

St. Catherine University

SOPHIA

Master of Social Work Clinical Research Papers

School of Social Work

5-2017

Mental Health Care for Clients who are Incarcerated: a Systematic Literature Review

Deborah Williams

St. Catherine University, jbrajoo@yahoo.com

Follow this and additional works at: https://sophia.stkate.edu/msw_papers



Part of the [Social Work Commons](#)

Recommended Citation

Williams, Deborah. (2017). Mental Health Care for Clients who are Incarcerated: a Systematic Literature Review. Retrieved from Sophia, the St. Catherine University repository website: https://sophia.stkate.edu/msw_papers/810

This Clinical research paper is brought to you for free and open access by the School of Social Work at SOPHIA. It has been accepted for inclusion in Master of Social Work Clinical Research Papers by an authorized administrator of SOPHIA. For more information, please contact amshaw@stkate.edu.

Running head: MENTAL HEALTH CARE FOR CLIENTS WHO ARE INCARCERATED

Mental Health Care for Clients who are Incarcerated: a Systematic Literature Review

by

Deborah Williams, BA, LADC

MSW Clinical Research Paper

Presented to the Faculty of the
School of Social Work
St. Catherine University and the University of St. Thomas St. Paul, Minnesota
in Partial fulfillment of the Requirements for the Degree of

Master of Social Work

Committee Members
Jessica Toft, MSW, Ph.D, (Chair)
Jane Hurley Johncox, MSW, LICSW
Anna Pederson, MSW, LICSW

The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

MENTAL HEALTH CARE FOR CLIENTS WHO ARE INCARCERATED

Abstract

The purpose of this systematic literature review was to explore the question: “What scholarly literature exists which explores the interrelated themes of treating Posttraumatic Stress Disorder and Substance Use Disorders in the presence of a Personality Disorder?”. Using the databases PILOTS: Published International Literature On Traumatic Stress, PsycARTICLES and PsycINFO and working within specific inclusion and exclusion criteria, seven peer-reviewed articles met the criteria and were reviewed. Each article was coded and five interrelated treatment themes emerged: 1) behavior is functional, 2) acceptance of self, 3) cognitive reappraisal, 4) collaboration, 5) healthy expression. The research shows that humans who experience trauma are best rehabilitated through a corrective experience rather than a correctional one. The difficulties in locating enough studies to complete this systematic literature review indicate that more research needs to be done in developing best practices to treat clients who are incarcerated.

MENTAL HEALTH CARE FOR CLIENTS WHO ARE INCARCERATED

Acknowledgments

I would like to thank Dr. Jessica Toft for her guidance, support, and grace throughout this process. Thank you to my committee members, Jane Hurley Johncox and Anna Pedersen for giving of your time to my project and foremost for being courageous and inspirational women. Thank you to my classmates and peers for your encouragement and camaraderie. Thank you to my husband Jeff for your laughter, your love, and your friendship which has kept me going. Finally, I would like to thank my cat Kieran for being a faithful and calming study buddy.

MENTAL HEALTH CARE FOR CLIENTS WHO ARE INCARCERATED

Table of Contents

Abstract.....2

Acknowledgements.....3

Table of Contents.....4

List of Tables.....5

Introduction.....6

Methods.....11

Findings.....13

Discussion.....20

References.....23

Appendix A.....27

MENTAL HEALTH CARE FOR CLIENTS WHO ARE INCARCERATED

Tables and Figures

Table 1 Included Articles12

MENTAL HEALTH CARE FOR CLIENTS WHO ARE INCARCERATED

Introduction

The United States has the highest number of people incarcerated of any country in the world. According to the Bureau of Justice, in 2014 approximately 1.5 million people were incarcerated (Kaeble, Glaze, Tsoutis & Minton, 2015). During 2014, the number of persons incarcerated in state or federal prisons and in local jails increased slightly, reversing a five-year decline since 2008 (Kaeble, Glaze, Tsoutis & Minton, 2015).

Though the overall jail census dropped 6.9% between 2008 and 2013, the number of woman incarcerated has increased 10.9% (Minton & Golinelli, 2014). Between 1999 and 2013, the population of females who are incarcerated increased by 48% (Minton, Ginder, Brumbaugh, Smiley-McDonald & Rohloff, 2015). This is a disturbing trend as women who are incarcerated are a particularly vulnerable population.

Women who are incarcerated are significantly more likely to suffer from mental illness and substance abuse when compared to men. It is estimated that more than 95% of women within the criminal justice system have experienced some type of physical and/or sexual abuse and possibly 98% have been exposed to some form of trauma. Additionally, women who are incarcerated are disproportionately re-victimized during incarceration by both staff and by other inmates. Women report inmate-initiated sexual victimization at a rate nearly twice that of men. Approximately 67% of incidents in which sexual misconduct is initiated by staff are reported by women (Walker, Conte & Grabner, 2014).

Prevalence of Mental Health Disorders in Correctional Clients

The prevalence of mental health disorders is disproportionately represented in incarcerated populations. More than half of persons who are incarcerated have a mental health disorder as compared to approximately 11% in the general population. Persons with mental

MENTAL HEALTH CARE FOR CLIENTS WHO ARE INCARCERATED

illness who are incarcerated often elicit more rule violations, spend more time in segregation, and serve longer sentences (Hoke, 2015). Despite mandates for equality of care within correctional institutions, there is disparity of mental health services provided for persons who are incarcerated compared to services provided for the general population. This lack of care leads to exacerbation of mental illness, substance abuse and increased recidivism (Hoke, 2015).

Prevalence of Substance Use Disorders in Correctional Clients

According to the National Center on Addiction and Substance Abuse, 64.5% of individuals who are incarcerated meet the criteria for a substance use disorder. Additionally, 85% of individuals who are incarcerated are “substance-involved”; meaning they either meet the criteria for a substance use disorder, have histories of substance abuse, were under the influence of alcohol or other drugs at the time of their offense, committed their offense to obtain drugs, were incarcerated for a violation related to alcohol or drugs, or shared some combination of these characteristics (2010).

The Bureau of Justice reported that 76.6% of inmates released in 2005 were arrested again within five years (Cooper, Durose, Snyder, 2014). In interviews conducted with incarcerated individuals diagnosed with a substance use disorder, most identified a relapse on drugs or alcohol as the primary condition of their recidivism (Phillips, 2010).

Prevalence of Posttraumatic Stress Disorder in Correctional Clients

The prevalence of Posttraumatic Stress Disorder (PTSD) is higher among persons who are incarcerated than that of the general population: approximately 21% versus 2% (Goff, Rose, Rose & Purves, 2007; Levin, Kleinman & Adler, 2014; Gillece, 2009). Left untreated, PTSD can lead to further antisocial behaviors such as interpersonal violence, suicide, self-destructive behaviors, further substance abuse, and a greater likelihood of recidivism (Goff, Rose, Rose &

MENTAL HEALTH CARE FOR CLIENTS WHO ARE INCARCERATED

Purves, 2007; Levin, Kleinman & Adler, 2014; Gillece, 2009). Studies indicate that jointly treating PTSD and a substance use disorder is essential in achieving and maintaining abstinence from mood-altering substances (Souza & Spates, 2008).

Prevalence of Personality Disorders in Correctional Clients

As with PTSD, the prevalence of a personality disorder diagnosis is also higher among people who are incarcerated than that of the general population: approximately 65% versus 10% in men and 42% versus 8% in women (Anasseril, 2007; Trull, Jahng, Tomko, Wood, & Sher, 2010). Individuals who are diagnosed with a personality disorder also have higher rates of substance abuse, with negatively related treatment outcomes (Fridel, Hesse & Johnson, 2006). The development of a personality disorder is often related to exposure to catastrophic events in early childhood which is similar to the development of PTSD. Treating PTSD and a personality disorder concurrently has efficacy as the disorders are thought to affect similar areas of the brain (Jones, 2015; Ingenhoven, 2015).

Treatment Strategies

Diversion programs. The high prevalence and enduring nature of these disorders requires a comprehensive treatment approach. A frontline intervention is to avoid incarcerating non-violent offenders who have a mental health issue. Diversion programs, such as Mental Health and Drug Courts, attempt to refer these individuals to appropriate community-based services as a less restrictive approach to stabilization and rehabilitation (Hoke, 2015; Jones, 2015).

Trauma-informed care. The Substance Abuse and Mental Health Services Administration (SAMHSA) defines trauma-informed care as “ a program, organization, or system that is trauma-informed: *Realizes* the widespread impact of trauma and understands

MENTAL HEALTH CARE FOR CLIENTS WHO ARE INCARCERATED

potential paths for recovery; *Recognizes* the signs and symptoms of trauma in clients, families, staff, and others involved with the system; *Responds* by fully integrating knowledge about trauma into policies, procedures, and practices; and *Seeks* to actively resist *re-traumatization*" (SAMHSA, 2015). Creating a trauma-informed correctional environment, one which provides education and structured support for both inmates and staff to respond to conduct issues in a more integrated manner, appears promising (Miller & Najavits, 2012). Studies in both the United States and England demonstrate that implementing facility-wide, trauma-informed care programs for inmates decreased facility violence, improved inmate mental health, and provided staff a framework to understand and to process behavioral issues (Gillece, 2009; McVey, Murphy & Saradjian, 2015).

Community re-entry programs. Research has shown that correctional clients who have received treatment for a mental health disorder have better outcomes with decreased recidivism and lower incidence of relapse on mood-altering chemicals when they transition into a residential community re-entry program (Sacks, Sacks & Stommel, 2003). While housing and employment have been receiving much-needed attention over the last several years, critical mental health services are often under-addressed in these programs (Garland & Hass, 2015).

Social Justice

Crime, relapse and recidivism are social problems that not only impact the individuals who are engaged in the criminal justice system, but certainly negatively impact society as a whole. Research substantiates that though mental health issues are a major problem for individuals who are currently involved with the criminal justice system, they seldom receive adequate care. Evidence further indicates that these issues are a major factor in their recidivism.

MENTAL HEALTH CARE FOR CLIENTS WHO ARE INCARCERATED

Scope and prevalence support that utilizing effective practices to treat individuals with co-occurring mental health issues who are incarcerated is an important social justice issue. Furthermore, recognizing the interrelated nature of these psychological and social problems would indicate a need to look at interventions that address them as a whole, rather than distinct phenomena.

Clarification is Needed

There is an evident correlation of the themes of substance use, trauma, and personality disorders related to recidivism in correctional clients. There is a massive amount of literature on each of these topics. However, due to the overwhelming amount of material written, it is difficult to locate studies which specifically address treating PTSD and Substance Use Disorders in the presence of a Personality Disorder.

A search of Master of Clinical Social Work research papers published by students at St. Catherine University was conducted using SOPHIA, which is an online database of literature created by the students, faculty and staff. This search yielded no papers published specifically to determine what literature exists about treating PTSD and Substance Use Disorders in the presence of a Personality Disorder. Further, a search was also done using PROSPERO, which is an international prospective register of systematic reviews. This search also yielded no scholarly literature published on this theme. There is a need for the current literature to be systematically reviewed to determine what interventions are currently used to treat the convergence of these mental health issues.

MENTAL HEALTH CARE FOR CLIENTS WHO ARE INCARCERATED

Methods

Research Purpose

This systematic literature review ciphred data through the research question: “What scholarly literature exists which explores the interrelated themes of treating Posttraumatic Stress Disorder and Substance Use Disorders in the presence of a Personality Disorder?”.

Search Strategies

To answer this research question, only peer-reviewed articles which included empirically-based, quantitative and qualitative studies were considered. Case studies, focus groups, interviews and other “gray literature” were excluded as identifying evidence-based treatment interventions was one of the goals of this research project. A search of peer-reviewed articles available through the St. Catherine University Library was done using the databases PILOTS: Published International Literature On Traumatic Stress, PsycARTICLES and PsycINFO.

Inclusion criteria. The search was conducted using terms “treatment” (which needed to be in the subject heading of the articles) and "substance use disorder or substance abuse or chemical dependency or drug use or alcohol use” and “PTSD or posttraumatic stress disorder or post-traumatic stress disorder” and “personality disorder or schizoid or schizotypal or paranoid or borderline or histrionic or antisocial or narcissistic or avoidant or dependent or obsessive-compulsive” and excluded the term “veterans”. Only articles published from 2010 to 2016 were considered. This search yielded a total of 308 peer-reviewed articles.

Exclusion criteria. The abstracts of each of the 308 articles were reviewed to confirm that they did include all initial search data which narrowed the number of articles from 308 to 65. These 65 articles were read through using the final criteria: treatment interventions used for a co-

MENTAL HEALTH CARE FOR CLIENTS WHO ARE INCARCERATED

occurring substance use disorder, posttraumatic stress disorder and a personality disorder. This left 7 final articles that were included in the systematic literature review. See Table 1 for a complete list of included articles. A detailed list of included articles with content summaries can be found in Appendix A.

Table 1: Included Articles

	Database	Title	Author(s)
1.	PsycARTICLES	A literature review and analysis of mode deactivation therapy	Apsche, J. A. (2010)
2.	PsycARTICLES	A neuroscience agenda for counseling psychology research	Gonçalves, Ó. F., & Perrone-McGovern, K. M. (2014)
3.	PsycARTICLES	Treating complex trauma in adolescents: A phase-based, integrative approach for play therapists	Green, E. J., & Myrick, A. C. (2014)
4.	PsycARTICLES	Alliance and outcome in varying imagery procedures for PTSD: A study of within-person processes	Hoffart, A., Øktedalen, T., Langkaas, T. F., & Wampold, B. E. (2013)
5.	PsycARTICLES	“Gender aware therapy” for professional men in a day treatment center	Robertson, J. M., & Williams, B. W. (2010)
6.	PsycARTICLES	The emerging role of Buddhism in clinical psychology: Toward effective integration	Shonin, E., Van Gordon, W., & Griffiths, M. D. (2014)
7.	PsycARTICLES	Family mode deactivation therapy (FMDT) as a contextual treatment	Swart, J., & Apsche, J. (2014)

MENTAL HEALTH CARE FOR CLIENTS WHO ARE INCARCERATED

Findings

The purpose of this systematic literature review was to explore the question: “What scholarly literature exists which explores the interrelated themes of treating Posttraumatic Stress Disorder and Substance Use Disorders in the presence of a Personality Disorder?”. Using the databases PILOTS: Published International Literature On Traumatic Stress, PsycARTICLES and PsycINFO and working within the inclusion and exclusion criteria laid out above, seven peer-reviewed articles met criteria and were reviewed.

Of the seven articles included in this study, three explored outcomes related to the treatment of adolescents (n=3, 42.8%), two explored treatment outcomes with adults (n=2, 28.5%) and two did not specify (n=2, 28.5%). Of the seven articles, one was a quantitative research design (n=1, 14.2%) one was a qualitative program review (n=1, 14.2%) and five were literature syntheses (n=5, 71.4%). Only one article explored a gender-specific intervention which was done with males.

Each of the seven articles reviewed a different therapeutic intervention as follows: Mode Deactivation Therapy (MDT), applied neuroscience, phase-based Integrative Play Therapy, building therapeutic alliance, Gender Aware Therapy (GAT), Buddhist-Derived Interventions (BDIs), and Family Mode Deactivation Therapy (FMDT).

Thematic Syntheses

Five interrelated treatment themes emerged from this systematic literature review. These themes were: 1) behavior is functional, 2) acceptance of self, 3) cognitive reappraisal, 4) collaboration, 5) healthy expression. These treatment themes appear to support the common treatment goal which also emerged through the analysis of the final articles: affect regulation.

MENTAL HEALTH CARE FOR CLIENTS WHO ARE INCARCERATED

Behavior is functional. Behavior is shaped through a learning process that is maintained by reinforcement (Apsche, 2010). Through experience, humans learn to avoid painful stimuli which is fundamentally a functional behavior (Apsche, 2010; Green & Myrick, 2014; Gonçalves & Perrone-McGovern, 2014). This avoidance shapes one's core beliefs which elicit certain thoughts, feelings and behaviors (Apsche, 2010; Green & Myrick, 2014; Robertson & Williams, 2010; Swart & Apsche, 2014). For example, Personality Disorders and PTSD are conceptualized as subconscious reactive adaptations to trauma (Apsche, 2010; Swart & Apsche, 2014).

In this context, substance use is a functional safety behavior which helps one to avoid feeling pain (Green & Myrick, 2014) and to decrease levels of stress (Robertson & Williams, 2010). This is likely why Substance Use Disorders are often a co-occurring diagnosis with PTSD and Personality Disorders (Green & Myrick, 2014).

Other problematic, avoidant safety behaviors related to trauma include: interpersonal violence (Apsche, 2010; Green & Myrick, 2014; Swart & Apsche, 2014), high-risk/aggressive sexual behaviors (Apsche, 2010; Green & Myrick, 2014; Swart & Apsche, 2014; Robertson & Williams, 2010) and suicide (Apsche, 2010; Green & Myrick, 2014; Robertson & Williams, 2010; Swart & Apsche, 2014).

Acceptance of self. Acceptance appears to be a countermeasure to avoidance. Practicing acceptance of pain as a normal part of the human experience defuses the strength of avoidance (Apsche, 2010). Literature suggests that the Buddhist principle of accepting the impermanence of life has been helpful in treating PTSD (Shonin, Van Gordon & Griffiths, 2014). The ability of an individual to practice radical acceptance of what they have done to others allows them to more objectively examine their belief-driven behaviors (Apsche, 2010). Acceptance of the past allows clients to develop a plausible and coherent understanding of how their problematic

MENTAL HEALTH CARE FOR CLIENTS WHO ARE INCARCERATED

behaviors developed. This understanding allows them to recognize that these safety behaviors are no longer helpful and is a motivator for change (Robertson & Williams, 2010). Feeling accepted and not judged within a therapeutic relationship provides a corrective experience for the client that increases their esteem for themselves (Green & Myrick, 2014). Skills that appear to facilitate acceptance of self are mindfulness and compassion.

Mindfulness. The operational definition of mindfulness gleaned from these articles appears to be the practice of becoming aware of what is happening in the present moment in the body. A client who is more aware of their own thoughts, feelings and bodily sensations will be more likely to have empathy for what others are feeling which might be a catalyst for change (Apsche, 2010). According to Gonçalves and Perrone-McGovern (2014), mindfulness practiced during therapy sessions not only decreased stress and improved attention in session, but it also had a positive impact on the brain both functionally and structurally. These changes might help a client improve their ability to regulate emotions and cognitions.

Literature indicates that the practice of mindfulness has been effective in the treatment of substance use and effective in reducing problematic avoidance patterns in individuals with PTSD (Shonin, Van Gordon & Griffiths, 2014). Relaxation techniques are often used in conjunction with mindfulness. Practicing relaxation skills within a mindfulness exercise can increase trust, decrease anxiety, and increase treatment commitment (Apsche, 2010).

Compassion. Experiencing trauma can lead to feelings of being inherently bad and damaged. A therapeutic relationship with a client that promotes unconditional warmth provides a positive attachment experience that allows the client to view themselves and the world in a more hopeful and positive light (Green & Myrick, 2014). Encouraging clients with PTSD to develop

MENTAL HEALTH CARE FOR CLIENTS WHO ARE INCARCERATED

self-compassion counters feelings of shame, guilt and self-criticism (Hoffart, Øktedalen, Langkaas & Wampold, 2013).

Studies of the Buddhist-Derived Intervention, Compassion-Based Cognitive Therapy (CBCT) suggest that CBCT has been effective in reducing automatic immune and stress responses, reducing salivary concentrations of C-reactive protein (a marker for psychopathology), reducing levels of depression, increasing empathy response, increasing emotional regulation and for positive changes to the brain (Shonin, Van Gordon & Griffiths, 2014). Compassion-Focused Therapy (CFT) is a technique that assists clients to move from shame and self-despair within the compassion and high regard of the therapeutic relationship (Shonin, Van Gordon & Griffiths, 2014).

Cognitive reappraisal. The operational definition of cognitive reappraisal gleaned from these articles can be described as the process of recognizing and reinterpreting an emotional or physiological trigger in order to produce a new behavior through affect regulation. Cognitive reappraisal then is a key component of mastering impulse control.

The experience of trauma has a neurotoxic impact on the brain. Studies indicate that long-term childhood neglect increases the volume of the amygdala in the brain which is associated with difficulties in emotional regulation (Gonçalves & Perrone-McGovern, 2014). Studies correlate maltreatment with reduced corpus callosum measurements and abnormalities to the frontal and prefrontal lobes of the brain. These changes suggest that trauma impacts the overall executive functioning of the brain and impairs the integration of right and left brain activity (Green & Myrick, 2014). Further, the effect of complex trauma on the developing brain appears to negatively alter cognitive functioning related to memory, focus, attention, concentration and language development. The traumatized brain appears to engage in

MENTAL HEALTH CARE FOR CLIENTS WHO ARE INCARCERATED

neurological pruning as way to avoid negative emotions related to traumatic memories with catastrophic outcomes (Green & Myrick, 2014).

Neuroimaging studies demonstrate that cognitive reappraisal changes the structure of the amygdala. The semantic counseling process of assigning new meaning to an experience through cognitive reappraisal appears to promote reconstruction of the temporal cortical networks in the brain associated with emotional regulation (Gonçalves & Perrone-McGovern, 2014). Though trauma is toxic to the brain, cognitive reappraisal appears to be literally life-giving.

Cognitive reappraisal encourages the client to seek balance. Rather than label thoughts as distorted and behaviors as dysfunctional, cognitive reappraisal validates the truth of the individual experience (Apsche, 2010; Shonin, Van Gordon & Griffiths, 2014; Swart & Apsche, 2014). However, it also invites the client to explore alternative responses to their emotional and physiological triggers. Clients who respond to stress with intense emotional dysregulation often engage in dichotomous thinking (Apsche, 2010). Cognitive reappraisal encourages clients to balance thoughts, emotions and behaviors to facilitate better impulse regulation (Apsche, 2010; Robertson & Williams, 2010; Shonin, Van Gordon & Griffiths, 2014; Swart & Apsche, 2014). Assisting the client in achieving balance and stabilization is at the core of trauma-informed treatment (Green & Myrick, 2014).

Collaboration. The theme of collaboration speaks to collaboration within the client-therapist relationship and also within an interdisciplinary treatment team. Completing a thorough client assessment and a comprehensive case conceptualization are key aspects of the collaborative process.

Assessment. A thorough client assessment gives the therapist and the clinical team a more complete understanding of the conglomerate experiences that have shaped the client's

MENTAL HEALTH CARE FOR CLIENTS WHO ARE INCARCERATED

beliefs, thoughts, emotions and compensatory behaviors (Apsche, 2010; Robertson & Williams, 2010; Swart & Apsche, 2014). In the same way, the information gathered in the assessment allows the client to grasp a better understanding of self which may facilitate behavioral change (Robertson & Williams, 2010). The assessment process allows the client to see that their beliefs and compensatory behaviors developed as a result of their life experiences regardless of how extreme they are. Therapeutic rapport is built when the clinician validates this truth as legitimate (Apsche, 2010; Swart & Apsche, 2014). Establishing a strong therapeutic alliance is crucial when working with clients who have experienced trauma (Green & Myrick, 2014; Hoffart, Øktedalen, Langkaas & Wampold, 2013) and predicts better clinical outcomes (Hoffart, Øktedalen, Langkaas & Wampold, 2013).

Case conceptualization. Case conceptualization is shaped by the information gathered in the assessment. It provides the clinical team a “blueprint” for establishing treatment strategies (Apsche, 2014). The guidelines provided in the case conceptualization keep the clinical team solution-focused on the presenting needs of the client (Apsche, 2014; Robertson & Williams, 2010). Clients designated as defiant and oppositional are more responsive to a treatment plan that is based on a case conceptualization shaped directly from their assessment. Within this framework, the clinician is viewed as a collaborative guide rather than an instructor which inherently decreases treatment resistance (Swart & Apsche, 2014). Collaborative treatment planning that allows for task agreement between the client and therapist has been shown to improve treatment outcomes for clients treated for PTSD (Hoffart, Øktedalen, Langkaas & Wampold, 2013).

Healthy expression. If the common treatment goal which emerged through the analysis of the final articles was affect regulation, the behavioral representation of this would be healthy

MENTAL HEALTH CARE FOR CLIENTS WHO ARE INCARCERATED

expression. To some extent, all seven articles indicated that the co-occurring presence of a Personality Disorder, PTSD and a SUD appears to be formed in the presence of trauma (Apsche, 2010; Gonçalves & Perrone-McGovern, 2014; Green & Myrick, 2014; Hoffart, Øktedalen, Langkaas & Wampold, 2013; Robertson & Williams, 2010; Van Gordon & Griffiths, 2014; Swart & Apsche, 2014). A partial list of functional and yet problematic outcomes of trauma presented in the literature are profound and include: anxiety, depression, aggression, unplanned pregnancy, dating violence, sexual offending, family discord, criminal behaviors and suicide. Brain abnormalities caused by the neurotoxic nature of trauma confound treatment strategies. Yet, hope does exist.

MDT and FMDT have been demonstrated as effective in reducing internal and external distress, fear, avoidance, aggression, sexual reaction and offending, criminal recidivism and self-harm and suicide in adolescents. There were corresponding increases in health behaviors including: self-awareness, self-compassion, increased trust, increased ability to verbalize thoughts and feelings, increased empathy for others and improved family interactions. Also promising is that the positive changes related to these treatments appear to be fairly consistent over time (Apsche, 2010; Swart & Apsche, 2014).

Even where cognitive deficits exist, phase-based Integrative Play Therapy shows researched-informed promise in treating complex trauma in adolescents by encouraging them to use other forms of healthy expression rather than relying solely on language (Green & Myrick, 2014). Similarly, Gender Aware Therapy works within male social norms by encouraging men to express themselves in task-orientated interventions which support desired male traits such as courage, providing for others, self-reliance, humanitarian service and humor (Gordon & Griffiths, 2014). The building of alliance through shared task agreement during therapy appears

MENTAL HEALTH CARE FOR CLIENTS WHO ARE INCARCERATED

to enhance clinical outcomes for clients being treated for PTSD (Hoffart, Øktedalen, Langkaas & Wampold, 2013). The simple act of giving a client with trauma a voice in their treatment planning appears to be empowering.

Discussion

The purpose of this systematic literature review was to locate, analyze, and synthesize existent scholarly literature which explored treatments for co-occurring Posttraumatic Stress Disorder, Substance Use Disorders and Personality Disorders. The original idea for this systematic literature review was to include a fourth theme in the research question, clients who are incarcerated, as this was the drive behind the project concept. When the project plan was approved by the research committee, it contained this fourth theme. It was not foreseen at that time that this search theme might be overly exclusionary for use in this project. The research project proceeded with the search terms listed above in the Methods section with the additional search terms “inmates or prisoners or offenders or prison or jail or corrections or probation or parole”. Though this search yielded 18 articles, upon review none of them met the criteria for inclusion. It was after a period of trial, error and finally success that the current inclusion criteria yielded a sufficient number of relevant articles to complete a systematic literature review.

One striking thing about the coded treatment themes that emerged was how at odds they are with the punitive nature of the criminal justice system. Some of the more troubling client presentations that we encounter in the correctional system are best treated with interventions that emphasize understanding, acceptance, awareness and compassion. Humans who experience trauma are best rehabilitated through a corrective experience rather than a correctional one.

MENTAL HEALTH CARE FOR CLIENTS WHO ARE INCARCERATED

Limitations, Strengths and Practice Implications

Limitations. One limitation is that none of the articles in this systematic literature review spoke specifically to interventions used to treat adults who are incarcerated and have been diagnosed with a Personality Disorder, PTSD and a SUD. One can make inferences about the possible efficacy of the treatments based on the similar symptoms; however it is impossible to predict how these interventions would extrapolate to a correctional facility.

Strengths. One strength of this systematic literature review is that two of the effective interventions, MDT and FMDT, are primarily used with mandated clients and has been integrated into a residential setting. However, the evidence-based implications are gathered from treating adolescents only. Another strength of this systematic review is the variety of treatment modalities that have been shown effective in treating a Personality Disorder, PTSD and a SUD.

Practice implications. Several of the articles emphasized the importance of proper training prior to utilizing trauma interventions so as not to further traumatize clients. It would be important to obtain proper training and adequate supervision when treating complex clients who rapidly dysregulate.

Suggestions for Future Research

The difficulties in locating enough studies to complete this systematic literature review indicate that more experimental and empirical research needs to be conducted. Due to the few studies available, it is difficult to make strong recommendations for treatment at this time. This systematic literature review demonstrates that though there appears to be promising treatment interventions, more studies are needed to feel confident in endorsing particular interventions.

Sand Tray Therapy, which the Green and Myrick (2014) article listed as a type of play therapy, has been used to treat veterans with PTSD. It would be interesting to introduce and to

MENTAL HEALTH CARE FOR CLIENTS WHO ARE INCARCERATED

study the efficacy of this treatment in a correctional facility. The MDT and FMDT articles purported these therapies to be the most effective evidence-based practices for treating adolescents with complex and troubling behaviors related to trauma. The articles reported they were successful in treating clients who had not responded to other popular regulatory therapies such as CBT and DBT. It would be exciting to see MDT adapted and rigorously researched in adult correctional facilities.

MENTAL HEALTH CARE FOR CLIENTS WHO ARE INCARCERATED

References

- Anasseril, D. (2007). Care of the mentally ill in prisons: Challenges and solutions. *Journal of the American Academy of Psychiatry Law* 35(4), 406-10.
- Apsche, J. A. (2010). A literature review and analysis of mode deactivation therapy. *International Journal of Behavioral Consultation and Therapy*, 6(4), 296-340. doi:<http://dx.doi.org/10.1037/h0100914>
- Durose, M., Cooper, A., Snyder, H. (2014). Recidivism of prisoners released in 30 states in 2005: Patterns from 2005 to 2010. *Bureau of Justice Statistics*. Retrieved from: <http://www.bjs.gov/content/pub/pdf/rprts05p0510.pdf>
- Fridell, M., Hesse, M., Johnson, E. (2006). High prognostic specificity of antisocial personality disorder in patients with drug dependence: Results from a five-year follow-up. *The American Journal of Addictions*, 15, 227-232.
- Garland, B., Hass, A. (2015). An outcome evaluation of a Midwestern prisoner reentry initiative. *Criminal Justice Policy Review*, 26(3), 293-314.
- Gillece, J. (2011, February). Understanding the effects of trauma on lives of offenders. *Corrections Today*.
- Goff, A., Rose, E., Rose, S., Purves, D. (2007). Does PTSD occur in sentenced prison populations? A systematic review. *Criminal Behavior and Mental Health*, 17(1), 152-162.
- Gonçalves, Ó. F., & Perrone-McGovern, K. M. (2014). A neuroscience agenda for counseling psychology research. *Journal of Counseling Psychology*, 61(4), 507-512. doi:<http://dx.doi.org.pearl.stkate.edu/10.1037/cou0000026>

MENTAL HEALTH CARE FOR CLIENTS WHO ARE INCARCERATED

- Green, E. J., & Myrick, A. C. (2014). Treating complex trauma in adolescents: A phase-based, integrative approach for play therapists. *International Journal of Play Therapy, 23*(3), 131-145.
doi:<http://dx.doi.org.pearl.stkate.edu/10.1037/a0036679>
- Hoffart, A., Øktedalen, T., Langkaas, T. F., & Wampold, B. E. (2013). Alliance and outcome in varying imagery procedures for PTSD: A study of within-person processes. *Journal of Counseling Psychology, 60*(4), 471-482. doi:<http://dx.doi.org.pearl.stkate.edu/10.1037/a0033604>
- Hoke, S. (2015). Mental illness and prisoners: Concerns for communities and health care providers. *Online Journal of Issues in Nursing, 20*(1), 1-18.
- Ingenhoven, T. (2015). The place of trauma in the treatment of personality disorders. *European Journal of Psychotraumatology, 6*. Retrieved from: <http://dx.doi.org/10.3402/ejpt.v6.27629>
- Jones, L. (2015). The peaks unit: from a pilot for ‘untreatable’ psychopaths to trauma informed milieu therapy. *Prison Service Journal, 218*, 17-22.
- Kaeble, D., Glaze, L., Tsoutis, A., & Minton, T. (2015). Correctional populations in the United States, 2014. *Bureau of Justice Statistics*. Retrieved from:<http://www.bjs.gov/content/pub/pdf/cpus14.pdf>
- Levin, A., Kleinman, S., Adler, J. (2014). DSM-5 and posttraumatic stress disorder. *Journal of the American Academy of Psychiatry Law, 42*(2), 146-148.
- McCollister, K. E., French, M. T., Inciardi, J. A., Butzin, C. A., Martin, S. S., & Hooper, R. M. (2003). Post-release substance abuse treatment for criminal offenders: A cost-effectiveness analysis. *Journal of Quantitative Criminology, 19*(4), 389-407.
- McVey, D., Murphy, N., Saradjian, J. (2015). From management to treatment: Changing and maintaining a therapeutic culture in a high secure prison. *Prison Service Journal, 218*, 35-40.

MENTAL HEALTH CARE FOR CLIENTS WHO ARE INCARCERATED

Miller, N., Najavits, L. (2012). Creating trauma-informed correctional care: a balance of goals and environment. *European Journal of Psychotraumatology*, 310(3), 1-8.

Minton, T., Ginder, S., Brumbaugh, S. M., Smiley-McDonald, H. & Rohloff, H. (2015) Census of jails: Population changes, 1999–2013. *Bureau of Justice Statistics*. Retrieved from: <http://www.bjs.gov/content/pub/pdf/cjpc9913.pdf>

Minton, T., Golinelli, D. (2014). Jail inmates at midyear 2013 - statistical tables (revised). *Bureau of Justice Statistics*. Retrieved from: <http://www.bjs.gov/index.cfm?ty=pbdetail&iid=4988>

Peters, R. H., Greenbaum, P. E., Edens, J. F., Carter, C. R., & Ortiz, M. M. (1998). Prevalence of DSM-IV substance abuse and dependence disorders among prison inmates. *American Journal of Drug & Alcohol Abuse*, 24(4), 573-587.

Phillips, L. (2010). Substance abuse and prison recidivism: Themes from qualitative interviews. *Journal of Addictions & Offender Counseling*, 31(1), 10-24.

Robertson, J. M., & Williams, B. W. (2010). “Gender aware therapy” for professional men in a day treatment center. *Psychotherapy: Theory, Research, Practice, Training*, 47(3), 316-326.
doi:<http://dx.doi.org.pearl.stkate.edu/10.1037/a0021163>

Sacks, S., Sacks, J., & Stommel, J. (200). Modified therapeutic community program for inmates with mental illness and chemical abuse disorders. *Corrections Today*.

SAMHSA. (2015). Retrieved from: <http://www.samhsa.gov/nctic/trauma-interventions>

Shonin, E., Van Gordon, W., & Griffiths, M. D. (2014). The emerging role of buddhism in clinical psychology: Toward effective integration. *Psychology of Religion and Spirituality*, 6(2), 123-137.
doi:<http://dx.doi.org.pearl.stkate.edu/10.1037/a0035859>

Souza, T., Spates, R. (2008). Treatment of PTSD and substance abuse co-morbidity. *The Behavior Analyst Today*, 9(1), 11-26.

MENTAL HEALTH CARE FOR CLIENTS WHO ARE INCARCERATED

Swart, J., & Apsche, J. (2014). Family mode deactivation therapy (FMDT) as a contextual treatment.

International Journal of Behavioral Consultation and Therapy, 9(1), 30-37.

doi:<http://dx.doi.org.pearl.stkate.edu/10.1037/h0101012>

The National Center on Addiction and Substance Abuse. (2010). Behind bars II: substance abuse and America's prison population. Retrieved from: <http://www.centeronaddiction.org/addiction-research/reports/substance-abuse-prison-system-2010>

Trull, T. J., Jahng, S., Tomko, R. L., Wood, P. K., & Sher, K. J. (2010). Revised NESARC personality disorder diagnoses: Gender, prevalence, and comorbidity with substance dependence disorders. *Journal of Personality Disorders*, 24(4), 412-26. doi:<http://dx.doi.org.pearl.stkate.edu/10.1521/pedi.2010.24.4.412>

Tsai, T., Scommegna, P. (2012). U.S. has world's highest incarceration rate. *Population Reference Bureau*. Retrieved from: <http://www.prb.org/Publications/Articles/2012/us-incarceration.aspx>

Walker, L. E., Conte, C. & Grabner, S. (2014). Women uniquely vulnerable in criminal justice system. *The National Psychologist*. Retrieved from: <http://nationalpsychologist.com/2014/12/women-uniquely-vulnerable-in-criminal-justice-system/102697.html>

MENTAL HEALTH CARE FOR CLIENTS WHO ARE INCARCERATED

Appendix A: Included Articles and Summary

	Database	Title	Author(s)	Summary
1.	PsycARTICLES	A literature review and analysis of mode deactivation therapy	Apsche, J. A. (2010)	A literature review of Mode Deactivation Therapy with adolescents. MDT targets avoidance. Core components of MDT are mindfulness, acceptance of self, validation of experience, clarification of beliefs and redirection of behavior. Thorough case conceptualization and client collaboration are key.
2.	PsycARTICLES	A neuroscience agenda for counseling psychology research	Gonçalves, Ó. F., & Perrone-McGovern, K. M. (2014)	A literature review of brain-behavior studies. Explains how experience shapes the brain and what neural processes are affected in certain mental health disorders. Encourages expansion of neuropsychology through a collaborative transdiagnostic developmental perspective when choosing counseling interventions.
3.	PsycARTICLES	Treating complex trauma in adolescents: A phase-based, integrative approach for play therapists	Green, E. J., & Myrick, A. C. (2014)	Presents an original treatment model for adolescents who have experienced trauma that is derived from current evidenced-based practices. This model targets trauma-related impairments related to cognition,

MENTAL HEALTH CARE FOR CLIENTS WHO ARE INCARCERATED

				dissociation, affect regulation, behavioral control, internalizing behaviors, externalizing behaviors, and self-concept through a three-phased play therapy which includes: stabilization and safety, trauma processing, and reconnection.
4.	PsycARTICLES	Alliance and outcome in varying imagery procedures for PTSD: A study of within-person processes	Hoffart, A., Øktedalen, T., Langkaas, T. F., & Wampold, B. E. (2013)	This quantitative research study explored the role of alliance in positive treatment outcomes (measured as fewer symptoms). Alliance components were identified as: shared goals, client-therapist bond and task agreement. The research indicated that shared goals did not predict better outcomes. The quality of the client-therapist bond was a factor; however a client could be highly symptomatic with a quality bond. The best predictor of positive outcome was shared task agreement.
5.	PsycARTICLES	“Gender aware therapy” for professional men in a day treatment center	Robertson, J. M., & Williams, B. W. (2010)	Application of Gender Aware Therapy at a behavioral treatment program for adult, professional men and a brief qualitative analysis of program outcomes. A thorough assessment and

MENTAL HEALTH CARE FOR CLIENTS WHO ARE INCARCERATED

				treatment by an interdisciplinary team are key components. Clients work collaboratively with the treatment team to develop self-understanding, self-regulation and self-monitoring behaviors.
6.	PsycARTICLES	The emerging role of Buddhism in clinical psychology: Toward effective integration	Shonin, E., Van Gordon, W., & Griffiths, M. D. (2014)	Article reviews literature concerning the effectiveness of Buddhist-Derived Interventions for treating various mental health issues. Also explains/defines Buddhist principles.
7.	PsycARTICLES	Family mode deactivation therapy (FMDT) as a contextual treatment	Swart, J., & Apsche, J. (2014)	The process of adapting MDT as family therapy (FMDT) is presented through a review of literature. As with MDT, FMDT hinges on a multi-dimensional assessment resulting in a thorough case conceptualization. The process of FMDT is to assist the adolescent and the family to practice mindfulness, acceptance of self, validation of experience, clarification of beliefs, and redirection of behavior. Client-therapist collaboration and treatment transparency are key components.