

**WHAT TRAUMA-INFORMED SERVICES AND SUPPORTS WOULD MEN  
WHO EXPERIENCED INCARCERATION WANT TO RECEIVE WHILE IN PRISON?**

by

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## Abstract

Canada's correctional system houses a large number of men and women with mental health needs and drug and alcohol problems, many of whom experienced trauma in childhood or adulthood. The Correctional Service of Canada is responsible for providing healthcare for inmates sentenced to more than two years of incarceration, including addressing the growing mental health needs and addictions issues of this population. This research involved interviewing men who had experienced trauma and been incarcerated in the federal correctional system. The research question was: *What trauma-informed services and supports would men who experienced incarceration want to receive while in prison?* Although most men had not discussed trauma previously, they reported they would have been willing to speak to professional and other staff to address their unresolved trauma. The findings of this study suggest that Registered Social Workers be encouraged to incorporate Trauma-Informed Care when working with these men on release plans.

## **Acknowledgments**

With gratitude, I would like to acknowledge Raven's Moon Resource Society, a non-profit organization that offers supportive transitional housing, and the men living in their facilities who participated in this research. I appreciate the time and vulnerability it took for these men to discuss some very painful events and difficult times in their lives, hopefully for the betterment of those incarcerated in the criminal justice system (CJS), as well as to educate members of society. I have been humbled by their strength of character, their resiliency, and their willingness to open up and discuss some of the most painful times in their lives. Without their voices, I would not have completed this research and would not have a better understanding of the needs of men who have experienced trauma who are incarcerated in the criminal justice system.

I would also like to acknowledge the Correctional Service of Canada (CSC), my current employer, for their support of my endeavour to earn my Master of Social Work degree. Throughout my years of working within the CJS, I have come to respect many who work within an often difficult and challenging environment to manage and uphold our Mission Statement for public safety.

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### **Acronyms**

CBT	Cognitive Behavioural Therapy
CJS	Criminal Justice System
CSC	Correctional Service of Canada
DBT	Dialectical Behavioural Therapy
MI	Motivational Interviewing
PTSD	Post-Traumatic Stress Disorder
RMRS	Raven's Moon Resource Society
SBT	Strengths-Based Therapy
SFT	Solution-Focused Therapy
TIC	Trauma-Informed Care
TICC	Trauma-Informed Correctional Care
TIL	Trauma-Informed Lens
WOS	Women Offender Sector



## Introduction

The Correctional Service of Canada (CSC) houses a large number of men and women who struggle with mental health, substance abuse, and poverty issues. In Canada, 80% of offenders serving prison sentences have problems with alcohol or drug misuse (Sapers, 2014, p. 2). The previous federal government's *Tough on Crime* approach was unsuccessful in the face of evidence-based research that was inconsistent with that policy. In fact, the so-called *Tough on Crime* agenda has been found to be a failure in the United States as well (Mallea, 2010). The reality is that the most vulnerable individuals in the criminal justice system are those who have been diagnosed with mental disorders. The incarceration of those who are most vulnerable in society does not address rehabilitation or treatment, but rather perpetuates the revolving door between corrections and the community for those living with mental disorders (Martin et al., 2012).

It has been recognized that there is a link between prior traumatic experiences and criminal behaviour, revealing that offenders present with a higher incidence of Post-Traumatic Stress Disorder (PTSD) and associated symptoms when compared with the general population (Ardino, 2012). PTSD is often undiagnosed and goes untreated in the criminal justice system, particularly among male offenders in Canada. Female offenders, by comparison, are treated and managed through a trauma-informed lens (TIL). According to CSC's Women Offender Correctional Programs and mental health programs, services are provided to address the significant abuse and trauma that women have experienced (Correctional Service of Canada, 2016). However, it is a fact that men in federal corrections do not have access to this same

opportunity or perspective, despite evidence-based research recognizing the benefits of this approach.

A history of trauma can pave the way for problems with attachment, self-regulation, and relational competence across the lifespan. Wotherspoon, Hawkins, Clinton, Vellet, and Pirie (2010) identified that childhood trauma is associated with emotional difficulties and adverse psychological conditions, including depression, low self-esteem, and suicidal ideation; physical problems, including chronic pain; psychiatric problems, including anxiety/panic, borderline personality disorder, post-traumatic stress, and dissociative identity disorders; and behavioural problems, including substance abuse, eating disorders, domestic violence, and self-injury (Knight, 2014, p. 2; Wotherspoon et al., 2010, p. 10).

Trauma-Informed Care involves the provision of both the trauma-informed lens and trauma-specific treatment services. The trauma-informed lens acknowledges the special needs some may have in a particular treatment setting or service, by promoting empowerment and acknowledging the impact of trauma on people's lives. Trauma-Informed Correctional Care (TICC) recognizes that individuals may have been affected by trauma; therefore, educating staff about these symptoms—as well not re-enacting these traumatic experiences within institutions—is conducive to rehabilitation (Miller & Najavits, 2012). These symptoms of trauma may be addressed through specific clinical interventions or through a lens of Trauma-Informed Care (pp. 5-6). The Trauma-Informed Lens (TIL) principles that staff would incorporate into their roles would minimize triggers, stabilize offenders, reduce critical incidents, and avoid the use of segregation as well as restraints (p. 1).

By healing from their past trauma, it is hoped that male offenders will address some of the factors that have influenced their choices in committing crimes and even reduce the risk of recidivism in their future, thereby improving public safety (Levenson, 2014). Research has demonstrated that incorporating trauma-informed care may address behaviours that have perpetuated the incarceration of some offenders (Knight, 2014). Addressing these issues therapeutically provides opportunities to rehabilitate offenders, adds to the safety of offenders within institutions, and improves public safety. By practicing trauma-informed correctional care with incarcerated men, maladaptive coping strategies may be reduced (Miller & Najavits, 2012).

The objective of this study was to gather the opinions, insights, and experiences of men who have been incarcerated and who have experienced trauma. Findings from this study provided insight into what kinds of trauma-informed supports and services these men would have wanted to be offered during their own periods of incarceration.

## **Literature Review**

### **Trauma**

Utilising the *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition*, Briere and Scott (2014) defined trauma as: "Exposure to actual or threatened death, serious injury or sexual violence in one (or more) of the following ways: (1) Directly experiencing the traumatic event(s); (2) witnessing, in person, the event(s) as it occurred to others; (3) learning that the traumatic event(s) occurred to a close family member or close friend – in cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental; (4) experiencing repeated or extreme exposure to aversive details of the traumatic event(s)" (p. 9).

These authors identified the major forms of trauma that may affect male offenders in correctional institutions to include child abuse, rape and sexual assaults, stranger physical assault, intimate partner violence, and witnessing or being confronted with the homicide or suicide of another person (pp. 11-19). They further identified post-traumatic responses to these types of trauma to be depression, anxiety, stress disorders (including PTSD), or somatic symptom disorders (pp. 33-37). The abuse of substances has also been found to be relatively common among those individuals who have been exposed to traumatic events and/or experienced interpersonal violence (Briere & Scott, 2014, p. 53).

### **Childhood Trauma**

van der Kolk (2001) recognized that individuals being treated in clinical settings for depression, substance abuse, or other mental health issues may not be addressing the underlying cause of these issues, which may include unresolved trauma (p. 2). Wotherspoon, Hawkins, Clinton, Vellet, and Pirie (2010) identified how an infant experiencing emotional or prolonged trauma can lead to significant and perhaps even irreparable harm in brain development and mental health. The stress response system is complex and involves the brain, the nervous system, and the immune system. This research described the impact of chronic stress or trauma in six areas, including: (1) problems within attachment relationships; (2) physical or medical problems; (3) problems with managing strong feelings or emotions, including dissociations; (4) behaviour problems, including aggressions and self-harm; (5) cognitive problems, including language and attention difficulties, and; (6) self-concept issues (Wotherspoon et al., 2010, p. 10). They recognized that the relationship between an infant and his primary caregiver builds and shapes brain development, which in turn organizes the growth of the physical, cognitive, and emotional systems.

Knight (2014) identified that childhood trauma is associated with emotional difficulties and psychological reactions, including depression, low self-esteem, and suicidal ideation; physical problems, including chronic pain; psychiatric problems, including anxiety/panic, borderline personality disorders, post-traumatic stress, and dissociative identity disorders; and behavioural problems, including substance abuse, eating disorders, domestic violence, and self-injury (p. 2). Knight found that clinicians might encounter trauma survivors in settings such as addictions, mental health, and corrections facilities who are likely to seek out services to address their day-to-day struggles. However, clinicians have come to realize that if—in addition to their present day struggles—the underlying issues of their trauma are not accounted for, the reasons that brought them to prison will not be adequately addressed (Knight, 2014).

Marshall, Galea, Wood, and Kerr (2013) found that severe sexual, physical, and emotional childhood abuse may result in a substantial risk of suicidal behaviour in adults and that those who abuse substances have most often been victims of earlier traumas. These researchers found evidence that early exposure to stress and trauma adversely affects brain development, which in turn results in an increased risk of psychopathological symptoms, such as alcoholism, depression, aggression, PTSD, and impulsivity. Clinicians and healthcare professionals working with people who abuse substances should be aware that those with a history of severe traumatic childhood experiences are at high risk for suicidal behaviour.

### **Men and Trauma**

According to Sorsoli, Grossman, and Kia-Keating (2008), 16% of men have experienced some form of sexual abuse and these men are significantly more likely to exhibit problem behaviours, including aggressive and criminal behaviours, drug and alcohol use, and suicide attempts (p. 333). These researchers found that acknowledging and disclosing the memories,

thoughts, and feelings associated with the abuse and trauma are viewed by clinicians as important aspects of healing. They also pointed out that male socialization might force men to deny or minimize their experiences of victimization, thereby exacerbating symptoms and hampering their recovery.

Sorsoli et al. (2008) found that, although men in their study described both positive and negative outcomes to their disclosure of childhood sexual abuse, in most cases the disclosure led to personal growth and an increased ability to trust others. However, disclosure did not necessarily mean they relayed the details or specifics of the abuse. These researchers identified that men not only had difficulty expressing their feelings, but even identifying their feelings about the childhood sexual abuse. They also recognized that a patriarchal society that emphasises societal demands for masculinity, strength, silence, and stoicism ultimately keeps men silent about their unresolved trauma. They referred to this phenomenon as the "myth of masculinity" (p. 342). Unless researchers had developed a trusting rapport with the participants and specifically asked if there was any sexual abuse, disclosure of their childhood trauma would not be shared. Finally, these researchers found that the following counselling implications are important considerations for clinicians working with men: developing rapport and then directly asking if there was any sexual abuse in their history in a non-shaming and supportive manner; not asking for details at the outset of the disclosure; and providing atmospheres of psychological safety to further develop trust and address treatment of the trauma.

### **Trauma Survival for Men**

Grossman, Kia-Keating, and Sorsoli (2006) studied the negative effects of childhood sexual abuse on men. These researchers discovered that, in spite of the negative impact of childhood sexual abuse, some survivors are able to lead enriching and fulfilling lives, but often

after years of recovery. They also identified that one crucial dimension to recovering from childhood sexual abuse was finding a way to make sense of what happened to them and identifying the meaning that the abuse has in their lives. Developing their own narrative or verbal account of the sexual abuse—their “healing stories”—was important to these male survivors of childhood sexual abuse (Grossman et al., 2006, p. 434).

This study recognized that a more action-oriented style of finding meaning in their childhood sexual abuse may include helping others, whereas some survivors became mental health professionals to further find meaning from their own experiences. These researchers also suspected that gender socialization influences how male survivors construct meaning of their childhood abuse. They recognized that men in American culture are socialized to be emotionally stoic, invulnerable, forceful, and aggressive. These pressures make it difficult for male survivors of childhood sexual abuse to acknowledge their victimization, seek support for themselves, and enter therapy—difficult even to identify meaning in the stories of their abuse (Grossman et al., 2006, p. 442).

### **Trauma and Criminal Behaviour**

Ardino (2012) recognized that there was a connection between traumatic experiences and criminal behaviour, revealing that offenders present with a higher prevalence of PTSD and associated symptoms when compared with the general population. Ardino also reported that victims of violence are vulnerable to negative future outcomes, including dissociation, substance abuse, depression, and PTSD (p. 1). As well, he found that chronic and prolonged exposure to violence might evolve into a dysfunctional routine, creating a link between experiences of violence as victims and later experiences of violence as perpetrators. The study further found that

PTSD rates co-occur with substance abuse, which demonstrates that male offenders with substance-abuse issues *and* PTSD are likely to have higher recidivism rates than those with substance-abuse issues alone. He also found that PTSD might drive individuals to engage in greater risk-taking behaviour or seek out dangerous and sensational situations as part of compulsive re-exposure, and as an attempt to heal unresolved traumatising through re-enactments of their early experiences of violence (Ardino, 2012, p. 2).

The characteristic of re-enacting trauma is not specifically mentioned in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition; however, van der Kolk explained this phenomenon as a "compulsion to repeat the trauma" (van der Kolk, 1989, p. 389). These re-enactments may be mirrored through both "acting in" behaviours—such as self-harm, suicide, or depression—and "acting out" behaviours—such as harm to others and criminal history with offenders that highlights the antisocial expression of unresolved childhood trauma (Ardino, 2012, p. 2). Ardino concluded by pointing out that a key reason for using trauma-informed care within correctional settings is to address behaviours that have perpetuated the incarceration of offenders. Addressing these issues therapeutically provides opportunities to rehabilitate offenders, adds to the safety of offenders within institutions, and addresses issues of public safety.

Brown (2013) recognized that some Canadian adolescents and adults who offend—as well as have mental health or substance-abuse issues—are survivors of physical and/or sexual abuse in their developing or adult years. Ramirez (2014) recognized that histories of trauma are much more common among women entering the criminal justice system than for men and that dealing with trauma is an important part of managing women's correctional populations. Brown further identified that trauma-informed correctional care improved female offender



responsibility, helped them internalize program material, and decreased behavioural issues within correctional institutions (p. 9).

Sirdifield (2012) recognized that perhaps one in four individuals in the general population experiences a mental health disorder. She also found that those on probation most likely have a higher incidence of mental health disorders than the public. The most commonly diagnosed disorders reported in Sirdifield's study were psychotic disorder, depressive episode, mood disorder, manic disorder, and PTSD (p. 494). Sirdifield also emphasized the importance of training staff working in the CJS to identify and recognize symptoms of mental health problems. This type of training is needed—not only for ethical reasons to address the needs of offenders with mental disorders—but also because it may lead to a reduction in re-offending behaviour in the future (Sirdifield, 2012).

van der Kolk (1989) established that those who were traumatized repeated the trauma on behavioural, physiological, and neuroendocrinologic levels. This researcher recognized that many people who were traumatized exposed themselves, seemingly compulsively, to situations reminding them of their original trauma, such as an abusive relationship, or by behaving aggressively towards others or themselves. He recognized that the re-enactment of victimization is a major cause of violence among male offenders who were physically or sexually abused as children. It was further reported that the association between childhood abuse and subsequent victimization—as well as self-destructive behaviours such as head banging, burning, or cutting—were linked. van der Kolk acknowledged that by addressing these issues, individuals could learn to protect themselves and make conscious choices not to engage in relationships or behaviours that are harmful (van der Kolk, 1989, p. 416).

## **Trauma, Offenders, and Substance Abuse**

Sindicich et al. (2014) found a significant rate of substance-abuse issues co-occurring with PTSD among male offenders in Australian prisons. They recognized that substance-abuse issues were more evident among men who struggled with undiagnosed and untreated symptoms of PTSD. Male offenders' exposure to multiple traumatic events, such as physical assaults and/or homicide, being held captive or kidnapped, as well as being sexually assaulted as a child or as an adult in prison, was evident in their exhibiting symptoms of PTSD. These researchers recognized that the prison environment could provide a unique opportunity to intervene with male offenders with substance-abuse issues, as well as address their symptoms of PTSD, thereby reducing the risk of re-offending in the future (Sindicich et al., 2014, p. 11).

## **Trauma and Sex Offenders**

Rasmussen (2013) found that most youth who sexually abuse have had a history of traumatic experiences, although not necessarily sexual abuse. She also found that up to 75% of these youth had experienced multiple traumas in their lives (p. 129). They often experience trauma such as murder or attempted murder, being threatened, or experiencing severe injury or gang violence. This researcher found that these youth were in fact three times more likely to have been sexually abused or to have experienced physical abuse or neglect. Sexually abusive youth were also identified as having problems in self-regulation and distorted self-perceptions, as well as deteriorating self-esteem and cognitive distortions. She further found that addressing criminal behaviours among youth using trauma-informed care and a holistic approach would address factors that could extinguish or manage their risk to re-offend as adults, thereby promoting public safety (pp. 132-133).

Levenson, Willis, and Prescott (2014) found that male sex offenders had a much higher incidence of adverse childhood events than did men in the general population. Sex offenders were more than three times more likely to be sexually abused as children; nearly twice as likely to be physically abused; thirteen times more likely to be subjected to verbal abuse; and four times more likely to experience emotional neglect and to come from a broken home (p. 1). These researchers recognized that a history of child abuse is common among criminal offenders, although they also found that male offenders often underreported their traumatic experiences. Perhaps this is because they normalized their adverse experiences or because they felt they would be viewed as being vulnerable (Levenson et al., 2014). These findings revealed that the prevalence of early trauma is significantly higher for sex offenders than for men in the general population, and suggested that many sex offenders were raised within a disordered social environment by caretakers with problems of their own—ones who were ill-equipped to adequately protect children from emotional, physical, and sexual harm.

Chronic trauma experienced in childhood lays the groundwork for a range of interpersonal problems and maladaptive coping skills stemming from long-standing relational deficits and distorted cognitive schemas about oneself and others. These findings suggest that before sexual offenders can build a better future, they may first need to recover from their past (Levenson et al., 2014). Because sex offenders may engage in impression management, these researchers acknowledged that it was possible that the subjects in these studies slanted their responses in socially desirable or undesirable ways, and thereby biased their findings.

In another study, Levenson (2014) acknowledged that early trauma paves the way for maladaptive coping and interpersonal deficits, which can lead to abusive behaviour. This researcher recognized that early adverse experiences might alter neurodevelopment, interfere

with relational attachment, and contribute to a reliance on maladaptive interpersonal skills. She found that among sexual offenders, early traumatic experiences were frequent and significant, with over two-thirds of participants reporting experiencing at least one adverse event before they turned eighteen years of age. Early traumatic experiences were identified as childhood physical abuse, childhood sexual and emotional abuse, witnessing domestic violence, having parents with substance abuse issues, or having a family member in jail or prison (Levenson, 2014, p. 12).

Levenson further found that male offenders who were incarcerated for a murder, violent offence, or sexual crime were clearly associated with adverse childhood events, in comparison with male offenders who did not experience adverse childhood events. Sex offenders of children were more likely to have themselves been sexually abused, but those who assaulted adults were more likely to have experienced physical abuse in childhood (Levenson, 2014, p. 13).

Finally, it was reported by Levenson that early childhood maltreatment is commonly believed to create a cycle of abuse in which individuals grow up to repeat behaviour witnessed and learned in childhood. The lack of nurturing and guidance provided by the offending parent or other adults leads to problems in social functioning, such as mistrust, hostility, and insecure attachment, which contributes to social rejections, loneliness, negative peer associations, and delinquent behaviour (p. 14).

### **Trauma-Informed Care**

Knight (2014) recognized that a client could have a history of childhood trauma (even if the client does not present themselves as a survivor) and social workers need to be sensitive to this possibility and the ways the client's current problems can be understood in the context of prior victimization. Knight identified four principles of trauma-informed care: (1) normalizing

and validating the client's feelings and experiences; (2) assisting them in understanding the past and its emotional impact; (3) empowering survivors to better manage their current lives, and; (4) helping them understand current challenges in light of their past victimization (p. 4). Knight acknowledged that as a clinician or staff member, one must fundamentally convey empathy, understanding, as well as affirm and validate the survivor's feelings and experiences, thereby reducing their isolation and feelings of being different. This researcher observed that CBT used to address trauma would challenge the thought distortions that survivors often struggle with, as well as normalize and manage their experiences, feelings, and reactions in trauma-informed care. She reiterated what earlier research has found—that connecting and addressing past trauma with present issues may empower survivors to thrive (p. 10).

### **Trauma-Informed Correctional Care**

Miller and Najavits (2012) recognized that addressing trauma issues within American correctional institutions creates an environment that is conducive to the rehabilitation of offenders. They focused on the safety of offenders and staff within institutions who could be affected by the behavioural issues exhibited by offenders living with PTSD. They found that male offenders most often reported traumas such as witnessing a death or violent assault, a physical assault, and childhood sexual assault. Addressing trauma would alleviate further violence by those who had been victimized and further victimization by those who had been affected by trauma (Miller & Najavits, 2012). They found that an estimated 38% of male offenders who were in treatment for substance abuse issues were also dealing with PTSD (p. 3). This suggests that there may be a much higher rate of childhood sexual abuse in correctional institutions than in the general population.

Miller and Najavits (2012) found evidence that criminal sanctions, authoritative and punitive measures—without trauma treatment—were least effective in reducing future criminal behaviour. In contrast, they discovered that treatment was more likely to be successful in reducing future criminal behaviour than enforcement strategies. Since childhood physical and sexual abuse are associated both with institutional difficulties and low program engagement, male offenders may have difficulty benefitting from even the most effective cognitive-behavioural programming unless the impact of their trauma is addressed (p. 5).

Some trauma-informed correctional care (TICC) principles—such as increasing empathy, compassionate care, grounding, and de-escalation—may be perceived as weak or pandering to male offenders, but ironically these principles help create a more secure and stable environment. The benefits of trauma-informed correctional care include controlling the costs of healthcare, managing staff turnover, controlling the high costs of mental health within institutions, reducing seclusion and restraints, as well as de-escalating critical incidents in the facilities—resulting in improved behaviour management, safer facilities, and increased job satisfaction for correctional staff (Miller & Najavits, 2012, p. 6).

To enhance and maintain a safe correctional environment, trauma-informed correctional care requires that environments be structured with consistent limits, incentives, and boundaries, as well as treat male offenders fairly and equally. Not only would correctional institutions be physically safer for staff and offenders, improved emotional regulation would be conducive to managing and treating offenders with PTSD (Miller & Najavits, 2012).

Miller and Najavits (2012) further identified that male offenders' trauma experiences typically involved witnessing and being exposed to violence, in particular from strangers. These

men externalized trauma symptoms by engaging in violence, substance abuse, criminal behaviour, and hyper-arousal. The study further observed that males were often in treatment for substance abuse rather than mental health issues (p. 2).

The provision of TICC to male offenders and the training of correctional staff to implement TICC were therefore indicated. Furthermore, the training of correctional staff in trauma-informed care would require leadership roles that would be better received by correctional officers and management and respected by staff. Incorporating the staff's intuition and experience into the training would make it more successful, thereby developing skills in trauma-informed care and increasing stability among its male offenders. The study further highlighted that the training should include stress management, self-care, and remedies to deal with burnout for correctional staff (p. 4).

Finally, Miller and Najavits (2012) found that the use of present-focused, cognitive-behavioural, and coping-skill treatments with strong educational components has helped stabilize male offenders with PTSD and substance abuse issues. They identified that the book, *Seeking Safety*, by Lisa Najavits (2002), was effective when working with male offenders without causing them distress or decompensation that required mental health professional intervention. *Seeking Safety* was noted to address the trauma and its impact as well as focus on present safety within correctional facilities. Addressing trauma with male offenders would alleviate the sometimes volatile and unstable correctional environment, not only by practicing trauma-informed care, but also by addressing specific behavioural issues often symptomatic of PTSD (p. 6).

Pomeroy, Kiam, and Green (2000) recommended that offenders participate in programs that would address their individual issues (such as depression, anxiety, and trauma symptoms) rather than correctional programming that encompasses a *one size fits all* approach. These researchers recognized that cognitive behavioural techniques had proven effective in the reduction of anxiety, depression, and trauma symptoms, as well as increasing their knowledge of HIV/AIDS (Pomeroy et al., 2000, p. 157). Psychoeducational group intervention was found to be of value to social workers who provide services to offenders in the correctional system when time and workload responsibilities make it difficult to work on a one-on-one basis.

Levenson (2014) reported that it was clearly identified that the therapeutic alliance and the client's experience of the counselling relationship account for significantly more variance in outcomes than theoretical framework or specific counselling techniques. Clinicians need to establish a non-threatening sex offender treatment environment that emphasizes personal choice and responsibility, one that can facilitate trust, emotional safety, and intimacy (Levenson, Willis, & Prescott, 2014). When working with offenders with PTSD, clinicians who respond with compassion, validation, and respect will foster an environment that will eventually correct maladaptive behaviours by addressing historical trauma (p. 15). When male offenders engage in the therapeutic process and experience an honest connection with others who validate their experiences, opportunities exist for developing and practicing interpersonal skills relevant to reducing recidivism. Trauma-informed care may reduce the negative effects of trauma by building healthy relational skills and providing CBT. It is in the process of re-engagement that healing may occur (Levenson, 2014, p. 16).

Levenson further discussed that trauma-informed care (TIC) emphasizes a holistic understanding of the individual in the context of their collective experiences. Maladaptive



attempts to cope are reframed as survival skills that were once necessary but now interfere with the ability to establish healthy interpersonal relationships and boundaries. Levenson concluded her study by stating that by helping sex offenders recognize their negative interaction patterns, they can learn and develop new skills, enhance their interpersonal relationships, and improve their general wellbeing (p. 18). By integrating TIC and cognitive behavioural therapy (CBT) in regular correctional programs, incarcerated men can address the underlying issues of their criminal behaviours and build a therapeutic relationship that heals their souls (Levenson, 2014, p. 18).

### **Challenges of Providing Trauma-Informed Care**

Knight (2014) identified challenges to the provision of trauma-informed care, which include clients' inability to share their trauma history due to shame and embarrassment, as well as clients who have little or no memory of the past trauma. Another challenge to providing trauma-informed care is that clinicians may be influenced by their clients' trauma narratives (p. 9). Clinicians need to be acutely aware of this factor.

Knight reported that it is imperative that clinicians take steps to minimize the impact of indirect trauma on their work, and themselves, by adopting self-care strategies: focusing on nurturing oneself, establishing fulfilling relationships, and being pro-active in managing stress (p. 9). Ultimately, the clinician neither ignores nor dwells on the trauma. Rather, the trauma-informed clinician is sensitive to the ways in which clients' histories affect their present day challenges by utilising the core skills of social work practice.

Anderson (2004) also recognized that clinicians are vulnerable to being exposed to both direct and vicarious sources of traumatic stress. Symptoms include compassion fatigue, intrusive

imagery, distressing emotions, burnout, somatic complaints, as well as changes in identity and/or worldviews (p. 1). Interestingly, Anderson found that participants who were experiencing vicarious trauma as a result of their work experienced lower levels of vicarious trauma when they perceived their employers to be supportive (p. 2).

### **Gaps in the Literature**

This review of the literature has been limited by its lack of representation of men in the Canadian criminal justice system. Further research is needed on male offenders in Canada's criminal justice system to support the evidence-based research conducted in other countries, which concludes that traumatic experiences addressed as part of trauma-informed care may identify some of the risk factors in offenders' criminal behaviour, and thereby reduce repeating offending behaviours.

The data have been gathered from countries including Australia, the United States, and some European countries, but do not address the demographics that are of particular significance to the Canadian context, including the over-representation of Aboriginal people in the CJS relative to the general population. In particular, addressing the cultural significance of residential schools, the *Sixties Scoop*, and the impact of inter-generational colonization on the Indigenous people of Canada requires further attention. Nor does the literature adequately address the historical and systemic oppression of Indigenous people by the federal government (Truth and Reconciliation Commission of Canada, 2015, p. 1). There are also significant gaps in the literature regarding other forms of diversity, including sexual orientation and gender identity.

Although the literature has linked the co-occurring conditions of substance abuse with mental health issues such as PTSD, there has been little done to support evidence-based practices

relevant to incarcerated men in the CJS. While CSC correctional programs do not address trauma in their substance abuse modules for men, the Women Offender Sector (WOS) recognizes that the perspective of the trauma-informed lens (TIL) among women is relevant in addressing underlying issues and that trauma is often one of many reasons why women have found themselves in the criminal justice system.

The Women Offender Sector (WOS) introduces TIC within many of its treatment regimens for women in CSC. At Fraser Valley Institution in the Pacific region, CSC recognizes that past trauma is prevalent among women in federal corrections. Not only is it recognized and addressed in their correctional programs, but WOS also addresses trauma specifically in programs such as *Survivors of Abuse and Trauma*. By addressing their PTSD, evidence-based research recognizes that it could help lower violence and improve behaviour within institutions. If TIC were implemented with male offenders in CSC, men who address their mental health issues may also lower their risk to re-offend.

Some of the literature addressed trauma-informed care in social work practice, yet it did not address the specific needs of social work practice within the CJS. It did not address the barriers that many social workers face working within the environment of the CJS, responsible for the custody of those serving a federal sentence of incarceration, rather than treatment or rehabilitation for those who are living with mental health issues or substance-abuse problems.

The literature review also did not address specific mental health conditions, such as schizophrenia, bipolar disorder, or schizoaffective disorder. It also did not address male offenders living with borderline and other personality disorders, as well as those who self-harm. These conditions, in particular, are difficult to manage and treat within a correctional setting that

does not address underlying issues of maladaptive coping strategies and mental health issues. Further studies are required to develop and evaluate effective interventions to prevent suicide in these high-risk populations and those individuals who abuse substances (Marshall, Galea, Wood, & Kerr, 2013).

### **Theoretical Framework**

The correctional system houses some of the most vulnerable in society and perpetuates a revolving door between corrections and the community for those living with mental disorders. The CJS does not adequately address the treatment needs of those who are incarcerated, in particular those who have experienced trauma. Consequently, the theoretical perspective that was utilized in this research is Trauma-Informed Care (TIC) from the perspective of anti-oppressive practice (Baines, 2011).

The definition of trauma-informed care was taken from Knight (2014) as well as the Klinik Community Health Centre in Winnipeg, Manitoba (2013). The four principles of trauma-informed care identified by Knight are: (1) normalizing and validating the client's feelings and experiences; (2) assisting them in understanding the past and its emotional impact; (3) empowering survivors to better manage their current lives, and; (4) helping them understand current challenges in light of their past victimization (p. 28).

The Klinik Community Health Centre's core principles of TIC include acknowledging that trauma is pervasive, that it is focused on safety, as well as trust and choice. The principles also incorporate control, compassion, collaboration, and a strengths-based perspective. Trauma-informed care service providers realize the impact of trauma as well as understand the potential paths for healing. TIC service providers also recognize the signs and symptoms of trauma in

staff, clients, residents, as well as others. These practitioners integrate knowledge about trauma into policies, procedures, practice, and settings (Klinik Community Health Centre, 2013, pp. 16-17).

Sorsoli et al. (2008) pointed out that male socialization may force men to deny or minimize experiences of victimization. However, acknowledging and disclosing the memories, thoughts, and feelings associated with the abuse and trauma have been viewed by clinicians as important aspects of healing. Some researchers have suggested that a patriarchal society—which emphasizes societal demands for masculinity, strength, silence, and stoicism—ultimately keeps men silent in their unresolved trauma. The *myth of masculinity*, as gender socialization, influences how male survivors construct meaning of their childhood abuse. Men in North American culture are socialized to be emotionally stoic, invulnerable, forceful, and aggressive (Sorsoli et al., 2008).

As a Registered Social Worker practicing from an anti-oppressive perspective, I seek to address these issues within the CJS and agree with Baines (2011) that some male offenders internalize their oppression by hating themselves, believing themselves incapable of change or deserving of help. This becomes their self-fulfilling prophecy—to become who and what society expects them to be: offenders for life.

By utilizing TIC with men in CSC, maladaptive coping strategies may be reduced. This is done in conjunction with practicing social work from a client-centered approach that incorporates many models for change, such as cognitive behavioural therapy (CBT), solution-focused therapy (SFT), and motivational interviewing (MI). The use of present-focused, cognitive behavioural, and coping skill treatments with strong educational components has

helped stabilize male offenders with PTSD and substance abuse issues. Incorporating SFT emphasizes male offenders' strengths, resources, and abilities (Corcoran, 2005). By building a therapeutic relationship and providing trauma-informed care that is integrated in common correctional programs—such as cognitive behavioural therapy and programs that address their risk for violence—male offenders will address underlying issues that have contributed to their criminal behaviour (Levenson, 2014).

### **Design and Methodology**

The objective of this study was to gather the opinions, insights, and experiences of men who have been incarcerated and who have experienced trauma by conducting individual interviews. The goal of the research was to offer insight into what trauma-informed supports and services men who have experienced incarceration and trauma would have liked to receive while in prison. This study was descriptive in design and sought to acquire qualitative and quantitative data by interviewing men who have been incarcerated in the CJS who have also experienced trauma (as defined in the DSM-V) during their developing years and/or adult lives.

The research question was: *What trauma-informed services and supports would men who experienced incarceration want to receive while in prison?* The study was approved by the Human Research Ethics Board of the University of the Fraser Valley before the commencement of the research interviews (see Appendix A).

### **Recruitment**

The study's sample was drawn from men living in Abbotsford, BC, at Raven's Moon Resource Society (RMRS), a charitable non-profit organization that offers voluntary, supportive, transitional housing to men and women whose lives have been affected by addiction, mental

illness, health issues, trauma, abuse, and involvement with the criminal justice system. The agency serves people of all cultural and spiritual backgrounds who are eager to make positive transformations in their lives while living in safe, inclusive, and empowering environments. In addition to paving the way for the interview-based research on men living at their facilities, RMRS was an invaluable source of input and direction (Raven's Moon Resource Society, 2016).

The directors of RMRS identified men eligible for the study based on their incarceration history, experiences of trauma, and readiness to discuss their trauma. The directors informed potential participants about the purpose of the study and the credentials of the researcher. The participants were told to expect a telephone call from the researcher. The researcher was then provided with a list of potential participants and contacted the men to ask if they were willing to participate in the study.

In order to be eligible to participate in the study, participants had to have resided for a minimum of three months at RMRS in order to have developed a working relationship with the staff in the RMRS housing program. Eight men volunteered to participate who were over the age of 18 years, English speaking, and provided informed consent. Men who were excluded from the study included those who had not been in federal custody, were non-English speaking, under the age of eighteen, unable to give consent, or unwilling to discuss their experiences of trauma.

The directors informed the eight participants that the researcher is a Correctional Service of Canada Registered Social Worker and confirmed that their voluntary participation would remain confidential, whether or not the men return to custody, or if they previously knew the researcher. RMRS staff obtained verbal consent from each participant before my arrival.

Participants were given the opportunity not to participate and could withdraw from the study at any time.

### **Data Collection and Analysis**

Participants were provided with an informed consent form to sign that described the purpose of the study and explained that their responses would remain confidential (see Appendix B). After obtaining each participant's written consent, individual interviews between the researcher and the participants were conducted. The interviews were audio recorded and transcribed by the researcher at a later date. The DSM-V definition of trauma was read to each participant and they were asked if they had any questions. The researcher then asked a series of twenty-nine open-ended and closed questions in a structured interview format (see Appendix C).

A director from RMRS was available if requested by the participant to support and provide help after each interview. Free counselling services were also available to the participants and they were encouraged to make use of them if they felt the need or experienced any distress, fear, anxiety, or trauma triggers. According to RMRS, none of the participants accessed these services and supports. The interviews were conducted in the office of the RMRS for reasons of privacy and familiarity in order for the men to feel comfortable. Coffee and snacks were provided, as were breaks, throughout the one-to-two hour interviews. Participants were given a \$10 gift card to thank them for participating in the study. Eight interviews were conducted between March 20, 2015 and July 14, 2015.

Participants were assigned a number to ensure their anonymity and the data were analyzed with all identifying information removed. The researcher contacted each participant by telephone to follow up informally about their participation in the study within one month of their



interview. After the research had been completed, the researcher contacted participants by telephone to schedule individual meetings to discuss the research findings. None of the participants asked about the findings. A copy of this paper will be provided to RMRS.

The participants answered questions related to their perceptions and experiences with the CJS as well as their trauma experiences. The guided interviews contained questions that included: age, index offense, trauma experiences in childhood or adulthood (or both), if services were provided to address trauma, and what supports and services would be helpful to address trauma. The researcher sought clarification from participants regarding their responses throughout each interview.

### **Ethical Considerations**

Some of the ethical issues in human research include maintaining respect for participants in the study as well as concern for their welfare. A potential negative consequence of this study is that participants may have experienced emotional discomfort when discussing past trauma. Some men might feel the need to please RMRS staff by agreeing to participate as well as be unaware that discussing these personal issues could trigger their emotional responses. One participant did ask to leave after discussing his childhood experiences. The researcher contacted the Directors of RMRS for follow up and was informed that he was well. While free counselling sessions were available if needed, none of the participants requested them.

Another ethical challenge was that the researcher might be interviewing former inmates with whom she had previously worked within CSC. Although my status as a CSC employee might be perceived as authoritarian, my professional identity as a Registered Social Worker has always been that of an advocate. This may help balance the power differential to a degree.

I acknowledge that being employed as a Registered Social Worker within CSC created the potential for a perceived or real conflict of interest. My role could be viewed as putting me in a position where there could be a positive or negative bias towards CSC and the services it provides, or that I might be reluctant to report any findings not seen to be favourable towards the CSC. This research was conducted as an independent investigation with no restrictions or cautions from the CSC in any regard other than to ensure that no direct research would be conducted with current CSC male offenders.

### **Findings**

Responses to the interview questions confirmed that all eight participants had been incarcerated in the federal CJS and had experienced trauma during their developing years and/or adult lives. Of the eight men who participated in this study, six of them were single and two were separated from their partners. The men's ages ranged from 26 to 62 years with the average age being 46 years. The cultural backgrounds of the participants included those of European descent as well as Canadian and Aboriginal ancestry. Participants' levels of education also varied: one had no formal education, one had elementary schooling, and three had achieved some secondary education. The remaining two participants had completed post-secondary degrees.

The men in this study disclosed that they were convicted of offences that included property offenses, break and enters, aggravated assault, armed robbery, home invasion, arson, and attempted murder. The federal sentences imposed also varied in length from a minimum of four years to a maximum of thirty years. The average length of sentence was nine years. Five of the men had served their first federal sentence, one participant had served his third, while another had served his fourth. One participant had served his ninth federal sentence.

Through a careful analysis of the information gathered from the interviews, five topic areas and themes emerged: (1) trauma in childhood; (2) trauma in adulthood; (3) trauma in prison; (4) barriers to speaking to prison staff, and; (5) opportunities to address trauma in prison.

### **Trauma in Childhood**

All of the participants in the study stated that they had experienced trauma in their childhood: emotional, physical, and sexual abuse, or the witnessing of violence. One participant had experienced a traumatic accident that hospitalized him for most of a year in his childhood but did not experience any form of childhood abuse. However, seven of the eight participants had experienced physical and emotional abuse by their family members. Six of them had experienced sexual abuse as well.

One participant reported that as a child he began to act out his anger in behaviourally maladaptive ways, which he stated was in response to the abuse he had endured. He had been sexually molested by his adopted mother for a number of years and was sent to see psychiatrists and psychologists, but stated: "I wouldn't break, though...I wouldn't say what was going on... 'cause I wasn't allowed to say anything..." He stated that he began to act out at a young age and would begin to assault other children—"taking out my anger on other people." Another participant stated that his mother would hold his head under cold water, after which she would beat him with a piece of wood.

A theme emerged regarding the lack of permanency that many participants experienced in childhood. One participant's history included being placed with thirteen adoptive families within a couple of years. Another participant stated that throughout his entire childhood he was a ward of the Children's Aid Society, but "they never sat down with me...and a counsellor asks me

why I was so angry...never asked me why I was having such a hard time in foster homes...they would just move me." He was eventually placed in twenty foster homes during his childhood.

Another participant began externalizing negative behaviours at the age of seventeen, when he would jump on tables in bars to provoke fights with other patrons. He stated: "It was reinforced as a child that I was a piece of shit so I went on to feel that way." Another participant was raised by his mother who had alcohol problems and often neglected her children, so his grandparents would often take custody of them. While he was residing in his grandfather's home, one of his older male family members sexually molested him on numerous occasions.

Many of the participants also found it difficult to engage in schoolwork. As one participant put it: "Do you know how hard it is to concentrate in school when you know you are going home to get your head bashed in?"

### **Trauma in Adulthood**

Five of the eight participants experienced trauma when they were adults residing in the community. Although at first many were unable to identify these experiences as traumatic, after further probing by the researcher the majority of the men stated that they had experienced and/or witnessed trauma. One participant denied experiencing or witnessing trauma in the community. However, he then relayed how he witnessed many others be violently physically assaulted, often in retribution for drug debts or criminal activity. One participant reported that a family friend sexually assaulted him when he was living on the streets as a young adult.

These men's inability to identify traumatic events is consistent with other researchers' findings that men tend to minimize the impact of trauma on their lives. Two of the participants shared the loss of their children in the interviews but did not acknowledge the trauma of

surviving this loss. One father reported that he eventually became emotionally numb after the loss of his child: "I just didn't care anymore; it was life—fuck that, fuck my life!" He further elaborated that he eventually became involved with drugs, gangs, and criminal activity.

### **Trauma in Prison**

All of the participants stated they had experienced or witnessed violent physical assaults while they were in prison. However, a theme in all of their responses was that no one believed that these incidents had negatively affected them psychologically. These physical assaults included yard fights, stabbings, suicide by hanging, gang sets [fights], and sexual assaults. One participant stated: "I witnessed a couple of fights...I was beaten a couple of times, but that was when I didn't see it coming...I saw people get hurt, a couple of shanks [stabbings] in the neck while in meal line, and a violent fight in the yard between two inmates." An older participant stated: "You get these jail house gangs going on...all trying to be the big wheels, but I've seen dogs piss on bigger wheels." He also reported that he remembered one incident in particular: "When I was in Matsqui Institution, I heard a commotion across from my cell and all of a sudden I saw a guy come stumbling down the hallway with a knife sticking out of his neck." He went on to say that this inmate proceeded to die on the floor in front of his cell.

When participants were asked if they had been sexually assaulted while in prison, none of them acknowledged this. However, one eventually uttered that if he did not comply with the forced sexual acts, then he would have been violently sexually assaulted. He further stated: "Yeah, I did [sexual acts]...it disgusted me and I didn't want to be participating but I had to do it...it was easier to just give in... I would end up in the hole [segregation] just to get away from it."

## **Barriers to Speaking with Prison Staff**

None of the participants spoke to clinical professionals when they were incarcerated to address unresolved trauma; however, some participants had mentioned some of their life experiences to other staff. Two of the participants said they had spoken to their Elders: "I believe that Elders are there to help me, to get me better, to help me understand what my path should be..."

Another participant mentioned speaking to his parole officer, but said he would not speak to correctional officers, stating: "They were there to punish us." Another said: "In the system, inmates and guards don't care about your feelings." Some participants also mentioned that when they were first placed in custody and assessed they had disclosed traumatic incidents and abuses but it was never followed up with therapeutic interventions or services. A comment made quite often by the participants when discussing the Federal CJS was: "No one cared...nobody asked...nobody cared enough to ask." Many of the participants identified the CJS as an oppressive, punitive system that does not always address the issues leading up to their criminal behaviours.

Another participant stated: "I don't know how many times I went to the console and they would say, 'I'm busy...I'm working on my computer'...then I would leave and walk around and then see they are playing solitaire on the computer." Yet another participant stated: "I would engage with staff if I could trust them...if they would believe me...make time for me...check in with me...give me solutions, ideas, direction."

Samuelson and Anthony (2007) reported that those most likely to become involved with the criminal justice system are characterized by inequalities of power and social position based

on race, social class, gender, and other factors. One participant identified that prison culture is characterized by an “us versus them” mentality of authority and superiority between correctional staff and inmates.

### **Opportunities to Address Trauma in Prison**

The researcher asked participants if they would be willing to address unresolved trauma while in prison. When asked whether they would be willing to discuss trauma in a group setting, many of the participants stated that they were open to this possibility. Participants reported that they would be willing to share openly with other men in custody. One participant stated: "Actually, I think a group setting would be good...you can listen and share...you are not alone [in these experiences]." Another participant stated: "It's difficult to do in prison." However, if working with clinical staff or an Elder, they would be willing to address PTSD and unresolved trauma. They also suggested spiritual leaders such as Elders, Wiccans, Buddhists, and Chaplains to help deal with trauma.

Most of the participants were more willing to meet with a clinical staff member to discuss trauma, as well as address their behavioural issues and/or anger issues on a one-on-one basis. Another participant stated: "I suppose I would [have spoken to staff about his issues] at that time, if it was available...would [have] been nice to talk to someone about where all my anger came from...to have s[a]t down and deal[t] with it." Participants shared their desire to meet with clinical staff—people they could trust and had built a rapport with—before discussing the issues that would often be difficult for them to share. As one participant stated: "Guys need someone they can talk to, someone that doesn't have a protocol that everything has to be written down."

However, some participants reported that they might not trust clinical staff to the point of sharing their trauma. Many underreport sexual violence because of guilt or self-blame as well as shame. The literature suggests that this is particularly true for men. Clinical and non-clinical staff must be cognisant of society's expectations that men be strong, silent, and unresponsive in addressing their trauma.

An older participant reported: "Back in the old RPC [Regional Psychiatric Centre]...in the old U building...they had more intensive groups...I did Prospect...about an eight month program and you went to group every day, you went morning and afternoon...you had to work on yourself...you had to share...and it was emotionally draining for a lot of guys...these were hard guys and they were sharing their autobiography and they would be crying...and CSC seemed to get away from that...they are just in jail now."

The majority of the participants reiterated that the building of trust between staff and the men in custody was vital to creating a respectful relationship that could help support them in their attempts to address the underlying issues that had brought them to the CJS. Another participant suggested retaining professionals from outside the CJS to work with inmates. This would be in addition to volunteers who could share their stories, challenges, and accomplishments, such as L.I.N.C. (Long-term Inmates Now in Community), a non-profit organization that works with men who have been incarcerated.

It is worth noting that most of these men, who have experienced multiple traumatic events during their lives, found it difficult to identify trauma and to articulate the kinds of supports and services they need in order to overcome trauma. Having come from so little and



with such heavy burdens to bear, it is not surprising that their expectations for treatment within the correctional system are low.

### **Conclusions**

Men incarcerated in the CJS are widely perceived to be perpetrators of traumatizing crime but are rarely considered among those who have experienced such trauma. There has been extensive research identifying that the majority of men who are incarcerated have experienced not only one traumatic event, but also, sadly, multiple events throughout their childhood and/or adult lives. Correctional staff often lacks awareness of how these unresolved traumas may drive aggressive behaviours and how the correctional setting itself can be triggering for men with PTSD. Examples include the procedures used in pat downs and strip searches, the seclusion, disciplinary actions, loud noises, and limited privacy that are prevalent in correctional settings.

Research participants were provided with an opportunity to narrate their trauma as well as provide important information for professionals to understand their specific wants and needs. The research community also benefits by better understanding these men's perceptions of the need for trauma-informed care while in prison. This study corroborates other studies' findings that men in the CJS have experienced trauma either in their childhood and/or adult lives. Addressing these issues in the CJS with PTSD interventions could ultimately reduce the risk of recidivism, thereby improving public safety. Participants stated that that they would be open to receiving supports in prison to address their unresolved trauma. It is this researcher's hope that the results of this study will influence policy and decision-makers of the benefits of introducing trauma-informed services for men within the CJS.

Trauma-specific treatment services are interventions designed to address the specific behavioural and interpersonal consequences of exposure to sexual, physical, and prolonged emotional abuse. Several trauma-specific treatment models have shown great promise as adapted for use in correctional settings. For example, *Seeking Safety*, developed by Dr. Lisa Najavits, has been implemented in many correctional programs in the United States. Addressing PTSD symptoms with therapeutic interventions provides opportunities to rehabilitate male offenders, adds to the safety of offenders and staff in institutions, and increases public safety.

Participants in the present study reported that TIC would have been beneficial to them in the CJS. Interpersonal communications skills, including reflective listening, empathy, genuineness, honesty, and trust—as well as evidence-based practices in teaching coping strategies, such as in CBT and grounding exercises among clinical and non-clinical staff in the CJS—would be beneficial in supporting male offenders. These participants' responses echoed this – TIC in the CJS would benefit them.

In addition, correctional staff requires education on how to support men to stabilize, emotional regulation skills to address PTSD, as well as substance abuse issues. By addressing male trauma, the CJS will also provide an environment that is safer, more stable, and structured—not only for offenders, but for staff as well. Incorporating Strengths-Based Therapy (SBT), Dialectical Behavioural Therapy (DBT), as well as CBT may ultimately address the maladaptive coping strategies displayed by men who commit violent criminal acts.

An important component of TIC is to educate and provide support to clinical staff members of the CJS who encounter those who have experienced trauma. They would then be able to identify these men in areas of mental health and addictions, as well as those with

behavioural issues in prisons. Clinicians who respond to men suffering from PTSD with compassion, validation, and respect will cultivate an environment that will eventually correct maladaptive behaviours by addressing historical trauma. When men in the CJS engage in the therapeutic process and experience an honest, genuine connection with others who validate their experiences—as well as have opportunities to develop and practice effective interpersonal skills—recidivism may be reduced. Building healthy relational skills and providing CBT may help to mitigate the effects of trauma. It is in the process of positive re-engagement that healing may occur.

Correctional staff and clinicians are also negatively affected by vicarious trauma. Training on TIC (as well as additional self-care strategies) needs to be implemented in order to work more effectively with male offenders. Although clinicians and correctional staff are involved in work that may be difficult, this work may also provide opportunities for clinicians and correctional staff to develop a deeper understanding of what life is about for themselves and for male offenders. This could be achieved by recognizing the resilience of those who have experienced trauma and connecting with a deeper understanding of human potential and hope.

### **Limitations of the Study**

Limitations of this study were evident in the small sample size of eight male participants. The sample size did not adequately represent cultural, sexual, or other forms of diversity amongst potential participants. However, it was instrumental in gathering important information from the perspective of men who are often vulnerable within the criminal justice system. This study provided an opportunity for men who have experienced trauma to give voice to their needs within the CJS.

As identified in previous research, clinical staff members of the CJS may have time constraints as well as commitments that leave them little opportunity to work with men who have experienced trauma (Martin, Dorken, Wamboldt and Wootten, 2012). Registered Social Workers may provide therapeutic interventions for PTSD and address the underlying issues that brought many of these men to the CJS, such as anger management, substance abuse, and unhealthy coping strategies. Most Registered Social Workers in the CJS are fulfilling the necessary role of developing release plans. However, they also have a unique opportunity to address trauma. A Registered Social Worker who incorporates the trauma-informed lens in preparing release plans will endeavour to address those issues that may have brought these men into the criminal justice system in the first place, thereby slowing closing the revolving door that appears to be so prevalent in the criminal justice system.

### **Recommendations for Future Research**

Further research is required to address the needs of men who are living with major mental illnesses as well as cognitive impairments. Aboriginals are an over-represented demographic in the CJS, so research needs to incorporate the legacy of genocide that intergenerational trauma has had on Indigenous people. Those individuals with fluidity in their gender orientation, identity, and expression are also deserving of more in-depth research. Finally, the CJS needs to find ways to incorporate TIC for those who are living with mental illness *and* those who are vulnerable because of their historical abuse so that we can close the revolving door between community and prison.

In *Correctional policy for offenders with mental illness: Creating a new paradigm for recidivism reduction* (Skeem et al., 2011), it was identified that utilising evidence-based mental health practices, such as supportive housing and employment, may make it easier for those who

are late-starters for criminal activity to address their issues than those who began their criminal activity earlier in life. By implementing early intervention programs in the youth criminal justice system, perhaps we will be able to alleviate the over-representation of young offenders in the adult system because the underlying issues of insecure attachment, emotional regulation, and maladaptive coping strategies have already been addressed with TIC.

In Canada's criminal justice system, those who have served their time should leave prison ready to become productive members of society. How can we offer men in custody essential healthcare services and not address underlying issues of unresolved trauma and substance abuse? How can we expect them to return to our communities as healthy, pro-social people? Failing these men while they are incarcerated does not make us safer. The criminal justice system must address these moral questions within its treatment and rehabilitation programs if it is truly to be about more than punishment.

I believe that when people make mistakes they deserve the opportunity to remake their lives. If we can give them the hope of a better future and a way to get back on their feet, then we will help create a nation that is safer, stronger, and worthy of our highest ideals. I believe there must be hope for all in Canadian society, including for those who have been victimized and who have harmed others in return.

*All the great things are simple, and many can be expressed in a single word: freedom, justice, honor, duty, mercy, hope.*

*Sir Winston Churchill*

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## Appendix A: Certificate of Human Research Ethics Board Approval



### Certificate of Human Research Ethics Board Approval

Contact Person Sylvia Ehrke	Department Social Work	Protocol # 739S-15
Co-investigator(s) Leah Douglas; Curtis Magnuson; Margaret Coombes		
Title of Project What trauma-informed services and supports would men who experienced incarceration want to receive while in prison?		
Sponsoring/Funding Agency N/A		
Institution(s) where research will be carried out University of the Fraser Valley; Raven's Moon Resource Society		
Review Date: 26-Feb-15	Approval Date: 13-Mar-15	Approval Term: 13-Mar-15 - 12-Mar-16
<p>Certification:</p> <p><i>The protocol describing the above-named project has been reviewed by the UFV Human Research Ethics Board, and the procedures were found to be in compliance with accepted guidelines for ethical research.</i></p> <div style="text-align: center;">  </div> <p>Andrea Hughes, Chair, Human Research Ethics Board</p> <p><i>NOTE: This Certificate of Approval is valid for the above noted term provided there is no change in the procedures or criteria given.</i></p> <p><i>If the project will go beyond the approval term noted above, an extension of approval must be requested.</i></p>		

## Appendix B: Participant Consent Form



### Participant Consent Form

*What trauma-informed services and supports would men who experienced incarceration want to receive while in prison?*

**Principal Investigator:** Sylvia Ehrke, BSW, RSW  
University of the Fraser Valley

**Co-Investigators:** Leah Douglas, PhD, RSW  
Curtis Magnuson, MSW, RSW  
Margaret Coombes, PhD, RCSW

We are interested in your thoughts and ideas about what trauma-informed services and supports would men who experienced incarceration want to receive while in prison? We would like your input and valuable insight as to what the criminal judicial system can do to help men deal with trauma when they are incarcerated.

You are invited to take part in an interview with myself, and the Raven's Moon Society staff members - Sharon or Jeanette will be available for support upon your request after the interview. You are asked to participate because you are a man who has been in Federal custody and have experienced trauma in your lifetime.

Your participation in this interview is entirely voluntary, so it is up to you to decide whether or not to take part in determining what services the criminal judicial system can offer to men who have experienced trauma. Before you decide, it is important for you to understand what the meeting involves. This consent form will tell you about it.

If you agree to participate, you will be asked to sign this form. Even if you sign the form, you are still free to withdraw at any time. If you do not wish to participate, you do not have to provide any reason for your decision, and you will not lose the benefit of any support or service from Raven's Moon Society. Please take time to read the following information carefully and to discuss it with anyone you wish, before you decide.

This study is being conducted by the University of the Fraser Valley, in collaboration with the Raven's Moon Resource Society, Abbotsford BC.

### Background and Purpose of the Meeting

Research that involves informed participants from the beginning stages is practical and meaningful. We value your knowledge and experience.

During the interview, the researcher and a staff member from Raven's Moon Society will discuss with you your experiences with trauma as well as your experiences in prison.

### **Participant Selection**

You are being asked to participate in this study because you are a man who had been in prison and have experienced trauma in your lifetime.

### **What is Involved**

You can decide whether or not to participate in this meeting. You can also choose not to answer some of the questions that are asked. It's totally up to you.

If you attend the interview, you will sit with us and talk about the research questions for 1-2 hours. You can leave the meeting at any point. Your name or other identifying information will not be used. The only information that will be written down will relate to potential research questions.

You will receive a \$10 Tim Horton's gift card for your participation in this meeting. You will still receive the \$10 gift card if you leave the meeting early.

### **Possible Risks and Side Effects of Participating**

Participation in this meeting may cause some inconvenience to you, including the time commitment of about one to two hours.

It might also be difficult to discuss the trauma you have experienced. If at any time during the interview, you are feeling unsafe or unwilling to continue, please feel free to withdraw. Jeanette and Sharon have stated that they, as well as the Raven's Moon Resource Society staff will be available to help you if needed after the interview.

If you choose not to participate you can still receive all the supports you already receive at the Raven's Moon Resource Society.

### **Benefits of Participating**

The information that you provide will help determine further research. Your thoughts, opinions, and suggestions are important. We want to hear from you, so that research and services can be healthy and helpful to men in prison.

I am writing a major paper for the Master of Social Work program, and hope to have this research published. I might also be submitting for peer review journals as well as possibly presenting it to the University of the Fraser Valley, and organizations, conferences that might find this research relevant.

### **Withdrawal of Consent to Participate**

Your participation in this meeting is entirely voluntary. You can leave at any time. You will still receive \$10 gift card if you leave the meeting.

Anything that has been discussed before withdrawing cannot be removed, because it will have contributed to the research questions.

### **Rights and Compensation**

By signing this form, you do not give up any of your legal rights and you do not release the study investigator or other participating institutions from their legal and professional duties. There will be no costs to you for participation in this study. You will not be charged for any research procedures. As appreciation for your participation in this study, you will be given a \$10 gift card.

### **Confidentiality**

Your confidentiality will be respected. Your name and any other information that could identify you as a participant in this study will not be used.

No information that discloses your identity will be released or published.

If you disclose that you are considering harming yourself or others, or that you abused or neglected a child, the researcher may be required to release this information to protect you or others.

If you disclose current criminal activity that puts others at risk, the researcher may be required to report this information to the police.

If you disclose information concerning a current court case, the researcher might be asked/required to testify about that information during the trial. Please do not discuss offences that are currently under investigation or before the courts.

### **Contacts**

If you have any questions or desire further information about meeting before or during participation, you can contact Sylvia Ehrke at [REDACTED] or [REDACTED]

If you have any concerns or complaints about your rights as a participant and/or your experiences while participating in this meeting, contact Adrienne Chan, AVP of Research, Engagement, and Graduate Studies at UFV, (604) 557-4074 or adrienne.chan@ufv.ca

This research has been reviewed and approved by the UFV Human Research Ethics Board.

***What trauma-informed services and supports would men who experienced incarceration want to receive while in prison?***

### **Consent to Participate**

I have read and understood the participant information and consent form and am consenting to participating in the meeting. *What trauma-informed services and supports would men who experienced incarceration want to receive while in prison?*

- I have had sufficient time to consider the information provided and to ask for advice if necessary.

- I understand that my participation in this meeting is voluntary and that I am completely free to refuse to participate or to withdraw from this study at any time without changing the service or support that I receive at Raven's Moon Society.
- I understand that if I disclose that I am considering harming myself or others, or that I have abused or neglected a child, the researcher may be required to release this information to protect me or others.
- I have been told that I will receive a signed and dated copy of this form.

_____ Printed Name of Participant	_____ Signature	_____ Date
_____ Printed Name of Witness	_____ Signature	_____ Date
_____ Printed Name of Principal Investigator	_____ Signature	_____ Date

### Appendix C: Interview Questions

Please remember that the interview will be anonymous and you may choose to leave at any time.

Audio recording begins:

1. What is your marital status? *Single, married, common-law.*
2. What is your age?
3. What is your cultural background?
4. What is highest level of education have you achieved?
5. What was your index offense? *Homicide, manslaughter, robbery, drug offences, assault, sexual offences, other violent offences, other non-violent offences.*
6. Researcher will check in with the participant – how they are doing, needing a break.
7. What was your sentence length? *Less than five years, more than five years.*
8. Was this your first federal sentence? *Second, third, fourth.*
9. According to DSM-V, 5th edition, Trauma is defined as: "*Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways: (a) Directly experiencing the traumatic event(s); (b) witnessing, in person, the event(s) as it occurred to others; (c) learning that the traumatic event(s) occurred to a close family member or close friend - in cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental; (d) experiencing repeated or extreme exposure to aversive details of the traumatic event(s)*" (p. 96).
10. Did you experience trauma in your childhood? *Emotional, physical, sexual, neglect.*
11. Tell me more about that.
12. Researcher will check in with the participant – how they are doing, needing a break.
13. Did you experience trauma as an adult in the community?
14. Tell me more about that.
15. Did you experience trauma while in prison?
16. Tell me more about that.
17. Did you ever tell anyone about your childhood trauma? Tell me more.
18. Did you ever tell anyone about your trauma as an adult in the community?
19. Was it reported to the police? Tell me more.
20. Did you ever tell anyone about your trauma in prison?

21. Why or why not? Whom?
22. While in prison, did you feel safe to tell staff? *Parole officer, correctional officer, programs officer, Elder, social worker, psychologist, psychiatrist, nurse, etc.* Tell me more.
23. Researcher will check in with the participant – how they are doing, needing a break.
24. What were the barriers to you discussing your trauma with staff? Tell me more.
25. Would you prefer to discuss your trauma on a one-to-one basis or in a group setting?
26. What could staff do to facilitate a safe environment for you to discuss your trauma?
27. What trauma-informed services or supports would you like prison to offer?
28. Is there anything else you would like to share with me?
29. Would you be open to participating in further research on this topic?