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The Correlation Between PTSD and Criminogenic Behaviors In Incarcerated Veterans

Recent research has shown there is a strong correlation between PTSD and criminogenic behaviors in incarcerated veterans. As more service members are returning home from the war, many are faced with a history of untreated PTSD that is often exacerbated by multiple deployments. The struggles with PTSD combined with difficulties returning back to life outside the combat zone can be complicated and oftentimes overwhelmingly anxiety provoking.

This article will explore the new DSM 5 criteria for PTSD, which was published at the American Psychiatric Association in San Francisco in May 2013. The prevalence of the problem will be discussed and

pertinent areas that contribute to this correlation will be reviewed.

PTSD, or Post-Traumatic Stress Disorder, is defined as the development of characteristic symptoms following exposure to an extreme traumatic stressor. In helping service members understand this phenomenon it is important to help the service member understand that the issue is not what is wrong with him or her but rather the issue is more about what happened to him or her. In the new DSM 5, the stressor condition for PTSD is more explicit with regards to how an individual experiences a traumatic event. The subjective reaction in the DSM 5 has changed from the DSM IV TR

in that this criterion has been eliminated. In assessing symptomology, the DSM 5 has delineated four symptom clusters: re-experiencing, arousal, avoidance/numbing, avoidance and avoidance/numbing and persistent negative alterations. Other changes from the DSM IV TR include special criteria for children six years and younger and a dissociative sub-type. Ultimately, PTSD may affect functioning in three major ways: thoughts, level of arousal and feelings.

Underlying Effects

In understanding behaviors and the correlation between PTSD and criminogenic behaviors, it is important to understand how the brain becomes

affected by PTSD. The three brain regions that have been implicated in the studies of PTSD include the hippocampus, the amygdala and the medial pre-frontal cortex. Studies have shown decreased hippocampus volumes in people with PTSD. These deficits are thought to cause symptoms of avoidance and numbing. The Amygdala is integral to the generation and maintenance of emotional responses including assessment of emotional and threat-related stimuli. Abnormalities may impair fear processing. Studies show Amygdala volume correlates strongly with PTSD. The medial prefrontal cortex is responsible for judgment, cognition, behavior, personality expression and decision-making. People with PTSD have a hypo-activation of the medial prefrontal cortex which means this may contribute to an inability to curb reactivity to trauma-related cues and other intense stimuli.

A High Prevalence of Incarcerated Veterans

The prevalence of veterans incarcerated in the United States is rather staggering. According to the Bureau of Justice Statistics, one in 10 inmates in a state prison reported prior service in the United States armed forces. In addition, 54% of veterans in state facilities and 64% of service members in federal facilities served during a wartime period. Vietnam-war era veterans are the most common wartime veterans. The average length of military service of veterans in prison was approximately four years. Of all veterans in prison, 99% are males. More than half (57%) of veterans in prison are serving time for a violent crime. According to the BJS, rape or sexual assault was the most common offense.

VETERANS TREATMENT COURT

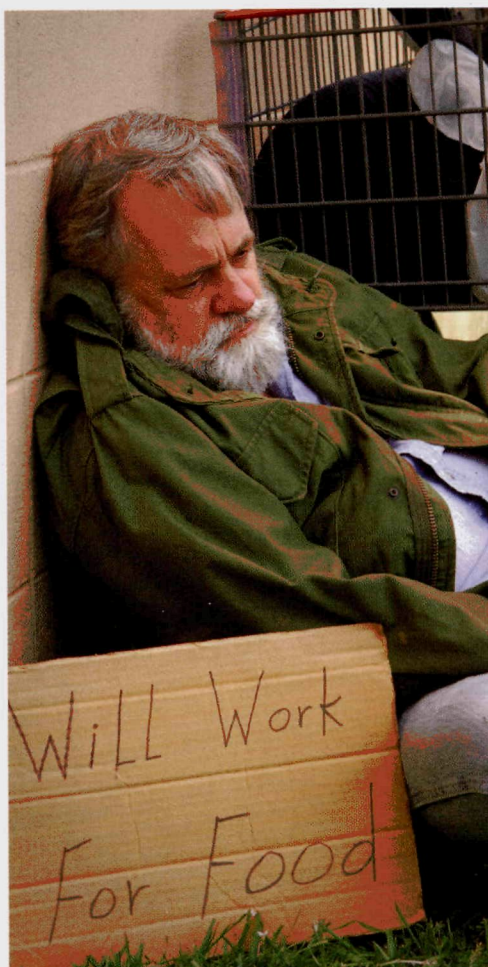
Most veterans are strengthened by their military service, but the combat experience has unfortunately left a growing number of veterans with Post-Traumatic Stress Disorder and Traumatic Brain Injury. One in five veterans has symptoms of a mental health disorder or cognitive impairment. One in six veterans who served in Operation Enduring Freedom and Operation Iraqi Freedom suffer from a substance abuse issue. Research continues to draw a link between substance abuse and combat-related mental illness. Left untreated, mental health disorders common among veterans can directly lead to involvement in the criminal justice system.

The Veterans Treatment Court model requires regular court appearances (a bi-weekly minimum in the early phases of the program), as well as mandatory attendance at treatment sessions and frequent and random testing for substance use (drug and/or alcohol). Veterans respond favorably to this structured environment given their past experiences in the Armed Forces. However, a few will struggle and it is exactly those veterans who need a Veterans Treatment Court program the most. Without this structure, these veterans will reoffend and remain in the criminal justice system. The Veterans Treatment Court is able to ensure they meet their obligations to themselves, the court, and their community.

WHY A VETERANS-ONLY DOCKET?

Veterans Treatment Courts allow jurisdictions to serve a large segment of the justice-involved veteran population as opposed to business as usual—having all veterans appear before random judges who may or may not have an under-

standing of their unique problems. Because a Veterans Treatment Court judge handles numerous veterans' cases and is supported by a strong, interdisciplinary team, he or she is in a much better position to exercise discretion and effectively respond than a judge who only occasionally hears a case involving a veteran defendant. A Veterans Treatment Court judge better understands the issues that a veteran may be struggling with, such as substance addiction, Post-Traumatic Stress Disorder, Traumatic Brain Injury, and military sexual trauma. A Veterans Treatment Court judge is also more familiar with the Veterans Health Administration, Veterans Benefit Administration, State Department of Veterans Affairs, Veterans Service Organizations, and volunteer Veteran Mentors and how they all can assist veteran defendants.



The Connection with Traumatic Brain Injury

One of the stronger indicators between PTSD and criminogenic behaviors in incarcerated veterans was the presence of a traumatic brain injury or TBI. As more soldiers are returning home from Afghanistan and Iraq, more veterans are presenting with a diagnosis of PTSD and a history of TBI. According to research, PTSD has been shown to occur more commonly in veterans with combat-related concussions (mild TBIs) than in those with other injuries. Three-quarters of Overseas Contingency Operations patients with a TBI diagnosis also had a diagnosis of PTSD. One-fifth of OCO patients with a PTSD diagnosis also had a diagnosis of TBI. When a veteran suffers from a combination of TBI and PTSD, his or her added symptomology often includes irritability, cognitive defects, insomnia, depres-



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research on treating both PTSD and TBI either psychologically or pharmacologically.

As shown, PTSD can easily manifest in criminogenic behaviors. Research has shown that veterans who struggle with the

2010). Psychodynamic conditions of wartime experiences that can lead to criminal behavior include: retaliation for being victimized, the omnipotent need to prove that crime may be committed without punishment, an attempt to be punished to overcome feelings of guilt, the result of substance abuse or the result of risky behavior (Sparr, Reeves & Atkinson 1987).

Research has also shown specific links between PTSD and criminal behavior. Offenses can be directly connected to the specific trauma that an individual experienced. Many symptoms of PTSD can lead to a lifestyle that is likely to result in criminal behavior. Individuals with PTSD are often plagued by memories of the trauma and are chronically anxious. The need to be on guard may cause veterans to misinterpret benign situations.

Oftentimes, it is difficult to ascertain why veterans may commit specific crimes. Research has shown that crimes can literally or symbolically recreate important aspects of trauma. Environmental conditions similar to those that existed at the time of the trau-



Research has shown that veterans who struggle with the anger and emotional outbursts of combat trauma are more than twice as likely as other veterans to be arrested for criminal misbehavior.

sion, fatigue and anxiety. There are currently no evidenced-based models of treatment to guide clinical practice for this population. There is limited

anger and emotional outbursts of combat trauma are more than twice as likely as other veterans to be arrested for criminal misbehavior (Elbogen et al,

ma can induce behavior similar to that exhibited during the trauma. Life events can trigger feelings that are unresolved that are connected to the trauma. With the recent addition of dissociation to the PTSD diagnostic criteria, some veterans may experience amnesia surrounding all or part of a crime.

Prior to discussing treatment alternatives, it is important to briefly discuss behaviors experienced by correctional officers returning home from war. These men and women may not be incarcerated, but they work in an environment with incarcerated veterans and often struggle with similar if not identical PTSD and/or TBI symptomology.

Research has shown that correctional officers are often hesitant to seek treatment due to not wanting to appear weak. Considering the nature of the work in a prison environment, PTSD developed abroad can be retriggered on the job by varying scenarios including assaults, hostage situations and inmate suicides. Some correctional officers liken working in a prison to that of being in a combat zone. This is very problematic when inmates are seen as the enemy.

Some suggestions for helping this population of veterans include: screen all returning veterans who are correctional officers for PTSD, train correctional officers on identifying signs and symptoms of combat-related trauma, hire a military liaison and ensure correctional officers utilize EAP services.

Treatment Options

There are several treatment options in treating incarcerated veterans with PTSD or offering suggested treatment to correctional officers. Some of the more popular approaches include: cognitive-behavioral treatments, EMDR, predominant cognitive treatments, predominant behavioral treatments, cognitive



Identifying, assessing and treating veterans in a prison environment no longer needs to be complicated. Many resources are available to treat this population.

processing therapy, cognitive restructuring and prolonged exposure therapy.

Several treatment models have also emerged in the literature. Sigafos (1994) developed a program whereby the veteran focused on re-experiencing life in a survival setting, stress management, PTSD and crime, conflict resolution, handling symptoms of PTSD, and the effects of PTSD on the family. Golden (2002) developed a Life Skills Training Model that consists of 20 90-minute group sessions provided over 10 weeks. Topics included: stress management, self-care, risk factors and triggers, medication and substance abuse, decision making and problem solving skills and anger management and communication skills.

From a pharmacological perspective, research has shown that SSRIs have received the most attention but are not always effective. The U.S. Food and Drug Administration has approved Sertraline and Paroxetine, as treatments for PTSD. Research has shown Propranolol to have promise in preventing PTSD-related psychophysiological arousal. Research has also shown little support for GABA receptors in treating PTSD.

Lastly, it would be inappropriate to discuss treating incarcerated veterans with PTSD without mentioning reentry initiatives. Some suggestions to reentry coordinators working with this population include: provide seamless and collaborative pre-release planning, assessment and coordination of services, interact with agencies on a local, state and national level, identify referral patterns and build coalition support and utilize a case management approach with this population beginning the first day of their incarceration.

It is clear there is a correlation between PTSD and incarcerated veterans. This article has attempted to explore the many facets connected to this correlation. Identifying, assessing and treating veterans in a prison environment no longer has to be complicated. There are resources and research that continues to examine this population and seek ways to treat and reduce recidivism. ★

"The Correlation Between PTSD and Criminogenic Behaviors in Incarcerated Veterans" is a presentation offered by Dr. Mark Fleming, Dr. Mark Simpson and CDR Norman Presecan at the American Correctional Association conference in August 2013 in National Harbor, Maryland.

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