A TRAUMA AND PTSD PRIMER:

CAUSES, CONSEQUENCES, AND INTERVENTIONS

Melissa J. Zielinski, Ph.D
August 2, 2022

1

DISCLOSURE STATEMENT

- I do not have any relevant financial relationships with commercial interests

2

OBJECTIVES

- Review the prevalence rates of trauma and PTSD among incarcerated people
- Summarize best practices for treatment of PTSD and how they can be implemented in correctional settings
- Discuss strategies to support evidence-based PTSD treatment uptake in corrections

3

SPEAKER

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- Research
  - What behavioral health interventions for trauma survivors work in legal settings such as prisons and jails?
  - How do you get things done there?

4

TRAUMA AND PTSD FOUNDATIONS

5

DSM-5

WHAT IS TRAUMA?

- Traumatic events ("trauma") are experiences that involve exposure to:
  - Death or threatened death
  - Actual or threatened serious injury
  - Actual or threatened sexual violence
- Exposure includes:
  - Directly experiencing
  - Directly witnessing
  - Learning that a violent or accidental traumatic event happened to a relative or close friend
  - Repeatedly hearing/seeing any of the above events in the course of your job

6

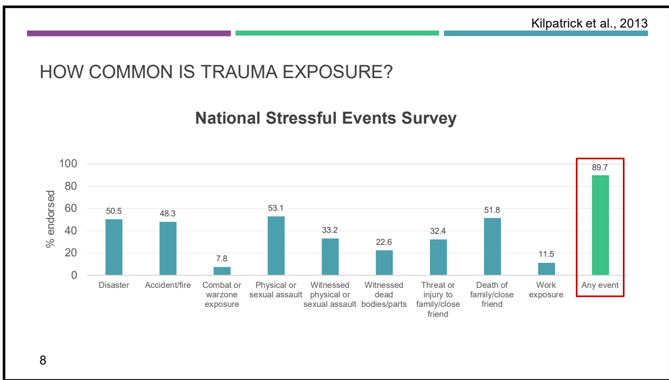
WHAT IS TRAUMA?

- What types of events do you think might fit this definition?
- Examples:
  - Combat or war zone exposure
  - Rape
  - Homicide or suicide
  - Domestic violence
  - Serious motor vehicle accidents
  - Natural disasters
  - Serious unexpected medical events
  - Arson or house fires
  - Torture
  - Childhood abuse

7

Kilpatrick et al., 2013

HOW COMMON IS TRAUMA EXPOSURE?



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HOW COMMON IS TRAUMA EXPOSURE?

- Many people have experienced more than one traumatic event
  - Most common number of events in the last study was 3
  - Chronic trauma exposure (repeated events of the same kind) is also common

9

QUESTION

Does experiencing a trauma mean that you will have PTSD?

10

ISTSS, 2020

WHAT HAPPENS AFTER TRAUMA EXPOSURE?

- After a severe trauma, almost everyone has some symptoms similar to those seen with PTSD (e.g., flashbacks, over arousal, avoidance, depression)

11

ISTSS, 2020

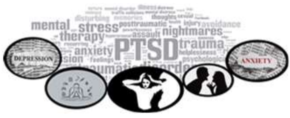
WHAT HAPPENS AFTER TRAUMA EXPOSURE?

- Most people get better without treatment over the first 3 months
- Some people get a little better in the first month but then stop getting better
  - These people are more likely to develop PTSD
  - We think of PTSD as healing that got interrupted or "stuck"

12

WHAT HAPPENS AFTER TRAUMA EXPOSURE?

- **Non-recovery** – experiencing lasting negative changes following trauma
- Mental Health Outcomes



- Additional health outcomes
  - Physical health issues
  - Problems with intimacy and relatedness

13

Zielinski, K23DA048162

WHAT HAPPENS AFTER TRAUMA EXPOSURE?

- **Posttraumatic stress disorder** (PTSD) – a mental health condition that can develop following trauma and includes:

14

IMPACT OF TRAUMA AND RELATION TO PTSD

- The majority of trauma survivors recover with time
- PTSD is a pathway involving non-recovery
- If PTSD does not remit within a year, it is likely to last a lifetime unless treated
- PTSD is a highly distressing and debilitating disorder
  - High psychiatric and medical comorbidity
  - High unemployment
  - High suicidality

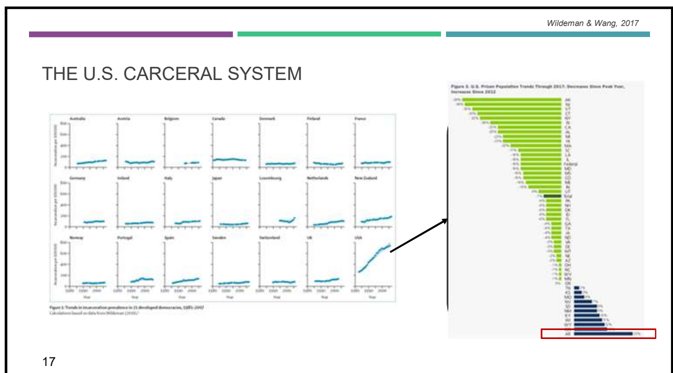
15

PTSD AND INCARCERATION

16

Wildeman & Wang, 2017

THE U.S. CARCERAL SYSTEM



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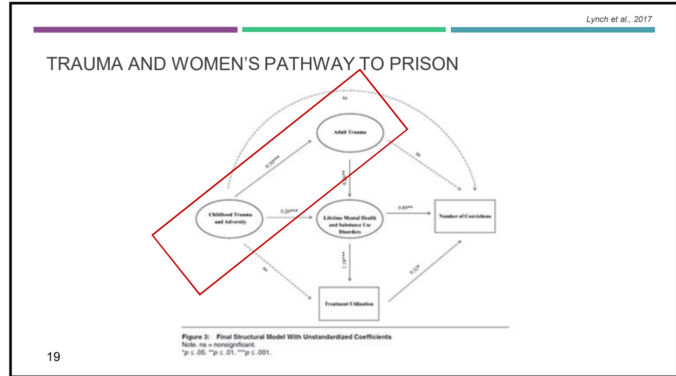
Fazel et al. 2017; Hasin et al., 2018, James & Glaze, 2006; Karlsson & Zielinski, 2020; Olff, 2017

BEHAVIORAL HEALTH AND INCARCERATION

- Most people in prison have at least one current mental illness
  - **Over 50%** have alcohol or drug use disorder
  - **Over 50%** have a mental illness unrelated to drugs and/or alcohol
  - **Few** receive treatment (~15% in some studies)
- Trauma-related mental illness unrelated to drugs and/or alcohol
  - **90-100%** of people in prison have experienced at least one traumatic event
  - **15-29%** of women and **4-32%** of men have posttraumatic stress disorder
  - **10-25%** of women and **10%** of men have major depressive disorder

18


Lynch et al., 2017
TRAUMA AND WOMEN'S PATHWAY TO PRISON
Adult Trauma
Childhood Trauma and Adversity
Lifetime Mental Health and Substance Use Disorders
Number of Convictions
Treatment Utilization
Figure 3: Final Structural Model With Unstandardized Coefficients
Note. ns = nonsignificant.
*p ≤ .05. **p ≤ .01. ***p ≤ .001.
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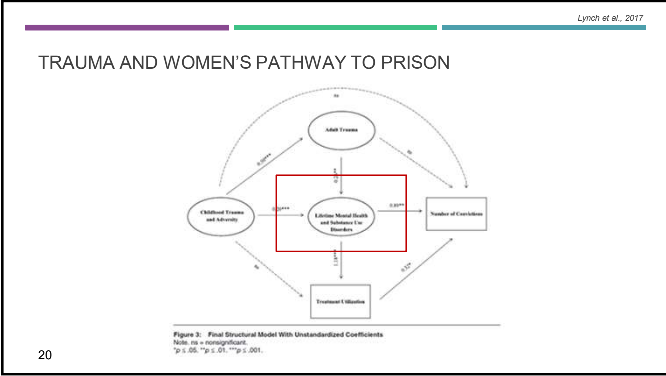
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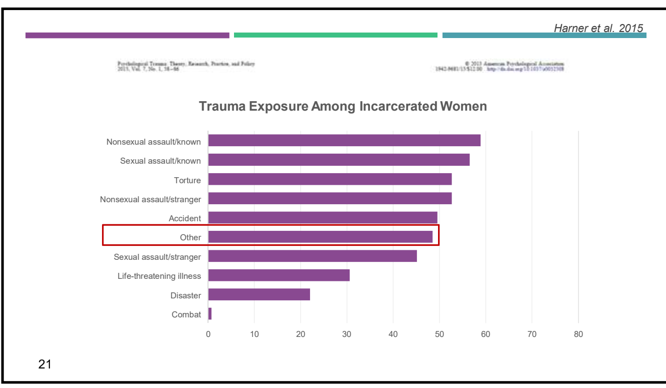
Harner et al. 2015
Trauma Exposure Among Incarcerated Women
Nonsexual assault/known
Sexual assault/known
Torture
Nonsexual assault/stranger
Accident
Other
Sexual assault/stranger
Life-threatening illness
Disaster
Combat
0
10
20
30
40
50
60
70
80
21

Harner et al. 2015

EXAMPLES OF "OTHER" TRAUMA

Table 4
Examples of "Other" Traumatic Events

Witnessing violence
- "Watching my mother get physically and mentally abused by my father as a kid. He broke into our home when I was 11 with a gun to kill my mom and himself."
- "I watched my mother be beaten by different men from the age of 5 to 12."
- "Found my father after he cut both of wrists in a suicide attempt. There was blood everywhere and he was very close to death."
- "Made to watch a pet tortured and killed when I was three."
- "Witnessed my stepfather being brutally beaten. He almost died and was left with 2/3 of his skull."
- "I witnessed the brutal murder of a 16 year old girl when I was 17."
- "Found brother dead with his head blown off."
- "My next-door neighbor stuck a shotgun in his mouth and pulled the trigger. His brains were in my drive way and there was a note pinned to his chest."

Long-term sexual victimization
- "Being molested by neighbor and cousins from the age of 6–12."
- "My mother pimping me out and my aunt setting me up for rape which resulted in pregnancy at 15 years old."
- "I had 2 of my toes cut off by my father. He started raping me after that."
- "It is something to be raped, but it was worse stress and pushed me over the edge when my daughter was molested. I stabbed him."
- "I was kidnapped at the age of 5 old by a stranger and raped for 3 months. Had to go to trial when I was 9."
- "Kidnapped at 15 sold to a pimp in Boston and walked away 9 months later."

Lifetime of traumatic events
- "Being beaten physically by my brother. Being put in a trunk of a car and overdosed- left for dead. Raped brutally at age 15. Watching my siblings shoot up dope."
- "Being verbally, sexually and physically assaulted by my children's father. Being physically attacked by a family member since the age of 8. Physically attacked by a stranger."
- "I was raped at gun-point at 16. Never told anyone. I was raped and molested by my biological sperm donor. I told and he went to jail. I had a lot of events in my life."
- "I've been beat all my life. Gang raped at 16, sexually molested. I've watched my mom be beat all my life then my brothers. Violence is all I'm used to being entrapped in."
- "My father tried to kill me, he tried suicide 2 times that I'm aware of, my brother was stabbed and robbed, my sister tried to kill herself and 2 of her kids, another brother and sister became drug addicts to cope with my father's abuses."
- "Molested from 7–14 years old by step father, and mother allowed him. Watching and listening to mom get beaten and raped by boyfriend. Abused by family and punched."
- "Boyfriend at 19 years old beat me regularly and made me miss-carry my baby. Locked in closet a lot not feed regularly as a child."
- "Mother killed my sister when I was 3. I have been beaten my entire childhood. Molested twice. Raped 1992. Beaten in the streets. Jumped, robbed, domestic violence."
- "House fire at the age of 16. Friend got shot. Foster father raped me have a child from that. Raped by a drug dealer's friend."

22

Sexual Victimization and Mental Illness Prevalence Rates Among Incarcerated Women: A Literature Review

TRAUMA, VIOLENCE, & ABUSE
1-24
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DOI: 10.1177/1524838018767933
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SAGE

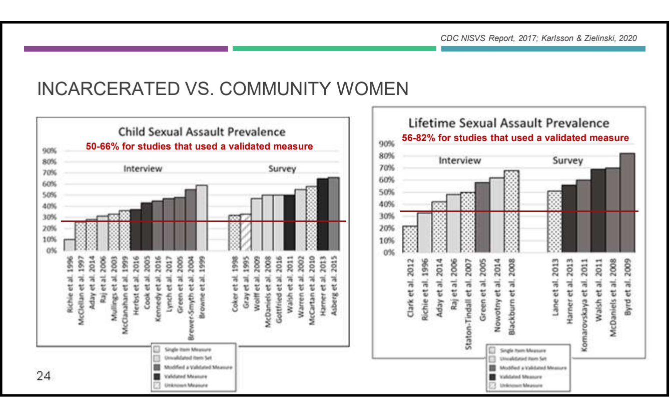
Marie E. Karlsson[1] and Melissa J. Zielinski[2]

Abstract
Incarcerated women evidence high rates of both interpersonal trauma and mental illness. In particular, the rates of sexual violence victimization are so high that some researchers have suggested that sexual abuse may be a pathway to prison for women, likely through the development of mental illness, including substance abuse. This review article summarizes the literature on sexual victimization (n = 32 articles; 28 independent studies) and mental illness (n = 11 articles; 8 independent studies) prevalence among samples of incarcerated women ($Ns \geq 100$) in context of methodological choices within included articles. Best estimates for sexual victimization from studies using established survey methods were as follows: 50–66% for child sexual abuse, 28–68% for adult sexual abuse, and 56–82% for lifetime sexual assault. Although data directly comparing prevalence of sexual victimization

23

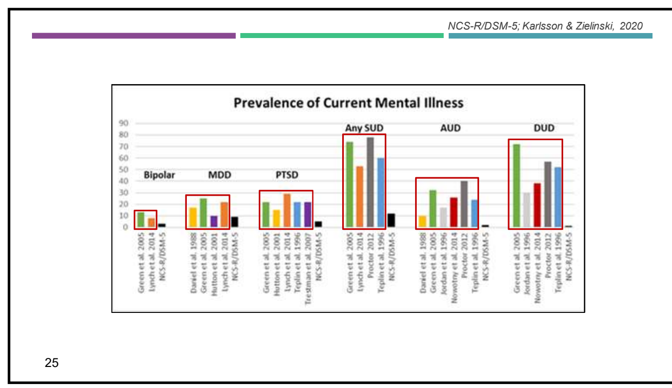
CDC NISVS Report, 2017; Karlsson & Zielinski, 2020

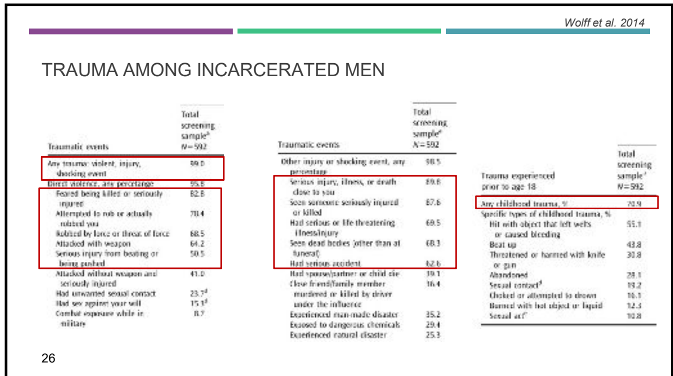
INCARCERATED VS. COMMUNITY WOMEN



Lifetime Sexual Assault Prevalence
56-82% for studies that used a validated measure
Interview
Survey

24




Wolff et al. 2014

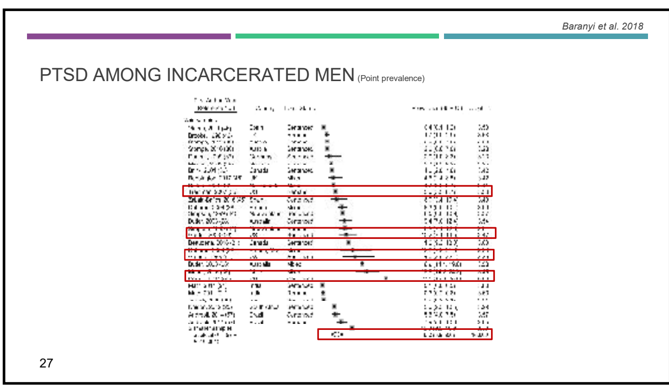
TRAUMA AMONG INCARCERATED MEN

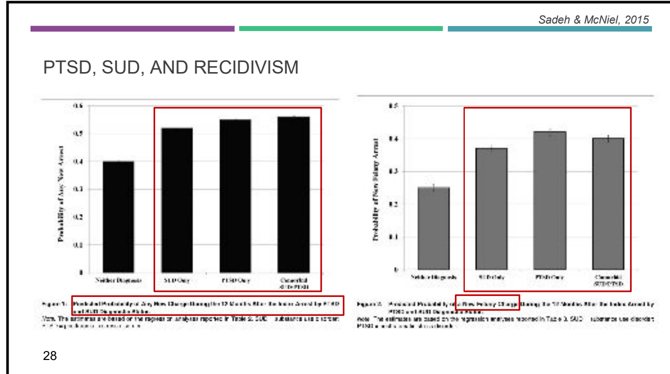
Traumatic events	Total screening sample[b] N = 592
Any trauma: violent, injury, shocking event	99.0
Direct violence, any percetange	95.8
Feared being killed or seriously injured	82.8
Attempted to rob or actually robbed you	70.4
Robbed by force or threat of force	68.5
Attacked with weapon	64.2
Serious injury from beating or being pushed	50.5
Attacked without weapon and seriously injured	41.0
Had unwanted sexual contact	23.7[d]
Had sex against your will	15.1[d]
Combat exposure while in military	8.7

Traumatic events	Total screening sample[a] N = 592
Other injury or shocking event, any percentage	98.5
Serious injury, illness, or death close to you	89.8
Seen someone seriously injured or killed	87.6
Had serious or life threatening illness/injury	69.5
Seen dead bodies (other than at funeral)	68.3
Had serious accident	62.6
Had spouse/partner or child die	39.1
Close friend/family member murdered or killed by driver under the influence	16.4
Experienced man-made disaster	35.2
Exposed to dangerous chemicals	29.4
Experienced natural disaster	25.3

Trauma experienced prior to age 18	Total screening sample[c] N = 592
Any childhood trauma, %	70.9
Specific types of childhood trauma, %	
Hit with object that left welts or caused bleeding	55.1
Beat up	43.8
Threatened or harmed with knife or gun	30.8
Abandoned	28.1
Sexual contact[d]	19.2
Choked or attempted to drown	16.1
Burned with hot object or liquid	12.3
Sexual act[e]	10.8

26





SUMMARY

- Trauma is highly prevalent
- So are trauma related disorders
- PTSD/SUD is especially common
- May put incarcerated people at risk for future incarceration

- Situation demands that we provide access to trauma-focused therapy

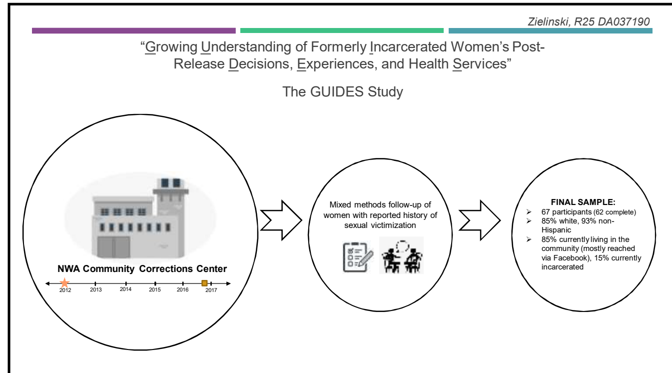
29

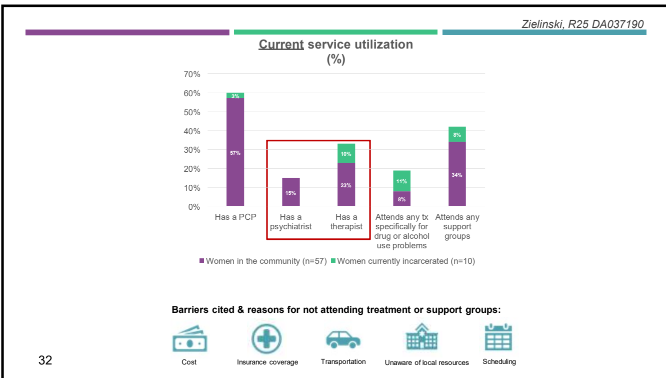
REMAINING QUESTIONS

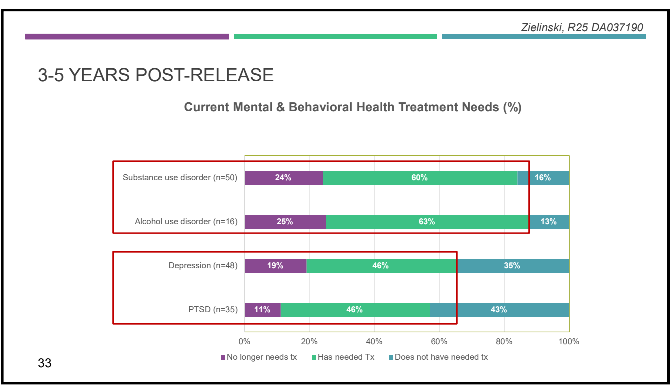
- What to do
  - What interventions should be offered?
  - When?
    - Wait until post-release?
    - Intervene during incarceration?

- How to get it done

30


Zielinski, R25 DA037190
"Growing Understanding of Formerly Incarcerated Women's Post-Release Decisions, Experiences, and Health Services"
The GUIDES Study
NWA Community Corrections Center
2012
2013
2014
2015
2016
2017
Mixed methods follow-up of women with reported history of sexual victimization
FINAL SAMPLE:
67 participants (62 complete)
85% white, 93% non-Hispanic
85% currently living in the community (mostly reached via Facebook), 15% currently incarcerated


Zielinski, R25 DA037190
Current service utilization (%)
70%
60%
50%
40%
30%
20%
10%
0%
57%
3%
15%
23%
10%
8%
11%
34%
8%
Has a PCP
Has a psychiatrist
Has a therapist
Attends any tx specifically for drug or alcohol use problems
Attends any support groups
Women in the community (n=57)
Women currently incarcerated (n=10)
Barriers cited & reasons for not attending treatment or support groups:
Cost
Insurance coverage
Transportation
Unaware of local resources
Scheduling
32


Zielinski, R25 DA037190
3-5 YEARS POST-RELEASE
Current Mental & Behavioral Health Treatment Needs (%)
Substance use disorder (n=50)
24%
60%
16%
Alcohol use disorder (n=16)
25%
63%
13%
Depression (n=48)
19%
46%
35%
PTSD (n=35)
11%
46%
43%
0%
20%
40%
60%
80%
100%
No longer needs tx
Has needed Tx
Does not have needed tx
33

Zielinski, R25 DA037190

3-5 YEARS POST-RELEASE

- Do women get trauma therapy?
  - **47%** have thought about getting therapy for trauma
  - **25%** reported that they have received at least some therapy for trauma

34

Should We? → How Do We?

35

INTERVENTIONS FOR PTSD

EVIDENCE-BASED OPTIONS

36

HOW PTSD DEVELOPS

- For those who don't recover from trauma, strong negative emotions lead to **escape** and **avoidance**

Memories & Thoughts → Negative Emotions → Escape/ Avoidance

Negative Emotions	Escape/ Avoidance
Guilt	Aggression
Shame	Suicidal thoughts/behaviors
Fear	Alcohol and drug use
Anger	Pushing thoughts away
Disgust	Avoiding places/people
	Dissociation
	Emotional numbing
	Withdrawing from people

37

AVOIDANCE

- Behaviors that people use to get away from trauma-related feelings, memories, or thoughts
- If you don't feel feelings and think thoughts about the trauma, it's hard to get better
  - If you feel feelings about the trauma, the feelings get weaker
  - If you look at thoughts about the trauma, you can see if they are extreme or balanced

38

WE HAVE EFFECTIVE TREATMENTS

THIRD EDITION
Effective Treatments for PTSD
Practice Guidelines from the International Society for Traumatic Stress Studies
edited by David Forbes, Jonathan I. Bisson, Candice M. Monson, Lucy Berliner

CLINICAL PRACTICE GUIDELINE for the Treatment of PTSD

VA/DOD CLINICAL PRACTICE GUIDELINE FOR THE MANAGEMENT OF POSTTRAUMATIC STRESS DISORDER AND ACUTE STRESS DISORDER

39

HOW DO YOU TREAT PTSD SYMPTOMS?

- HELP clients
  - Feel their feelings
  - Look at their memories and beliefs about what happened during the trauma
- Many beliefs can be affected by trauma
- We can work on them
- Talking about two evidence-based therapies for PTSD today
  - Cognitive Processing Therapy (CPT)
  - Prolonged Exposure (PE)

40

MOST IMPORTANT POINTS

- Recovery happens, without intervention, for many people
- Even if problems emerge or worsen, there are effective treatments
- You can gain the knowledge to help people be effective consumers of those treatments
- Goal = Establishing confidence/competence talking about trauma treatment
  - Even if you never do these treatments you need to be someone who can:
    - Normalize people's experiences and the impact of those experiences
    - How to find a good therapist/therapy for PTSD if warranted

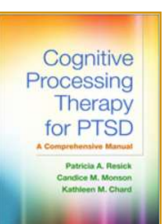
OVERVIEW OF CPT

Individual CPT	Group CPT
• 12 sessions, 50 minutes each • 1-2 times per week	• 12 sessions, 90 minutes each • 1-2 times per week • Group size of 8-10
Both include: Practice assignments following each session	

43

OVERVIEW OF CPT

- Originally developed for rape survivors (Resick & Schnicke, 1993)
  - Manual updated 2016
- Demonstrated effectiveness across many trauma types including child abuse, combat, IPV, and disasters.
- Effective in low-resource and conflict settings.
- 20 RCTs between 2002-2018



44

OVERVIEW OF CPT

- A trauma-focused, cognitive therapy in which clients learn to identify and modify trauma-related thoughts that are keeping them stuck.
- Time-limited and structured
- Clients are encouraged to process the natural emotions from the trauma, rather than avoid them

45

CPT THEORY AND RATIONALE

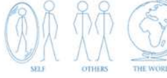
Social Cognitive Theory

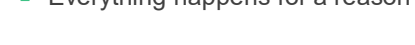
- How one responds to trauma is related to pre-trauma beliefs regarding:

46

CPT THEORY & RATIONALE

- Most of us put great weight on our beliefs and thoughts
- We use our beliefs to make sense of the world and our experiences in it
  - Examples:
    - Good things happen to good people
    - Treat people like you want to be treated
    - Everything happens for a reason





- What beliefs were you taught?
- What beliefs do you teach your children?

47

CPT THEORY & RATIONALE

- Cognitive therapy involves teaching skills to change extreme thoughts to be more balanced
- Example:
  - Men can never be trusted.
  - Some men cannot be trusted, but some men can be trusted.
- Changing thoughts will:
  - Improve feelings
  - Lead to more positive behaviors

48

CPT KEY INGREDIENTS (STRATEGIES)

Socratic Questioning

- Used to transition assimilated and overaccomodated beliefs from the trauma in to more balanced beliefs.

Assimilated	Accomodated	Overaccomodated
- I should have prevented it. - It was my fault. - Because I didn't tell sooner, I deserved it.	- I could not have prevented the rape and it was not my fault. That doesn't mean I have no control over my life now. - Sometimes bad things happen to good people.	- Men can't be trusted. - I am powerless. - I am a terrible person.

49

CPT SESSION OVERVIEW

- S1 – Psychoeducation and Impact Statement
- S2 – Impact Statement + Teach ABC sheet
- S3 – ABC sheet and Trauma
- S4 – Challenging Questions
- S5 – Patterns of Problematic Thinking
- S6 – Challenging Beliefs
- S7-12 – Continue Challenging Beliefs + Add Themes
  - Safety, Trust, Power & Control, Esteem, Intimacy
  - Last session – Impact Statement

50

CPT KEY INGREDIENTS (TOOLS)

HANDOUT 1.0
Practice Assignment after Session 1 of CPT

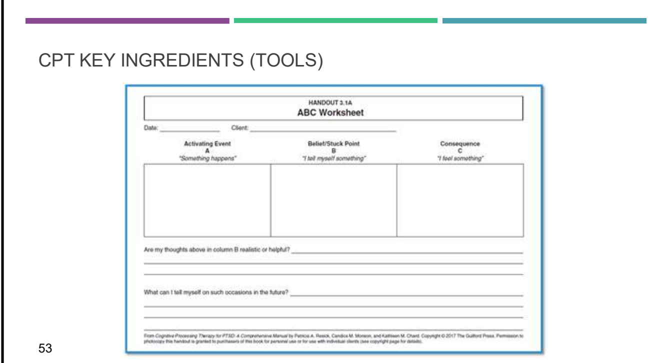
Date: ________ Client: ________

51

CPT KEY INGREDIENTS (TOOLS)

Stuck Point Log

52



HANDOUT 3.1A

ABC Worksheet

Date: ____________ Client: ______________________

Activating Event A *"Something happens"*	Belief/Stuck Point B *"I tell myself something"*	Consequence C *"I feel something"*

Are my thoughts above in column B realistic or helpful? ______________________

What can I tell myself on such occasions in the future? ______________________

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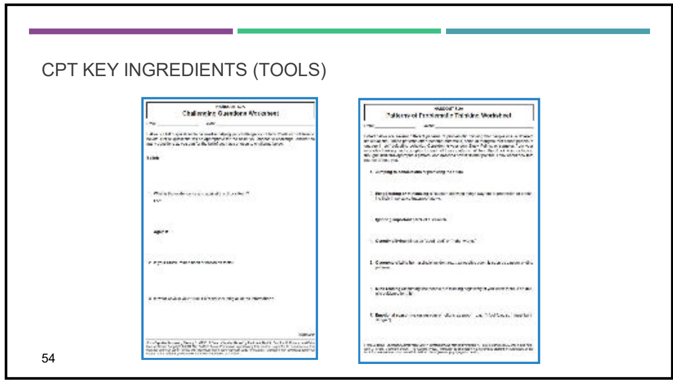

CPT KEY INGREDIENTS (TOOLS)

HANDOUT 7.2A
Challenging Beliefs Worksheet

55

CPT KEY INGREDIENTS (TOOLS)

HANDOUT 7.2A
Challenging Beliefs Worksheet

Session 2-3

56

CPT KEY INGREDIENTS (TOOLS)

HANDOUT 7.2A
Challenging Beliefs Worksheet

Session 4

57

CPT KEY INGREDIENTS (TOOLS)

HANDOUT 7.2A
Challenging Beliefs Worksheet

Session 5

58

CPT KEY INGREDIENTS (TOOLS)

HANDOUT 7.2A
Challenging Beliefs Worksheet

Session 6+

59

CPT TRAINING PROCESS

- Initial 2-day training
- 20 weekly consultation calls
- Requires 2 case presentations demonstrating implementation of, and fidelity to, the CPT model

60

POSSIBLE CHALLENGES TO DELIVERY IN CARCERAL SETTINGS

Residential Setting

Power and control dynamics

Forced programming participation

Competing with release dates

Possible re-traumatization

61

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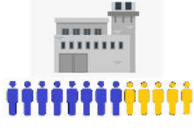
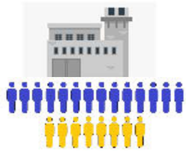
THE STRIDES PROJECT

- **Pilot a trauma therapy (CPT) in two community corrections centers**
  - Test whether it helps residents while they are incarcerated and after they are released
  - Measure factors that affect implementation outcomes like how many people receive the therapy
  - Pilot a strategy to support staff in delivering CPT with fidelity (meaning "as designed")

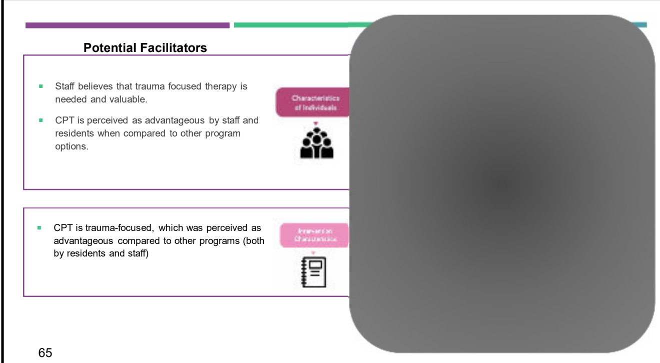
PRE-IMPLEMENTATION WORK

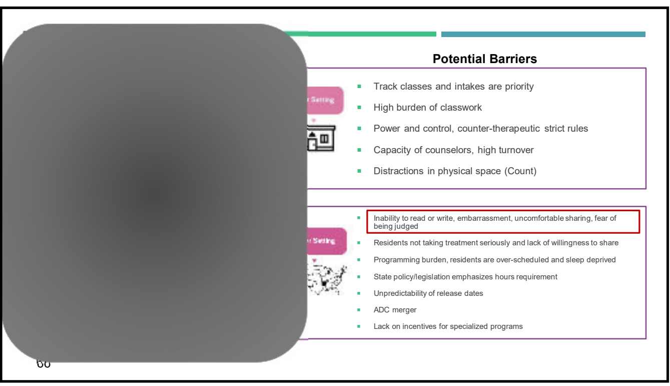
- Interviewed staff and residents at each center about anticipated barriers and facilitators to CPT implementation
- Used information to plan implementation and adapt CPT

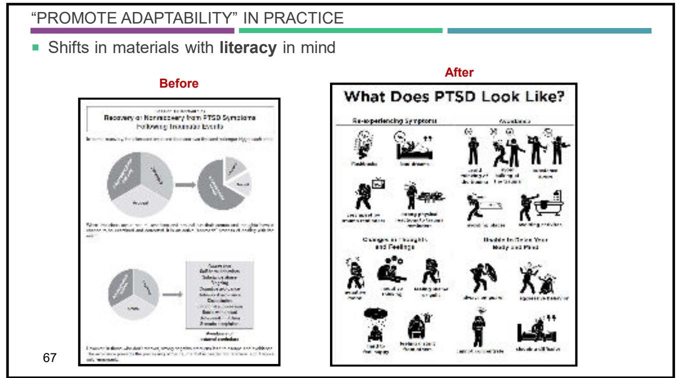


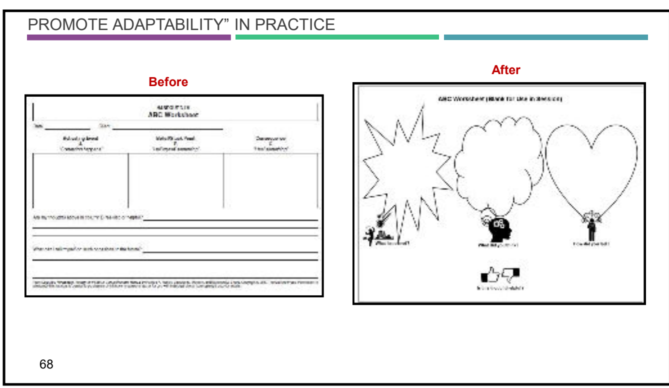


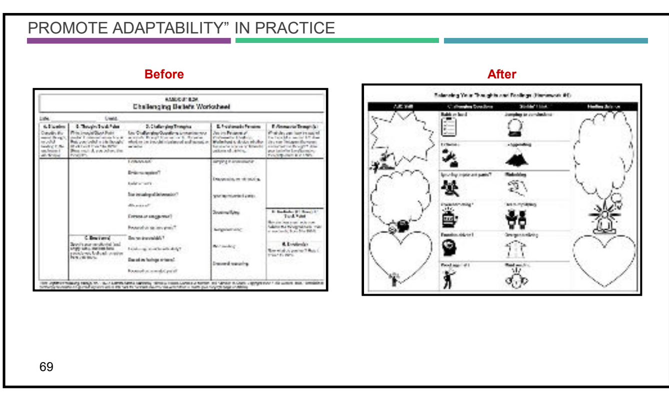
Potential Facilitators
Compatibility with facility population, programming already in place, practical resources, with culture/work flow.
Practical resources available, time for residents to participate and complete homework.
Computerized record keeping
Inner Setting
Residents respond highly to certificates and need for trauma treatment.
Residents have time to participate and do the homework.
Outer Setting
64

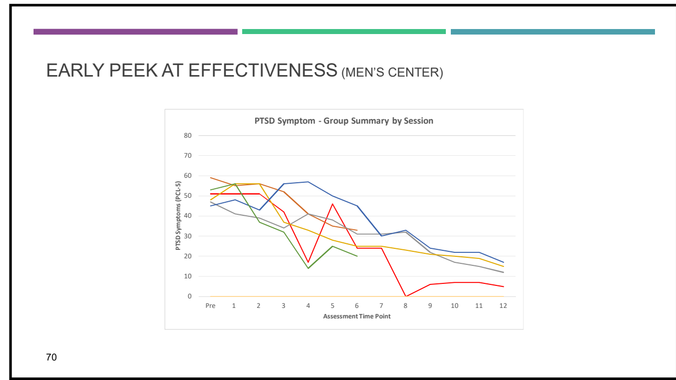

Potential Facilitators
Staff believes that trauma focused therapy is needed and valuable.
CPT is perceived as advantageous by staff and residents when compared to other program options.
Characteristics of Individuals
CPT is trauma-focused, which was perceived as advantageous compared to other programs (both by residents and staff)
65

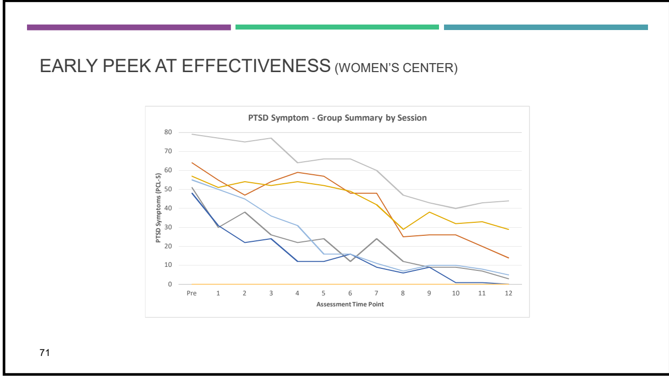

Potential Barriers
Track classes and intakes are priority
High burden of classwork
Power and control, counter-therapeutic strict rules
Capacity of counselors, high turnover
Distractions in physical space (Count)
Inability to read or write, embarrassment, uncomfortable sharing, fear of being judged
Residents not taking treatment seriously and lack of willingness to share
Programming burden, residents are over-scheduled and sleep deprived
State policy/legislation emphasizes hours requirement
Unpredictability of release dates
ADC merger
Lack on incentives for specialized programs


"PROMOTE ADAPTABILITY" IN PRACTICE
Shifts in materials with literacy in mind
Before
After
What Does PTSD Look Like?
67


PROMOTE ADAPTABILITY" IN PRACTICE
Before
After
68


PROMOTE ADAPTABILITY" IN PRACTICE
Before
After
Challenging Beliefs Worksheet
69


EARLY PEEK AT EFFECTIVENESS (MEN'S CENTER)
PTSD Symptom - Group Summary by Session
PTSD Symptoms (PCL-5)
Assessment Time Point
70


EARLY PEEK AT EFFECTIVENESS (WOMEN'S CENTER)
PTSD Symptom - Group Summary by Session
PTSD Symptoms (PCL-5)
Assessment Time Point
71

PROLONGED EXPOSURE
MELISSA J. ZIELINSKI, PH.D.
72

OVERVIEW OF PE

- A trauma-focused behavioral therapy in which clients learn to gradually approach safe, trauma-related stimuli (memories + trauma reminders)
  - Approach (exposure) teaches clients that their fears do not occur and that they can tolerate associated distress, lessening/eliminating fear/symptoms
- Time-limited and structured
  - Generally 8-15 sessions that are 90 minutes each
- Clients are encouraged to feel the emotions that arise from memories and reminders of the trauma, rather than avoid them

73

OVERVIEW OF PE

- Primary target is **fear** reduction
- Historical "roots"
  - Definition of trauma as inducing fear, helplessness, and/or horror
  - PTSD as an anxiety disorder

74

PE THEORY & RATIONALE

Emotional Processing Theory (Lang, 1977)

- Brain encodes a "fear structure" that includes information about:
  - Stimuli present before, during, and after a trauma
  - Associated internal and behavioral responses (e.g., emotions felt, sensations experienced, actions taken)
  - Meanings associated with the stimuli and responses
    - Associations are not necessarily realistic

- Example of tiger walking in to the room and attacking me
  - Tiger in the zoo vs. the above

75

PE THEORY & RATIONALE

- Main factors that prolong post-trauma problems:
  1. Avoidance of trauma-related situations
  2. Avoidance of trauma-related thoughts and images
  3. Problematic automatic thoughts (e.g., I can't handle this; The world is very dangerous)
- Avoidance strategies prevent clients from processing the trauma and from changing their thoughts about the trauma
  - Pathway to healing is approaching #1 and #2

76

PE KEY INGREDIENTS (STRATEGIES)

Imaginal exposure

- Repeatedly imagining (and verbalizing/listening to) the traumatic event, in detail
- Add more and more detail over time
  - Hot spots in the memory
  - Under-engagement is much more common than over-engagement
- Underlying premise = while the memory is painful, it is a *memory*—it is not dangerous and the person can learn to handle it/will not lose control or lose their sanity.
  - Technique promotes a sense of competence and mastery

77

PE KEY INGREDIENTS (STRATEGIES)

In vivo exposure

- Repeatedly approaching safe, trauma-related situations that have been avoided since the trauma
- Plan is guided by a "fear hierarchy"
  - Extensive list of avoided situations and associated distress ratings called "SUDS" (subjective units of distress)
- Over time and with repeated exposure clients realize that these situations are not as dangerous as feared and SUDS lessen

78

PE KEY INGREDIENTS (PROCESS)

- Psychoeducation & Breathing Retraining
- Imaginal and in vivo exposure to activate memory/fear structure and allow for modification
- Cognitions change through exposure alone
  - No direct focus on changing thoughts

79

PE SESSION OVERVIEW (BASED ON 10-SESSION EXAMPLE)

- S1 – Assessment, treatment overview, psychoeducation, breathing retraining
- S2 – Fear hierarchy construction (in vivo exposure continues throughout)
- S3-5 – Imaginal exposure
- S6-9 – Imaginal exposure with focus on "hot spots"
- S10 – Final imaginal exposure, wrap-up

80

POSSIBLE CHALLENGES TO DELIVERY IN CARCERAL SETTINGS

Residential Setting

Power and control dynamics

PUSH

Forced programming participation

Competing with release dates

Possible re-traumatization

Can't do in vivo exposure

81

"SHARE" GROUP THERAPY

"SHARE" = SURVIVORS HEALING FROM ABUSE: RECOVERY THROUGH EXPOSURE

82

SHARE GROUP THERAPY

- Survivors Healing from Abuse: Recovery through Exposure (SHARE) is an 8-session group therapy for incarcerated women who have:
  - Survived sexual violence
  - Who identify as continuing to have problems as a result of those experiences
- Exposure-based
  - Imaginal exposure comprises the bulk of the time in the therapy

84

WHAT IS SHARE?

Session #	Agenda
1	• Group norms, confidentiality • Psychoeducation
2	• Treatment rationale • Metaphors, Cycle of anxiety • Coping skills
3- 7	• Imaginal exposure + group feedback • Gently challenge cognitions while "hot," as relevant • (If time) Discuss trauma themes
8	• Consolidate gains (lessons learned, progress) • Directions for continued healing

Evidence-Based Components:

- Psychoeducation
- Coping skills training
- Imaginal exposure
- Challenging trauma cognitions

85

WHAT IS IMAGINAL EXPOSURE IN SHARE?

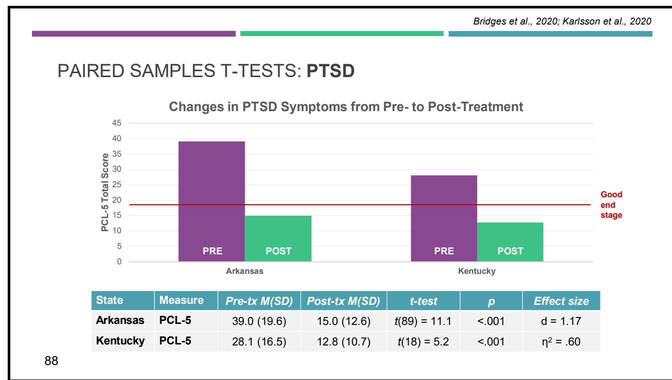
- In SHARE, the group leaders help group members to approach their most distressing memory of experiencing sexual violence and retell it in detail, while recalling it vividly.
- Why do this?

86

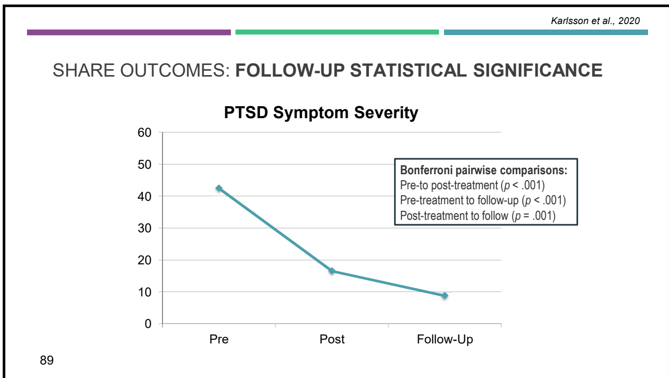
SHARE DEVELOPMENT AND IMPLEMENTATION IN ARKANSAS

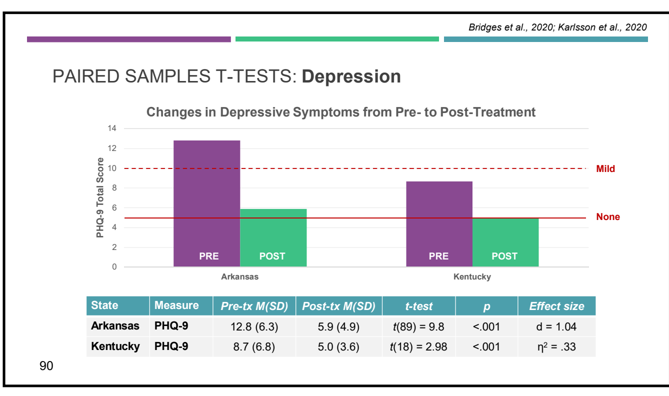
- Survivors Healing from Abuse: Recovery through Exposure (SHARE)
  - Exposure-based group therapy for incarcerated women survivors of sexual violence
  - January 2012 – Present at Northwest Arkansas Community Correction Center
    - Over 50 groups, 350+ treatment completers
  - Several open-label pilots of effectiveness
  - Studied implementation and long-term influences on sustainability

87

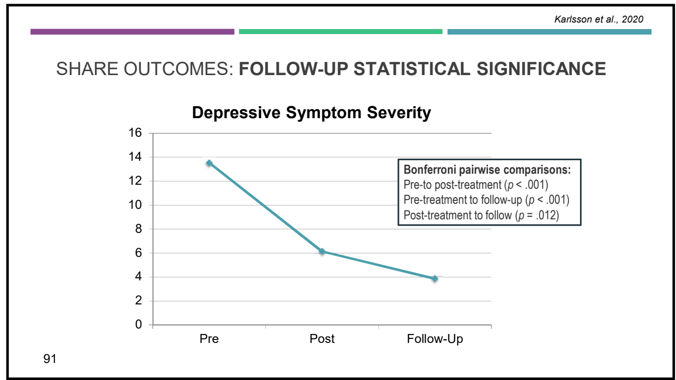


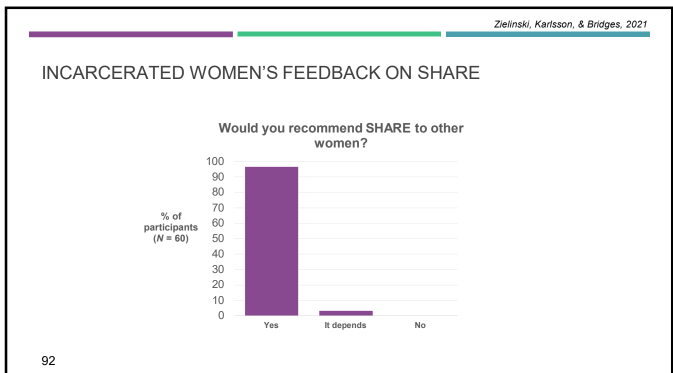
State	Measure	Pre-tx M(SD)	Post-tx M(SD)	t-test	p	Effect size
Arkansas	PCL-5	39.0 (19.6)	15.0 (12.6)	$t(89) = 11.1$	<.001	d = 1.17
Kentucky	PCL-5	28.1 (16.5)	12.8 (10.7)	$t(18) = 5.2$	<.001	$\eta^2 = .60$

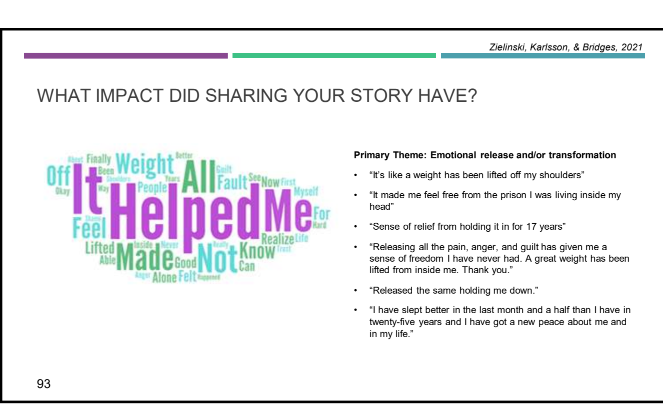




State	Measure	Pre-tx M(SD)	Post-tx M(SD)	t-test	p	Effect size
Arkansas	PHQ-9	12.8 (6.3)	5.9 (4.9)	$t(89) = 9.8$	<.001	d = 1.04
Kentucky	PHQ-9	8.7 (6.8)	5.0 (3.6)	$t(18) = 2.98$	<.001	$\eta^2 = .33$


Karlsson et al., 2020
SHARE OUTCOMES: FOLLOW-UP STATISTICAL SIGNIFICANCE
Depressive Symptom Severity
16
14
12
10
8
6
4
2
0
Pre
Post
Follow-Up
Bonferroni pairwise comparisons:
Pre-to post-treatment (p < .001)
Pre-treatment to follow-up (p < .001)
Post-treatment to follow (p = .012)
91


Zielinski, Karlsson, & Bridges, 2021
INCARCERATED WOMEN'S FEEDBACK ON SHARE
Would you recommend SHARE to other women?
% of participants (N = 60)
100
90
80
70
60
50
40
30
20
10
0
Yes
It depends
No
92


Zielinski, Karlsson, & Bridges, 2021
WHAT IMPACT DID SHARING YOUR STORY HAVE?
Off It Helped Me Weight All Fault Feel Made Not Know Lifted Alone Felt Realize People Myself For Good Can
Primary Theme: Emotional release and/or transformation
"It's like a weight has been lifted off my shoulders"
"It made me feel free from the prison I was living inside my head"
"Sense of relief from holding it in for 17 years"
"Releasing all the pain, anger, and guilt has given me a sense of freedom I have never had. A great weight has been lifted from inside me. Thank you."
"Released the same holding me down."
"I have slept better in the last month and a half than I have in twenty-five years and I have got a new peace about me and in my life."
93

Zielinski, Karlsson, & Bridges, 2021

WHAT IMPACT DID LISTENING TO OTHERS' STORIES HAVE?

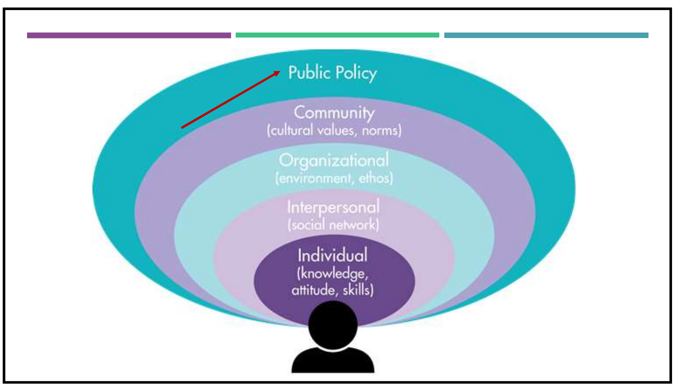
Primary Theme: Realized I'm not alone

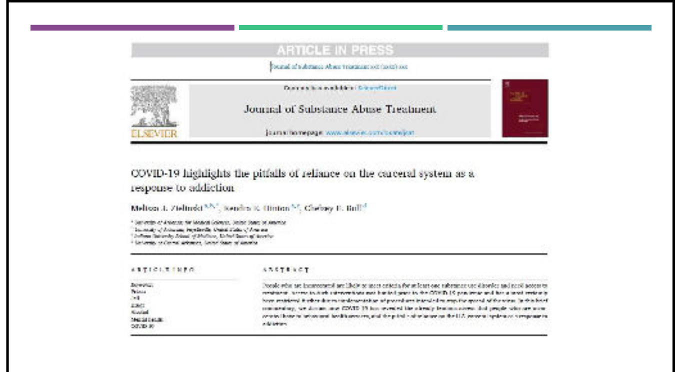
- "That they hurt just like me. That I'm not alone."
- "Huge. Hearing other women feeling the same."
- "To know I'm not alone."
- "Realizing I'm not alone and that there are others out there who have been through similar traumatic events and that people are willing to help."
- "It helped me see that I'm not alone and I have a right to my feelings."
- "That it's okay to feel the way I do. I'm not alone, my story matters."

94

CLOSING THOUGHTS & NOTES…

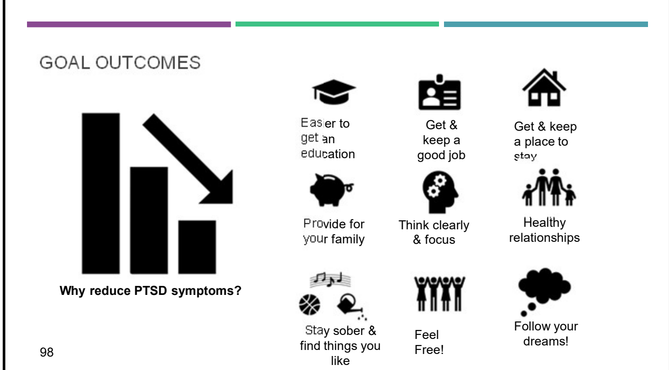
95




ARTICLE IN PRESS

Journal of Substance Abuse Treatment

COVID-19 highlights the pitfalls of reliance on the carceral system as a response to addiction



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99

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100

FOR MORE INFORMATION OR TO PARTNER

- Dr. Melissa Zielinski at MJZielinski@uams.edu

101

KEY REFERENCES

- Baranyi, G., Cassidy, M., Fazel, S., Priebe, S., & Mundt, A. P. (2018). Prevalence of posttraumatic stress disorder in prisoners. Epidemiologic Reviews, 40(1), 134–145. https://doi.org/10.1093/epirev/mxx015
- Foa, E. B., Hembree, E. A., & Rothbaum, B. O. (2007). Prolonged exposure therapy for PTSD: Emotional processing of traumatic experiences, therapist guide. New York, NY: Oxford University Press, Inc.
- Harner, H. M., Budescu, M., Gillihan, S. J., Riley, S., & Foa, E. B. (2015). Posttraumatic stress disorder in incarcerated women: A call for evidence-based treatment. *Psychological Trauma: Theory, Research, Practice, and Policy*, *7*(1), 58–66. https://doi.org/10.1037/a0032508
- Karlsson, M. E., & Zielinski, M. J. (2020). Sexual Victimization and Mental Illness Prevalence Rates Among Incarcerated Women: A Literature Review. Trauma, Violence, and Abuse, 21(2). https://doi.org/10.1177/1524838018767933
- Karlsson, M. E., Zielinski, M. J., & Bridges, A. J. (2020). Replicating outcomes of Survivors Healing from Abuse: Recovery through Exposure (SHARE): A brief exposure-based treatment for incarcerated survivors of sexual violence. *Psychological Trauma: Theory, Research, Practice and Policy, 12*(3), 300-305. doi: 10.1037/tra0000504
- Karlsson, M. E., Zielinski, M. J., Calvert, M. U., & Bridges, A. J. (*In Press*). Decreases in psychiatric symptoms persist following exposure-based group therapy for sexual violence victimization among incarcerated women. *Psychological Services.* doi:10.1037/ser0000570 [accepted 6/10/21; online first 7/22/21]
- Lynch, S. M., DeHart, D. D., Belknap, J. E., Green, B. L., Dass-Brailsford, P., Johnson, K. A., & Wong, M. M. (2017). An examination of the associations among victimization, mental health, and offending in women. Criminal Justice & Behavior, 44, 796-814.
- Resick, P. A., Monson, C. M., & Chard, K. M. (2017). *Cognitive Processing Therapy for PTSD: A Comprehensive Manual*. Guilford Press.
- Sadeh, N., & McNiel, D. E. (2015). Posttraumatic stress disorder increases risk of criminal recidivism among justice-involved persons with mental disorders. Criminal Justice and Behavior, 42(6), 573–586. https://doi.org/10.1177/0093854814556880
- Wolff, N., Huening, J., Shi, J., & Frueh, B. C. (2014). Trauma exposure and posttraumatic stress disorder among incarcerated men. Journal of Urban Health, 91(4), 707–719. https://doi.org/10.1007/s11524-014-9871-x
- Zielinski, M. J., Karlsson, M. E., & Bridges, A. J. (2021). "I'm not alone, my story matters:" Re-evaluating assumptions about conducting imaginal exposure to sexual violence memories in psychotherapy groups for incarcerated women. Health & Justice, 9, 25. doi: 10.1186/s40352-021-00148-4

102