration. Phase 2 emphasizes developing, practicing, and refining coping and emotion regulation skills to help recently released men navigate an early and uncertain post-release environment. According to relational theory, individuals view “self” as a fluid entity that shifts in the contexts of relationships (Miller, 1984). The context of men leaving prison and reentering into the community is complex and wrought with conflicting messages of who “self” should be. During incarceration, “self” should be tough and respected by their fellow prisoners and at the same time viewed as a “flawed” offender/convict/felon in need of correction by staff. By removal from community to confinement, incarceration disrupts relationships leaving any positive influences remaining in the community in need of being renegotiated upon reentry to the community. Renegotiation of relationships (both old and new) can be destabilizing to perception of self as well as to the relationship of self to the post-release community. The psychological disorientation of incarceration and the need for renegotiation of the post-release environment heightens stress (potentially exacerbating trauma symptoms) and threatens the ability to establish connection and authenticity in positive post-release relationships by impeding the ability to cope with stress or emotions (Miller, 1984; Scheyett et al., 2010). Therefore, skill development and practicing of those skills is critical to phase 2 of the intervention approach.

Phase 2 Intervention components. In order to individualize post-release intervention experiences, this phase includes an assessment of trauma history, emotion
regulation difficulties, social support and interpersonal challenges, risky or harmful behaviors, and existing coping strategies. During phase 2, participants will be encouraged to regularly practice distress reduction strategies and coping skills when they encounter situations that may trigger problematic thoughts (e.g., craving to use illicit substance) or behaviors (e.g., aggression or crime). Providing intervention participants with enhanced emotion regulation skills will further increase the likelihood of achieving coping self-efficacy and decrease the risk of engaging in negative coping strategies. With these acquired skills, participants will be better equipped to actively enhance interpersonal relationships and engage in trauma processing to the extent needed during phase 3.

As formerly incarcerated men navigate their transition from a hypermasculine environment and begin re-engaging with interpersonal relationships, addressing gender role issues is crucial. Phase 2 thus addresses this issue in preparation for phase 3, where relationships are likely to intensify in the context of other stressful factors related to discharge from incarceration. Among the many issues experienced by formerly incarcerated males, hypermasculine behaviors such as aggression heighten the risk for re-incarceration substantially. Because gender roles are generally seen as largely socially constructed, this logically implies that gender roles may change, and be shaped through intervention (Baljon, 2011). Thus, phase 2 of this intervention will also address gender role issues, which will facilitate healthier relationships, hopefully leading both to less aggressive behaviors post-release and healthier relationships overall, which can only be helpful in transitioning. Ideally intervention deliverers in the community will be the same intervention deliverers from the pre-release context. However, giving that most prisons are far distances from the communities in which men live after release, it is likely the
intervention deliverers in the community will be different. To improve post-release intervention retention and success, it will be important for the community based intervention deliverers to have at least one contact with men before they release from incarceration.

**Phase 3: Post-Incarceration (begins 5-6 months after release).** As men adjust to post-incarceration and refine coping and emotion regulation skills, the intervention focus will shift to enhancing interpersonal relationships. A wealth of research has established that how well men do after they release from prison is largely influenced by the quality of their interactions with others (see Pettus-Davis, Howard, Roberts-Lewis, & Scheyett, 2011 for a review). The stress buffering model of the social support perspective explains the connection between relationships and post-incarceration outcomes. According to the stress buffering model, social support operates by reducing maladaptive psychological and behavioral responses to stressful or major life transitions such as reentry to the community after incarceration. Yet, how well individuals are able to engage with and benefit from positive social supports is dependent on their relational capacity. LTEs, cultural norms of male independence, and the inherent dependence on others after release from incarceration collide to create substantial relational challenges. From a relational theory perspective then, Phase 3 aims to promote the likelihood of authentic connection to others (Miller, 1984) even if full authentic connection is not achieved. With personal growth towards authentic connection men increase the capacity to fully represent oneself in relationships that are characterized by mutual respect (Miller, 1984). Authentic connection can occur in relationship with loved ones and in more formal relationships such as at the workplace. In addition to enhancing protective factors
such as social support during Phase 3, some men will need to delve deeply into the processing of one or more LTEs.

Trauma theory suggests that treatment needs during phase 3 may be highly individualized because each individual’s response to LTEs is unique and may vary in the extent to which persistent impairment is present (Bloom, 1999). However, given the rates of cumulative experiences of LTEs among incarcerated and formerly incarcerated men and that incarceration in itself is a traumatic experience, the need for more in depth treatment is probable for most formerly incarcerated men. That is because, according to trauma theory, when individuals are in perceived danger they experience a fight-or-flight response. Each experience of danger builds on a prior experience of danger and the more danger one is exposed to, the more perceived danger they have (Bloom, 1999) despite the actual presence of danger. In turn, with every fight-or-flight response a network of mental connections get triggered. Despite the volatility or stability of a given man’s post-release environment, the hostile environment of incarceration is likely to have generated multiple fight-or-flight episodes escalating levels of arousal to perceived threat. Even with enhanced coping skills, trauma theory suggests that untreated trauma can lead to difficulties in thinking, remembering, and implementing skills when under stress or emotional numbing (Bloom, 1999) prompting the need for intensive cognitive processing of the trauma.

**Phase 3 Intervention components.** The primary goal for the final phase is to improve functioning in daily life. Phase 3 will turn toward building healthy relationships and a strong support network. In doing so, intervention components will need to respond to negative relational images – ideas about relationships that have formed through one’s
experiences and used to make assumptions about current and future relationships – that are products of histories of LTEs. Intervention components will help men to correctly appraise interpersonal relationships. Men will be encouraged to spend less time with those who are primarily negative influences or invoke high amounts of distress, and more time with those who are positive social support providers. Once healthy relationships are beginning to develop or flourish, men will be ready to enter the final components of the intervention that focus on the cognitive processing of LTEs more directly.

Cognitive processing or narrative storytelling therapy will be applied during this phase to help men to give language to their experiences and receive help on overcoming LTEs in a way that promotes healing and growth. Cognitive processing therapy helps individuals to (1) learn about their specific trauma symptoms; (2) become aware of thoughts and feelings related to those symptoms; (3) learn skills to counter maladaptive thoughts and feelings; and (4) develop ability to change beliefs that better balance beliefs developed as a result of LTEs and those beliefs that occur in the context of healthy life experiences (Resick, Monson, & Chard, 2006). Furthermore, the issue of posttraumatic growth will be addressed through psychoeducation, as well as tailoring the clinical approach based on the clinician’s judgment and client presentation. Attrition is common as interventions proceed in both time and intensity. Introducing the idea of post-traumatic growth will act as an incentive to remain in treatment, as well as providing hope, an important element of therapeutic change.

**Next Steps to Advance Practice and Research**

Trauma treatment researchers and intervention developers could adapt a range of existing empirically supported trauma treatment components to our proposed gender
specific and phased intervention approach. We are in the early phases of adapting STAIR/NST to this approach. However, in order to advance the field, a surge of research focus is needed in this area. To that end, we propose next steps toward incarceration and gender specific trauma treatment adaptations.

Targeted trauma interventions for incarcerated men are urgently needed. Unprecedented rates of men experience and release from incarceration – nearly 13 million men cycle in and out of incarceration settings (including both jails and prisons) annually in the United States. Incarcerated men cannot be viewed as similar to others who receive trauma interventions. Incarcerated men experience LTEs at dramatically higher rates than the general population and they are housed in a hostile environment as they prepare for release from prison. Practitioners and researchers must collaborate to identify how to best adapt trauma interventions for men during and after incarceration. We hope to move the field closer to implementing targeted interventions for men by offering a guiding intervention approach. We conclude by suggesting practice-based factors that need additional consideration. We propose a future research agenda to further aid trauma treatment dissemination.

It is clear that most practitioners may never be able to fully understand the experience of incarceration and the disorientation of release from incarceration. As the field moves toward the adaptation of trauma treatment for incarcerated men, it will be important to recognize and monitor whether those treatment components that are traditionally viewed as critical for progress also conflict with survival tactics that are needed during incarceration.
Hypermascuinity, domination, and the need to avoid displaying vulnerability while incarcerated may require the tailoring of certain treatment components for incarceration and reentry phases for men. We have proposed how such tailoring may occur, but acknowledge that additional testing and innovation is warranted. Ideally, such ongoing refinement of trauma treatment for men should also integrate ethnic, racial, and cultural factors (e.g., high levels of stigma in some ethnic groups), in order to maximize recruitment, retention, and efficacy (i.e., Alim et al., 2006; Johnson et al., 2004).

Incarceration releases are highly concentrated in a few urban areas around the country (Sampson & Loeffler, 2010). For those releasing to areas of high concentration of formerly incarcerated individuals, the survival techniques needed during incarceration may still be required once an individual is released. This is because informal social control is disrupted in communities that have high incarceration rates of residents (Clear, 2008) and the tendency is for these communities to also have high rates of violence (Blumstein & Beck, 1999; Fagan, West, & Holland, 2003). Thus for some, violence may have positive appraisal both in incarceration settings and in post-release neighborhoods (Sampson, 2015). When positive appraisals are too fully embraced, barriers to interpersonal relationships and help-seeking could be substantial (Haney, 2002).

Researchers and practitioners need to grapple with how positive appraisal of, or non-reactivity to, violence can be addressed with some men releasing from incarceration.

While incarcerated men have experienced high rates of LTEs, there is not always a clear line between their own victimization and the victimization they have imposed on others (Sampson, 2015). For example, gun violence may result in an individual being seriously wounded by a gun shot and that same individual having seriously wounded or
killed another individual with a gun. Delivering trauma interventions may require practitioners to use different therapeutic techniques to help recipients recognize the impact of LTEs on their perceptions and actions while at the same time recipients grapple with the LTEs that they may have imposed on others. The field needs to explore those lessons that can be learned from interventions with other groups where high rates of victimization overlap, such as sex offenders (Levenson, Wills, & Prescott, 2016), to help practitioners and criminal justice-involved recipients navigate the grey area of being both victim and offender.

Achieving therapeutic alliance and trust between providers and incarcerated men occur differently than in other contexts. In addition to releasing from a culture of distrust, previous failed treatments for substance use and other interventions are not uncommon for incarcerated men. One issue the field must seek to identify is who is the appropriate treatment provider to deliver trauma interventions during and post-incarceration. Contracted mental health staff that work full-time in correctional settings may not be the most appropriate because of their perceived role as being a corrections employee. Is it feasible for community-based practitioners to deliver Phase 1 of a trauma intervention prior to men’s release and continue that same treatment in the community? Although the feasibility of continuity of care for a multi-phased trauma intervention will be challenging to figure out, it is an important topic to address. Research on non-trauma specific rehabilitative interventions that occur during incarceration (e.g., substance use treatment) without follow-up aftercare in the community have limited or no effects on positive post-release outcomes (Wilson & Davis, 2006). The few studies that have been conducted on trauma interventions with incarcerated individuals have not yet established differential
impacts on post-release outcomes by timing of the intervention delivery (e.g., pre-release only versus post-release only versus both pre and post-release intervention).

A series of feasibility, acceptability, and pilot trials is an important next step for determining the appropriate adaptations needed, and intervention development targets, for incarcerated men. For example, there are likely to be differential responses to trauma interventions by gender. Miller & Najavitz (2012) offer that trauma treatment for incarcerated men should emphasize feelings, relationships, and empathy while treatment for women should address empowerment, emotion regulation, and safety. In addition to treatment components, given the well-established role of masculine norms in treatment engagement, gender differences with treatment engagement should be assessed. It should also be acknowledged that while understanding gender differences on the aggregate is important, the extent to which any given individual adheres to gender norms will vary.

Other characteristics that may influence the efficacy of trauma interventions may be the length of time incarcerated, the type of neighborhood one returns to, or cultural norms as it relates to help-seeking by race/ethnicity. Future research should also address the myriad other questions that exist given the paucity of research in this area. For those who have been incarcerated for longer periods of time, are sessions needed in the intervention that entail basic re-orientation to pro-social norms? How does violence appraisal impact treatment engagement and responsiveness (Boxer et al., 2011)? Are there lessons that can be learned from trauma intervention approaches that have been delivered in combat war zones to assist with tailoring interventions to those who will release to neighborhoods with high crime and violence?
Another area for future research to explore are interventions that seek to address longer-term trauma consequences. Research outside of this population has established the biological markers (i.e., cortisol and c-reactive protein) and brain impact related to trauma being stored in the somatic memory (Van der Kolk, 2014), but it has yet to explore this impact on incarcerated men and the appropriate trauma intervention adaptations needed to respond to these physiological changes.

Incarcerated men have family members that may have also been exposed to disproportionate amounts of LTEs (Fagan et al., 2003). The field needs to identify the role of loved ones in trauma interventions post-release. How are loved ones engaged if they have challenges with interpersonal relationships as a result of their own LTEs that may have led to disruptive trauma symptoms? Is development of targeted trauma interventions for loved ones of formerly incarcerated individuals needed?

A staged intervention research approach with practitioners and incarcerated men may help begin to answer these questions. We suggest using Onken and colleagues’ (1997) staged model of behavioral therapies research. Staged model of research is important for filling treatment gaps because it represents an ordered progression from intervention development to establishing feasibility and assessing efficacy of interventions before ultimately evaluating the intervention’s transportability. The proposed intervention model responds to the trauma treatment gap for record-breaking numbers of men releasing from incarceration. The high rate of re-arrest of these men underscores the need for effective interventions tailored to the needs of releasing prisoners. Interventions designed for this population not only promote increased well-being of formerly incarcerated men, but improve public safety and increase community
health. With growing efforts to reduce high rates of incarceration in the U.S., the time for the field to close this treatment gap is now.
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