IMPACT OF TRAUMATIC EXPOSURE ON CORRECTIONS PROFESSIONALS

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SECTION 1: BEYOND BURNOUT

Corrections work of all disciplines, whether in institutional or community-based settings, has been recognized as being exceptionally stressful. This ongoing stress is likely to contribute to "burnout" among corrections professionals. "Burnout" has been attributed mainly to staff's exposure to multiple organizational stressors (e.g., role ambiguity, demanding social contacts with other staff or justice-involved individuals), and also to operational stressors (e.g., shift work, mandatory overtime or overcrowding). However, exposure to potentially dangerous circumstances and exposure to actual violence have also been recognized as stressors (Finn and Kuck 2003; Schaufeli and Peeters 2000).

Recently, a more insidious source of occupational stress has been recognized in the corrections profession—that of continual exposure to potentially traumatic work-related material, e.g. incident reports, case files, crime reports. These developments have taken place in conjunction with recent research confirming the high prevalence of trauma histories and trauma symptoms suffered by justice-involved adults (Messina and Grella 2006; Wolff et al. 2013) and youth (Dierkhising et al. 2013). It has also been recognized that incarceration itself is a potentially traumatizing experience (DeVeaux 2013). These two ongoing occupational sources of traumatic exposure in corrections work—exposure to materials related to justice-involved individuals and exposure to their trauma-based histories and behaviors—has led to questions regarding the secondary or vicarious traumatization of corrections professionals.

In combination with the work mentioned earlier on burnout and on potential danger and violence, this recognition of the degree of staff exposure to both indirect (secondary) and direct (primary) traumatic stress has led to discussions about the overall impact of psychological trauma on corrections professionals. The recent move in numerous human services professions toward trauma-informed workplaces (Bloom and Farragher 2013) further underscores the importance of acknowledging the complexities of this issue in corrections agencies.

The primary focus of corrections work is on the management of justice-involved individuals (whether in confinement or not) and their rehabilitation. Corrections work requires individuals to maintain an unusually heightened and sustained level of mental and physical vigilance and strict adherence to security protocols. This is necessary in order to maintain the physical safety of justice-involved individuals, the staff managing them, and members of the surrounding communities. Despite this sustained vigilance, the routine work-related exposure to traumatic material and incidents remains unavoidable, considerable, and significant in its impact (Spinaris, Denhof, and Kellaway 2012).

Corrections professionals are <u>indirectly</u> exposed to traumatic material when they:

- read criminal records, pre-sentencing and investigative reports (which may include graphic descriptions);
- hear about or view photographs or videotapes of injuries sustained by assaulted or self-mutilating justice-involved individuals;
- hear about or view photographs or videotapes of injuries sustained by staff who have suffered assaults;

- do the actual reporting and documentation of injuries or deaths involving staff or justice-involved individuals;
- participate in debriefings or incident reviews following critical incidents;
- testify in court regarding violent or otherwise traumatic incidents;
- discuss cases involving violent/gruesome material as part of safety and security training;
- listen to justice-involved individuals describe their own traumatic experiences that occurred prior to or during their incarceration;
- listen to justice-involved-individuals describe what they did to their victims; or
- the staff themselves or their family members are threatened with physical or sexual violence by justice-involved individuals.

Corrections professionals are directly exposed to traumatic material when they:

- witness and respond to physical or sexual violence among justice-involved individuals;
- witness and respond to violence directed at co-workers;
- are assaulted themselves by the justice-involved individuals they manage;
- witness and respond to facility riots and other large group disturbances;
- witness arson;
- witness self-mutilation or other disturbing behavior by justice-involved individuals, possibly in relation to psychotic episodes;
- discover the dead body of a justice-involved individual due to murder, suicide or natural causes;

- intercept a suicide attempt;
- act as part of an execution team;
- are assaulted with bodily fluids(with the associated risk of contracting HIV or Hepatitis C);
- have family members assaulted by justice-involved individuals; or
- have property vandalized by released or community-based justice-involved individuals or their associates.

Other types of direct and indirect traumatic exposure are specific to field services agents, i.e. parole and/or probation officers. These include:

- finding disturbing pornographic and/or violent photographs, images or videotapes on the computers or cell phones of justice-involved individuals;
- encountering child, adult or animal abuse or neglect during home visits with justice-involved individuals;
- interviewing victims;
- being stalked in the community by justice-involved individuals or their associates; and
- being confronted by armed justice-involved individuals upon entry into their homes.

These examples do not include two other potential sources of correctional traumatic stress: incidents that can be described as “near-misses” regarding violent behaviors directed toward staff or other justice-involved individuals, and “what could go wrong” situations that may result in anxiety prior to high-risk interactions or events. Examples of “near misses” would be

finding out that one was a target of a "hit" that was intercepted at the last minute, or leaving a location shortly before staff are assaulted in that very same area. Examples of worrying about "what could go wrong" include preparing to confront a parolee about a parole violation (which would result in parole revocation) or preparing for use of force. Such "near misses" and anticipatory anxiety about "what could go wrong" activate similar physiological and psychological reactions in affected individuals as does exposure to actual dangerous/traumatic incidents (Lewis 2011).

Below are composites of personal communications sent to the first author by email from corrections professionals. They illustrate the impact of work-related indirect and direct traumatic exposure on staff's personal and professional functioning, and are reproduced here with permission, with identifying information removed.

> *Prison staff learn to apply a thin layer of "Machismo" as a result of each incident they respond to. It's like a Band-Aid. But this type of Band-Aid doesn't protect the wound from infection or aid in the healing process. Instead it covers and seals in your emotions and your feelings; otherwise you're weak, a punk, or a sissy. Because we all know, "Maximum security staff are the real gladiators, and we run these inmates." After a while and numerous incidents, you have so many Band-Aids on you that inmates can't penetrate them and get to you or your "old" heart. The only problem is the Band-Aids don't come off after work. They stay on. So you live your life and miss all the beauty and the real experiences because you are a heartless, emotionally numb, and desensitized a__. You see an awful car accident with injuries, big deal. You have a friend that gets hurt really bad, big deal. Your family member dies in his fifties and you truly love the man, big deal. An inmate gets stabbed 47 times, big deal. You get mad because your kid wrecks his bike and cries because he skinned up his knees, big deal. Tell him to man-up*

and quit being a baby and walk away. Then, if you are blessed, your friends and family or maybe a co-worker persuades you to go to a counselor and they begin the long process of removing your Band-Aids. Then slowly over time you realize, S___! I hollered at my kid because he wrecked his bike and hurt his knees. He is only 6 years old. I should have picked him up and carried him inside. Babied him a bit and took care of him. Let him know I am here for him and can take care of him. But, that's not the gladiator way! I have to be tough because I have several years in corrections and 500+ Band-Aids of armor to show what a tough guy I am. How frustrating! I can't wait for the rewarding part, when I can look in the mirror and feel like a normal human being.

As a probation/parole officer, part of my job is to write pre-sentencing reports. To do so I pore over documents related to crimes committed. I've always thought of myself as a tough guy. Lately though, when I deal with cases where the victim was a child, I can't shake the anger I feel. I find myself wanting to punch something. Sometimes I've even felt like crying, but I just won't allow myself to do that. I'm not weak! Instead I end up hating the world. More than once I caught myself putting off looking through files. On my way home I usually buy a six-pack. I then go to take care of my horses, drinking while I do that. I stay away from my family's happy chatter as much as I can. They are so naïve and ignorant! I don't want to burst their bubble, so I don't tell them about my work. But I worry constantly about my children's safety. I am very strict with them, especially about where they go and who they hang out with. I get into arguments with my wife who objects to my repetitive coaching of my kids to not trust anyone outside immediate family. I often fantasize about what I would do to a guy on my caseload if he tried to hurt one of my kids.

Nothing that I see at work upsets me anymore. During the course of my 15-year career as a jail deputy I have watched countless videos of inmate fights, stabbings, and killings. That's part of our training. Once in a while they show us videos of staff getting

assaulted, or I read on the Internet about such assaults all over the country. I have also witnessed many such incidents first-hand, probably about 10 serious ones (inmates were killed or had to receive medical care at a hospital), and another 15-20 garden-variety assaults and group fights. I myself have been seriously assaulted three times—cold-cocked while we were trying to restrain an inmate, kicked, and cut with a shank. I've also responded to three inmate suicides (they didn't make it). I had to perform CPR on one of them, even though he was cold—too far gone. Like I said before, nothing that I see at work upsets me anymore. My wife tells me that I've become hard, cold, uncaring. The other day she asked me how I can possibly deal with inmate murders and suicides and not blink an eye. She said, "Does this come with the job or are you just heartless?" How do I explain to her that we are so short-staffed, we keep running from one incident to another and from one task to another, throughout our shift? It all runs together after a while.

Three inmates got into a fight during the shift change from day shift to evening shift, two on one. The inmate who was hurt had his head smashed open like a grapefruit. His brains were running out of his ears. They say if he lives he will be a vegetable. He was rushed to the hospital for emergency brain surgery. We then had to shoot an inmate off the tier with the L-8 containing .60 caliber sting ball rounds. I was left alone on a post where two are normally assigned. I was like the exorcist trying to scramble to do the job by myself. Thank God no staff were injured. I was wired all night long. Of course, for investigative purposes the blood was left on the floor to coagulate all night so everyone who walks into that unit will be traumatized by the gruesome display of violence that occurred there. I know that inmates are violent, and that they are in prison for a reason, and we all scoff at another one being taken off the count, and we are thankful it was not staff. But, the thought of another human being meeting his end or suffering through such an ordeal still haunts my thoughts. I think about the ones I care for and how I would feel

> *if something like that ever happened to one of them. Even though they are convicts, it bothers me. I pray for God's wisdom and peace to go back in today. I pray that it won't happen again today. I pray that my #2 is not pulled. What if I don't do as good of a job next time? Please God, guide my hands and my mind when I react, help me to do a good job. That is what I say when I bow my head before I walk into the dungeon.*

When both indirect and direct traumatic experiences are taken into account, it becomes clear that virtually *everyone* in the corrections arena is inherently at risk for being exposed to trauma or of having experienced trauma. *In fact, there may be no other work environment where a significant percentage of all involved—both the corrections professionals and the justice-involved individuals they manage—suffer from the consequences of exposure to psychologically traumatic material and other high-stress events.* That makes understanding the nature and impact of traumatic stress, its interactions with organizational and operational stressors, and strategies to counter these effects, an urgent necessity in corrections systems. This matter becomes particularly pressing as more light is shed on the detrimental effects of trauma on the health and functioning of staff and on the health of the corrections workplace climate and culture (Spinaris et al. 2012).The issue is critical, as unhealthy or otherwise impaired employees are likely to also be impaired in the performance of their professional duties, in their home/family lives, and in their conduct in their communities. Moreover, individuals so impaired add to the labor costs in their agencies through increased missed work days and health-care use (Denhof and Spinaris 2013a).

Just as importantly, if not more so, occupational traumatic exposure may affect not only individual corrections staff, but also employee groups, negatively coloring the workplace climate and eventually shaping the culture of corrections organizations. That is, through sheer repetition,

unhealthy behaviors born individually and collectively in response to repeated exposure to trauma might become the organizational norm (Bloom and Farragher 2013).

The impact of traumatic exposure on employees is a subject that has not been widely understood or addressed in corrections. As illustrated in the narratives above, the workplace culture in corrections tends to be characterized by an attitudinal emphasis on self-sufficiency and emotional "toughness," even outright denial of vulnerability and "soft" emotions. In order to be able to walk easily and comfortably into the home of a justice-involved individual in the community, or when facing large staff-to-inmate ratios in corrections facilities, employees feel the need to project the image of remaining unflappable and in control, and of being fearless when confronted with the potential for aggression. Historically, corrections professionals have been trained to act in this manner, and with good reason, since correctional work settings are predatory environments to those who cannot protect themselves. Further, admitting to being affected or needing help in managing one's emotions or mental health is often considered by corrections staff as being "weak" or, worse yet, as being "unfit" for corrections work and/or a liability to coworkers. Even simple awareness of the concerns and worries that would normally accompany a person in these types of settings is seen as the first step in letting those emotions take hold and ruin an employee's command presence. To date, an aura of physical courage has been seen as the only safe alternative.

With the inclusion of Employee Assistance Programs (EAP) in many corrections agencies, and with the provision of health insurance coverage, administrators may assume that sufficient resources have been provided to staff to deal with psychological distress or personal problems, and that there is no need to single out a particular occupational issue (traumatic exposure) for special attention. This however, is very likely a faulty assumption. Within the

corrections context of emotional denial and minimizing of the effects of trauma, there may be little awareness of the magnitude of some of these issues. When the "wounds" are internal, there is no way to know if the distress is small and thereby manageable through the limited frequency that EAP services typically provide, or if it is in fact quite disabling, as in the case of individuals with suicidal thoughts and urges. In addition, corrections employees may resist seeking the help of behavioral health providers through the use of their own health insurance due to personal denial of their mental health needs as well as due to the professional stigma attached to seeking help.

There is also little understanding of the fact that the impact of traumatic exposure is systemic, affecting whole organizations, not only individuals. As a result, agencies may end up with emotional "band aids" in their employee mental health first-aid kit, providing short-term instead of long-term solutions to problems that are in some cases severe and warranting more attention and care. The situation is often compounded by the fact that community-based EAP and other behavioral health providers typically have limited experience in dealing with the severity of mental health issues that arise from the direct or indirect traumatic exposure routinely encountered in corrections work. Employees' lack of understanding of the impact of traumatic exposure coupled with their emotional denial may result in presenting problems being attributed to relationship or family issues, when in fact they may stem directly from the multiple stressful factors inherent to corrections environments, including traumatic exposure.

SECTION 2: THE IMPACT OF TRAUMATIC EXPOSURE—A BRIEF OVERVIEW

The definition of traumatic stress in the newly proposed *Diagnostic and Statistical Manual for Mental Disorders, Fifth Edition* (American Psychological Association 2013) indicates that much of what corrections professionals are routinely exposed to at work *is* in fact traumatic. In addition to *directly* witnessing or experiencing actual or threatened serious injury, actual or threatened sexual violation, and death or threatened death, *indirect* exposure—such as learning about the violent or accidental death or threatened death of a close friend (or coworker, in the case of corrections staff), is considered to be potentially traumatic. Additionally, what has in the past been labeled as "secondary trauma," such as being repeatedly or extremely exposed indirectly to details of traumatic events as part of one's vocational role, is now recognized to be "primary trauma," which may result in the development of trauma symptoms and conditions. Moreover, witnessing death, serious injury or sexual violation through various electronic media or pictures as part of one's vocational role, is now also considered to be "primary trauma," again involving indirect exposure.

The term "trauma" comes from the corresponding Greek word for injury or wound. Psychological trauma results from an event or series of events that is experienced by an individual as physically or emotionally harmful or threatening. Psychological trauma often has lasting adverse effects on a person's functioning, and on their physical, social, emotional, or spiritual well-being (SAMHSA 2012a).

Adverse effects of traumatic exposure on an individual may occur immediately, gradually over time, or have a delayed onset. Traumatic experiences may result in one or more of four clusters of symptoms: a) *spontaneous or cued intrusive remembering of the event* with accompanying emotional distress and physiological arousal (such as nightmares or

flashbacks); b) *persistent avoidance of stimuli associated with the trauma* (such as avoiding people, places or situations); c) *negative judgments and changes in thinking and mood* (such as persistent negative judgments of self or others, or having negative expectations about the future; persistent distorted blame of self or others regarding the perceived cause or consequences of traumatic events; pervasive negative emotions; feeling detached or estranged from others); and d) *alterations in arousal and reactivity* (such as irritability, anger, aggressive behavior, hypervigilance, sleep disturbances, or reckless or destructive behavior). If a certain number and type of criteria are met, a trauma-exposed individual can be diagnosed with the clinical condition of Post-traumatic Stress Disorder (PTSD).

Psychological trauma may affect a person's ability to: function in relation to normal challenges of daily living; exhibit trust and interact appropriately with others; and regulate emotions, memory, imagery, attention, thinking, and behavior. Underlying these more visible effects, there may also be changes in a person's physical health and well-being (Kendall-Tackett 2009; Walker et al. 2003), as well as changes in brain volume, due to grey matter reduction in particular brain areas (Kroes et al. 2011).

It seems worth noting that an individual's *subjective experience* of potentially traumatic circumstances can influence whether or not psychological trauma results. Some individuals may be traumatized by a particular incident, whereas others exposed to the very same event might not. Likewise, a person who was not negatively affected by a traumatic incident at one point in time might be negatively affected upon exposure to a similar event at a later time.

The individual variability regarding vulnerability to trauma is made evident by research indicating that the vast majority of individuals in the general population—approximately 60.7%

of men and 51.2% of women (Kessler et al. 1995) —is exposed to at least one potentially traumatic incident during their lifetime. However, only 6.4% (Pietrzak et al. 2011) to 6.8% (Kessler et al. 2005a) of adults in the general population exposed to trauma demonstrate PTSD symptoms to a diagnosable degree during their lifetime, and 3.5% meet diagnostic criteria for PTSD for symptoms experienced over the past 12 months (Kessler et al. 200b).

Another finding in this field of study relates to gender differences. The likelihood of suffering from PTSD in one's lifetime is substantially and consistently impacted by gender. Women in the general population demonstrate a PTSD lifetime rate more than twice that for men, at 9.7% for women vs. 3.6% for men (National Comorbidity Survey 2005) and 8.6% for women vs. 4.1% for men (Pietrzak et al. 2011). Researchers report similar gender differences for PTSD symptoms occurring during the last 12 months, with women again showing more than twice the rate of men at 5.2% for women vs. 1.8% for men (National Comorbidity Survey 2005). This is particularly noteworthy as PTSD rates based on gender were found to be reversed in corrections settings—with male staff meeting PTSD criteria significantly more frequently than female staff (Spinaris et al. 2012). This observation will be discussed in greater detail later in this paper.

Given the increased traumatic exposure rates of professionals in hazardous occupations, such as police officers and military personnel, it is to be expected that these individuals would exhibit higher PTSD rates than those of the adult general population. Verifying this expectation, the following PTSD prevalence rates have been reported for police officers, firefighters, and military personnel: 7.2 % for post-9/11 New York police officers (Perrin et al. 2007), 14.3% for post-9/11 New York firefighters (Perrin et al. 2007), 22% and 17% respectively for U.S. and

Canadian firefighters (Beaton et al. 1999), 18.2% for German firefighters (Wagner, Heinrichs, and Ehler 1998), 12-20% for Operation Iraqi Freedom/Enduring Freedom soldiers (Hoge et al. 2004), and 14%-16% for U.S. military personnel who experienced combat (Gates, et al. 2012).

Research in both the general population and in high-trauma occupations strongly supports the notion that both direct and indirect traumatic exposure can lead to trauma symptoms that develop in similar ways (Pietrzak et al. 2011). Research evidence also strongly suggests that direct exposure results in more severe and longer-lasting symptoms than indirect exposure (Kim et al. 2009; Pietrzak et al. 2011). Moreover, studies support the notion that the occurrence of trauma symptoms, their severity and their chronicity increase with the number of different *types* of traumatic events to which a person is exposed (Kolassa et al. 2010; Spinaris et al. 2012).

A noteworthy distinction has been made in the research literature between "full" and "partial" PTSD (Marshall et al. 2001). Full PTSD refers to the clinical condition when all diagnostic criteria are met or exceeded for that diagnosis. Partial PTSD refers to the circumstance in which trauma-exposed individuals develop clinically significant PTSD symptoms, but without meeting full diagnostic criteria for PTSD.

Compared to trauma-exposed individuals with no PTSD, trauma-exposed individuals with PTSD (full or partial) have been found to demonstrate: a) elevated rates or severity of physical disorders, such as cardiovascular disease, diabetes, gastrointestinal disorders, respiratory diseases, chronic pain conditions, and cancer; and b) elevated rates or severity of psychological health and functioning impairments, such as anxiety, depression, substance use disorders, and suicide attempts (Pietrzak et al. 2011; Sareen et al. 2007). Individuals who meet criteria for partial PTSD have been found to demonstrate symptom severity, comorbidity (co-

occurrence with other disorders such as anxiety or depression), and functional impairments that fall between those of trauma-exposed individuals with no PTSD and those with full PTSD (Pietrzak et al. 2011; Sareen et al. 2007). This supports a "continuum of symptoms" model of PTSD for trauma-exposed persons. Symptoms of full PTSD and partial PTSD may persist for years (Jeon et al. 2007).

Researchers have examined factors that may increase or reduce the risk of developing PTSD following traumatic exposure. A study of firefighters in the U.S. and Canada (Beaton et al. 1999) identified both protective factors (i.e., factors that seem to deter PTSD development) and risk factors (i.e., factors that seem to facilitate PTSD development) in relation to meeting PTSD criteria following occupational traumatic exposure. Organizational (administrative) stressors were associated with a significantly higher risk for PTSD development in both trauma-exposed U.S. and Canadian firefighter samples. Workplace social support and family social support were found to be protective factors. These findings suggest how various factors or circumstances unrelated to trauma can interact to influence health-related consequences of traumatic exposure for individuals and groups.

A recent data analysis from twenty-one studies (Gates et al. 2012) identified three characteristically distinct groups of factors that increased the risk of PTSD development in military and veteran populations exposed to traumatic incidents: *pre-trauma factors, trauma characteristics factors, and post-trauma factors.* It was found that factors that increased the risk of PTSD development had effects of varying magnitude or strength in their contribution to the likelihood of a PTSD diagnosis. According to Gates et al. (2012), basic demographic factors in the pre-trauma group were found to be of intermediate strength (that is, their presence

moderately increased the risk of PTSD development), including: *lower education, lower intelligence, lower military rank, lower socioeconomic status, prior trauma, prior psychiatric history, family psychiatric history,* and *childhood abuse or adversity*. One noted exception was *younger age at which the military trauma occurred,* which had a weak effect, meaning that it contributed only slightly to an increased risk for PTSD development.

Trauma characteristics risk factors of *exposure to death, exposure to killing and exposure to abusive violence* were found to demonstrate effects of intermediate strength. (That is, the presence of these factors contributed moderately to an increased risk for PTSD development.) *Trauma/combat exposure severity, perceived life threat, combat-related injury,* and *peritraumatic distress or dissociation* (i.e., distress or dissociation occurring during the traumatic incident) were found to demonstrate effects of strong magnitude. That is, the presence of these factors strongly increased the risk of PTSD development. Similarly, all post-trauma risk factors, *lack of social support, negative homecoming experiences*, and *exposure to additional life stressors,* also showed strong effects in increasing PTSD risk.

Similar risk factors were identified in a data analysis based on 68 general population and military samples (Ozer et al. 2003). This analysis identified the following set of factors as being relevant to the development of PTSD following traumatic exposure: *prior trauma, prior psychological adjustment, family history of mental illness, perceived life threat during the trauma, peritraumatic emotional responses* (i.e., emotions experienced while the traumatic incident was occurring), *peritraumatic dissociation* (i.e., dissociation experienced while the traumatic incident was occurring), and *post-trauma social support*. All seven factors demonstrated significant effect sizes, with family history, prior trauma, and prior adjustment having the smallest effect and peritraumatic dissociation having the largest effect. Based on these

results, researchers concluded that the nature and influence of psychological processes occurring during exposure to traumatic events are more strongly related to PTSD development than individual historical variables. Another noteworthy finding was that low social support was a stronger predictor of PTSD for combat veterans than for individuals experiencing other types of trauma. Given some similarities between military service and corrections security work, it would seem plausible to assume that post-trauma social support may be similarly crucial for corrections professionals following traumatic exposure.

SECTION 3: THE CASE OF SECONDARY TRAUMATIC STRESS/VICARIOUS TRAUMA

Adverse psychological impact on professional caregivers due to a certain type of indirect traumatic exposure has been studied in various helping professions under the name of Secondary Traumatic Stress/Compassion Fatigue (Figley1995) or Vicarious Traumatization (Pearlman and Saakvitne 1995; Saakvitne and Pearlman 1996). Both of these concepts were proposed to describe the impact on professional helpers, such as psychotherapists, of exposure to trauma experienced by their clients. This was thought to occur mainly while listening empathically to the narrative accounts of trauma survivors during the course of their psychological treatment.

The term Compassion Fatigue (CF) was proposed by Figley (1995) as a less stigmatizing label for what he named "Secondary Traumatic Stress" (STS), and it is used interchangeably with that term. STS refers to the emotional distress and PTSD-like symptoms that result when professional helpers hear about the firsthand traumatic experiences of persons whom they are

helping. As Figley (1995) noted, "the process of empathizing with a traumatized person helps us to understand the person's experience of being traumatized, but, in the process, we may be traumatized as well" (p. 15). STS is understood to mimic the symptoms of PTSD, but to a lesser extent and without meeting all criteria for the disorder. In this way, the definition of STS parallels that of partial PTSD.

Vicarious Traumatization (VT) is defined as "the transformation that occurs in the inner experience of the therapist that comes about as a result of empathic engagement with therapy clients' trauma material" (Pearlman and Saakvitne 1995; p. 31). The concept of Vicarious Traumatization is based on the Constructivist Self Development Theory (CSDT) proposed by McCann and Pearlman (1990), and describes changes in the self/personality of survivors of psychological trauma.

The areas proposed to be affected by VT are: a) the psychotherapist's self-identity, worldview and spirituality; b) the capacity for emotional self-regulation and relationship management; c) beliefs about the psychological needs for safety, trust, control, esteem, and intimacy; and d) the psychotherapist's perception and memory, including imagery.

The development of VT is understood to be shaped by interactions among the following factors: a) characteristics of the clinician (e.g., personality, prior trauma and clinical history, family mental health history, degree of relevant professional experience), b) the workplace setting (e.g., caseload, degree of support offered, degree to which the impact of trauma upon the therapist is acknowledged, adequacy of supervision), and c) the extent and magnitude of traumatic material presented by the client.

The study of STS and VT has been expanded from the initial focus on psychotherapists to include a wide range of professional caregivers who assist trauma survivors, such as clergy (Day et al. 2006), social service workers (Pryce, Shackelford, and Price 2007), attorneys (Levin and Greisberg, 2003), health care providers (Madrid and Schacher 2006), humanitarian aid workers (Shah, Garland and Katz 2007), and journalists (Ward 2012). The terms STS and VT have also been used to describe adverse traumatic effects upon law enforcement officers who interact with child sexual abuse survivors (Follette, Polusny, and Milbeck 1994). It appears that the use of these terms has loosened over time, and they do not serve to distinguish between secondary and primary traumatic exposure very well. In many of the professions listed above, practitioners may witness trauma's aftermath directly and/or indirectly.

The following risk factors have been identified as contributing to the development of VT in social workers and other clinicians who treat trauma survivors (Bell, Kulkarni, and Dalton 2003): a) large caseloads of traumatized individuals; b) type and intensity of clients' traumatic events; c) the circumstance of treatment providers' personal safety being threatened on the job; d) lack of education and/or formal supervision around the impact of trauma on treatment providers; e) lack of staff opportunities to debrief informally and process traumatic material with supervisors and peers; f) younger age of the treatment providers; g) less professional experience; and h) lack of effective coping strategies for dealing with the effects of VT.

Researchers have also studied the concept of "burnout" (Maslach 1993) in high-stress occupations. The concept of "burnout" differs from PTSD, CF/STS, and VT in that it is mostly understood to not be a result of traumatic incidents, but instead a consequence of organizational and operational stressors, such as job demands, long working hours, little down time, and

continual peer, customer, and supervisor demands and surveillance. Maslach (1993) described burnout as having three dimensions: a) emotional exhaustion; b) depersonalization, defined as a negative attitude towards clients, personal detachment, or loss of ideals; and c) reduced personal accomplishment and commitment to the profession. The following are some of the factors that have been found in empirical studies to contribute to burnout: unsupportive administrators, lack of professional challenge, low salaries, difficulties encountered in providing client services, and limited autonomy at work (Arches 1991; LeCroy and Rank 1986), lack of supervision (Poulin and Walter 1993), and role conflict and perceived unfairness in rewards (Himle and Jayaratne 1990).

Researchers such as Gentry (2002) have also proposed that among helping professionals there is an interactive relationship among the effects of primary traumatic stress (PTSD), STS, and burnout. They also acknowledge that the effects of indirect (secondary) and direct (primary) traumatic exposure often interact with the impact of organizational and operational stressors that contribute to burnout. The effects contributed by these interacting stressors cannot be readily teased apart. According to Gentry (2002), a caregiver being affected in any one of the three areas (i.e., primary trauma, secondary trauma or burnout) has decreased resilience and increased vulnerability to the adverse impact of the other two. He even proposed that, because of these interactions, and in order to treat STS and/or burnout among caregivers, primary traumatic stress, i.e., full or partial PTSD, must be addressed and treated successfully first. Further supporting the significance of interacting factors, a study by Adams, Boscarino and Figley (2006) reported finding that Figley's measure of Compassion Fatigue/STS in fact measures two factors—secondary traumatic stress and job burnout. These findings underscore the need to consider all identified contributing categories of stressors when examining occupational health issues of

those serving in high-trauma professions.

SECTION 4: FROM COMPASSION FATIGUE TO CORRECTIONS FATIGUE

There are distinct differences in the work experiences of corrections professionals of all disciplines, e.g., security, medical, classification, food service, mental health, education, maintenance, probation or parole, compared to non-corrections helping professionals, e.g., community-based behavioral health providers, social workers, or case managers. Perhaps most importantly, there tends to be a conflicting relationship between corrections staff and justice-involved individuals. This conflict stems from the involuntary conditions inherent to this work setting. The primary task of corrections professionals to ensure safety and security often results in a firm disciplinary approach when managing the justice-involved population, an approach that requires control over people and conditions, and with an "us against them" perspective being frequently the outcome. Consequently, correctional staff tend to be perceived by justice-involved individuals as adversarial and depriving them of freedoms.

Differences also include, but are not limited to, the greater potential for immediate violence and direct trauma in corrections environments compared to non-corrections community-based helping environments. Safety issues are not typically of primary concern for non-correctional therapeutic helpers who deliver services to trauma survivors. Behavioral health providers normally conduct their work in physically and psychologically safe environments, with a focus on assisting voluntary clients to heal from their traumatic experiences. Non-correctional helping professionals are also likely to be perceived by their clients as advocates and allies.

Since there are stark differences in the work experience of corrections staff of all disciplines versus non-corrections helping professionals, and given the high potential for direct and indirect traumatic exposure in corrections settings (Spinaris et al. 2012), it could be argued that the concepts of STS and VT fail to fully capture the complexity and uniqueness of the work realities of corrections professionals. For this reason, a more encompassing and occupation-specific term seems appropriate.

The term *Corrections Fatigue* has been proposed to better capture the nature and impact of traumatic exposure on corrections professionals (whether indirect or direct), and its interactions with organizational and operational stressors. The concept of Corrections Fatigue is based on the Constructivist Self Development Theory (McCann and Pearlman 1990)—the same theory on which the concept of Vicarious Traumatization is based. Corrections Fatigue is understood to be fueled by repeated exposure to traumatic and other high-stress events, potentially manifesting in a negatively altered outlook on self and others, functional impairments, and, in more severe cases, in the development of psychiatric disorders.

The onset of Corrections Fatigue is proposed to stem from a variety of types of stressors inherent to corrections work, and their interactions. These workplace stressors can be divided into three major categories: a) *traumatic stressors* (indirect, e.g., reading about justice-involved individuals' attacks on victims; or direct, e.g., witnessing one justice-involved individual stabbing another); b) *organizational stressors* (e.g., staff interpersonal conflict); and c) *operational stressors* (e.g., high work load).

Corrections Fatigue is understood to be contingent not only upon the extent of detrimental work environment conditions, but also upon the degree to which individuals and

agencies have implemented effective strategies for bolstering staff health and functioning, and for countering and even preventing the negative consequences of Corrections Fatigue. The concept of Corrections Fatigue has a practical definition meant to encourage strategic and systemic action within organizations to address and prevent the consequences of the problem, using techniques such as training on the nature of Corrections Fatigue and strategies for deterring or reducing it. The "treatment" of Corrections Fatigue can also be understood as a process of stripping away its negative aspects and opening a path toward improved health, functioning, and even job fulfillment.

Corrections Fatigue is understood to be an unavoidable occupational hazard. No one who works in corrections is completely immune to it. Corrections Fatigue can also be understood to come into play gradually over time. Typically it is not brought on by a single event. It develops with the accumulation of the effects of high-stress experiences over time, moderated by aspects of the work culture which can be either unhealthy or promote health.

Corrections Fatigue can show itself in recognizable ways that corrections professionals behave both on and off the job. Warning signs and their level of severity can be understood and usefully described as occurring on a continuum. Experiencing Corrections Fatigue is emotionally distressing, as it often results in negative thinking and negative emotions. It is also associated with negative physical and psychological health. Nevertheless, Corrections Fatigue appears to consist of changeable components, and can be seen as treatable, preventable, and reversible, at least to a very significant degree.

Self/personality changes associated with Corrections Fatigue fall mainly into the following categories:

a) Identity changes, i.e. staff come to view themselves mainly in terms of aspects of their professional role.

b) Worldview changes, i.e. staff's perception of the world, even outside the workplace, becomes negatively skewed.

c) Spirituality changes, i.e. staff develop difficulty experiencing feelings such as hope, compassion, zest for life, and life meaning.

d) Changes in emotions and the ability to regulate those emotions, i.e. staff may alternate between periods of emotional numbness, where they "shut down" and appear indifferent towards others, or times of brooding and excessive irritability or anger outbursts, and/or self-medicating behaviors such as substance use or other behaviors performed with an impulse to manage psychological distress or symptoms.

e) Changes in interpersonal relationships, i.e. staff may avoid interacting with people, especially at a level of emotional intimacy, and/or become overly controlling and perhaps even aggressive in their relationships.

Corrections Fatigue is fueled by deficits in seven content areas associated with workplace health. These areas correspond to psychological needs that are negatively affected by trauma: *physical safety*, *psychological safety*, *trust*, *power*, *respect*, *connection*, and *meaning* in regard to staff's professional role. Moreover a vicious cycle gets established in relation to Corrections Fatigue and the satisfaction of these key needs. Corrections Fatigue is not only a *consequence* of trauma and insufficiently fulfilled elements of workplace culture, such as psychological and physical safety; it is also a *deterrent* to the fulfillment of these elements, leading to further deficits in these areas. That is, Corrections Fatigue results in deteriorating behaviors and attitudes

among staff, and these attitudes and behaviors, left unaddressed, can further promote Corrections Fatigue. As a corrections professional once remarked, "We do not only suffer from Corrections Fatigue. We also create it in our coworkers."

In the absence of these key aspects of the workplace climate/culture, staff are more likely to: become hypervigilant and chronically tense, feel socially uncomfortable or distressed around other employees, be mistrusting of other staff, feel either disempowered or all-powerful and above the rules/law, perceive themselves as not getting respect and/or become disrespectful of other staff and people in general, become emotionally disconnected from coworkers and loved ones, and/or believe that what they do at work has no positive meaning or value in their lives or the lives of others. The table below further defines each of the seven areas.

Table 1. Key Aspects of Workplace Culture that are Negatively Impacted by Trauma

Physical Safety	This refers to the need of corrections staff to have the sense that they are relatively safe from physical harm during the course of their work, and that necessary precautions have been taken to ensure that. By definition, corrections work can be unsafe. Whether planned or spontaneous, the potential for physical danger never disappears. Physical safety can also be compromised by staff complacency and failure to follow procedures due to boredom, weariness and/or indifference that may result from the repetitiveness of daily tasks, a heavy work load, shift work and overtime.
Psychological Safety	Psychological safety helps people feel comfortable and relaxed when in the presence of others. Lack of psychological safety creates social anxiety and discomfort that promote social isolation and irritability in interactions with others. Psychological safety gets destroyed in corrections workplaces when employees mistreat each other by spreading negative rumors, betraying

	confidences, ridiculing the struggles and vulnerabilities of others, or harassing, intimidating or undermining coworkers.
Trust	This refers to the belief that other corrections employees are honorable, have integrity, and can be depended upon to follow through on agreements, to perform duties that contribute to safety and efficiency of operations, and to care about the welfare of their coworkers. Corrections employees learn that trusting the wrong person can cost them their careers or even their lives. They interact daily with justice-involved individuals in what often is an "us versus them" setting. Staff can end up questioning nearly everything and everybody. Inability to trust results not only in additional anxiety, but can also channel staff vigilance into unproductive areas. Staff who have experienced fear, who "froze" in an emergency, lost their self-control, or crossed policy lines, may subsequently feel less able to trust even themselves.
Power	This refers to the need of corrections staff to have some degree of predictability and control over themselves, their work environment and circumstances, as well as the ability to influence their work environment operationally and in terms of decision-making. Corrections staff can at times feel powerless for a number of reasons. In community settings, parole agents may go to the homes of justice-involved individuals unarmed. In correctional facilities, officers are vastly outnumbered by justice-involved individuals they manage, often with nothing more than their communications skills, a radio and their badge to enforce rules. They have to carry out the orders of supervisors, often with little input over issues that impact them directly and with little latitude in their decision making. In addition, they often do not have the peace of knowing for certain when their workday will end, due to emergencies or mandated overtime when staffing is short.
Respect	This refers to the need of corrections professionals to be regarded and treated with decency and civility by others, regardless of rank or status. Justice-involved individuals often resent their

	legal circumstances and their consequences and having rules imposed on them and enforced by staff. As a result, staff are often exposed to some degree of disrespectful communication or behavior on the part of at least some individuals. Staff may become jaded by this behavior over time and become disrespectful themselves, including in their interactions with coworkers. Staff can even lose respect for themselves over time when they fail to meet their own professional expectations and goals. On top of it all, the general public tends to be unaware of what corrections work entails and may show little respect corrections professionals.
Connection	This refers to the need of corrections staff to have relationships, social support, camaraderie, and open and honest communication with co-workers, within the limits of professional boundaries. Corrections staff often operate away from other staff, or with minimal interaction with coworkers, while primarily dealing with justice-involved individuals, their crises and their needs. An environment of mistrust adds to the emotional isolation of corrections professionals. So corrections staff may get used to living behind both literal and psychological walls and fences. Daily re-entry into family life can be daunting, because loved ones usually expect emotional intimacy and closeness.
Meaning	This refers to the need of corrections employees to believe that they are making a positive difference in their work environment and in the lives of justice-involved individuals through their choices and behaviors, and that they are developing on both the career and personal levels. While public safety is the mission of the profession and therefore the meaning that staff can assign to their work, nevertheless, employees often lack opportunity to see the fruits of their labors. Recidivism rates tend to be high for justice-involved individuals, which can also be disheartening. One good workday at a time is necessary for maintaining physical safety, and one successful probationer or parolee case boosts staff morale, but these accomplishments may not

	be sufficient for building an enduring sense of professional significance.

These effects are not limited to individual corrections professionals. Rather, the climate and culture of entire organizations can become dysfunctional, with core beliefs and behaviors of individuals that stem from Corrections Fatigue becoming the norm of the organizations where they work. This phenomenon has also been described as occurring in human services organizations that serve trauma survivors, where there is high prevalence of traumatic and other high-stress exposure (Bloom and Farragher 2013; SAMHSA 2012a). Symptoms of post-traumatic stress exhibited by individual workers may become incorporated in the cultural fabric of their organization.

Attitudes and behaviors that characterize trauma-affected corrections professionals can become accepted as part of the culture of corrections organizations, with costly outcomes. These trauma-based, dysfunctional attitudes and behaviors may become widely adopted, tolerated and expected to occur, i.e., "This is the way we do it in corrections." Corrections work cultures might collectively and historically exhibit cynicism, pessimism, disrespectful behaviors, a negative mood, emotional callousness, indifference, minimizing and denying emotional realities, mistrust of other staff, a susceptibility to conspiracy theories, disproportionate/extreme vigilance, hostility, aggression, and ridicule or even persecution of those among them who openly acknowledge these issues—considering them to be "weak" and unfit for corrections work. These "normalized" behaviors can drastically affect staff wellness and functioning, and counter what new employees are taught at the training academy.

And lastly, changes in the seven content areas can also impact staff's personal and family lives, resulting, for instance, in safety concerns and over-reactions when at home or in the community, suspicion, substance abuse and other addictive behaviors, power struggles, family violence, profiling of people in the community, social withdrawal and isolation, and feelings of hopelessness and futility.

SECTION 5: EVIDENCE SUPPORTING THE CONCEPT OF CORRECTIONS FATIGUE

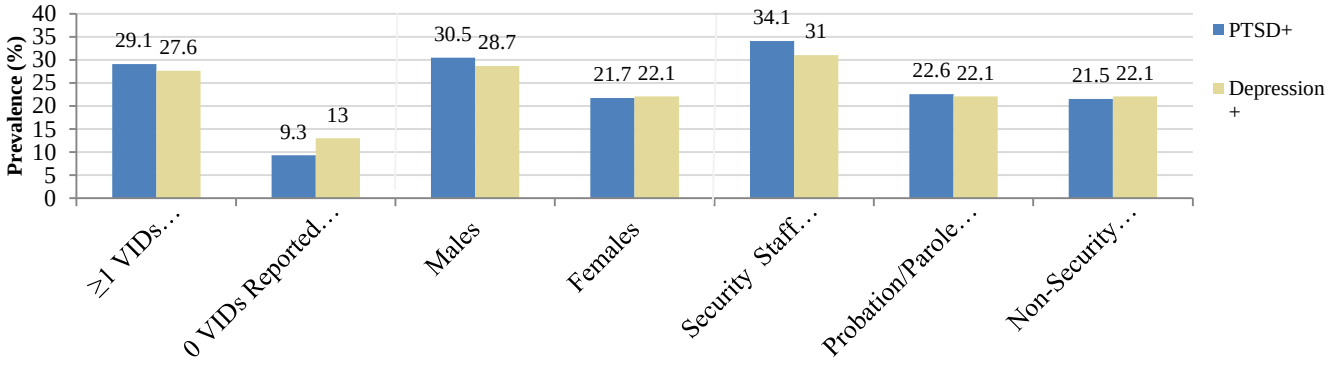
The concept of Corrections Fatigue is supported by empirical studies performed with corrections professionals nationwide, e.g. the Desert Waters Correctional Outreach Corrections Data Collection Initiative (DWCO Initiative—Denhof and Spinaris 2013a; Spinaris et al. 2012). Analysis of data from the DWCO Initiative revealed a spectrum of health statuses and conditions associated with Corrections Fatigue. Levels and types of exposure to potentially traumatic incidents of violence, injury, and death (VID) in the corrections workplace were examined in conjunction with a large number of health-related variables. The prevalence of PTSD and Depression, clinical conditions considered to be more severe manifestations of Corrections Fatigue, was estimated using psychometrically[*] sound and widely used clinical assessment and screening tools.

[*] Psychometrics is the branch of psychology that deals with the design, administration, and interpretation of quantitative tests for the measurement of psychological variables, such as intelligence, aptitude, and personality traits.

Study participants reported having been exposed, over the course of their corrections careers, to an average of approximately 28 VID events, five different types of VID events, and two directly-experienced assaults. Male corrections professionals reported being exposed to more VID events and more types of VID events, and experienced more assaults than female staff. Security staff, who tend to have the most direct and frequent contact with justice-involved individuals, also reported witnessing more VID events and more types of VID events, as well as experiencing more assaults than non-security staff.

In the entire sample studied (N=3,599) the occurrence of PTSD and Depression were found to be 27% for full PTSD, 14% for partial PTSD and 26% for Depression. Figure 1 illustrates PTSD and Depression prevalence estimates for various subgroups of corrections professionals, including individuals reporting witnessing one or more VID events (PTSD 29.1% and Depression 27.6%) and no VID events (PTSD 9.3% and Depression 13%; males (PTSD 30.5% and Depression 28.7%) and females (PTSD 21.7% and Depression 22.1%); security staff (PTSD 34.1% and Depression 31%), non-security staff (PTSD 21.5% and Depression 22.1%); and probation/parole staff (PTSD 22.6% and Depression 22.1%). The illustrated disorder rates seem clearly corrections-specific and far exceed estimates for the general population (Pietrzak et al. 2011; United States Centers for Disease Control and Prevention 2010), and are higher than estimates for other high-trauma occupations (Gates et al. 2012; Perrin, et al. 2007). Males met criteria for both PTSD and Depression more frequently than females—a pattern that is opposite of what has consistently been found in the general population (National Comorbidity Survey 2005; Pietrzak et al. 2011).

Figure 1. Disorder Rates for Subgroups of Corrections Professionals

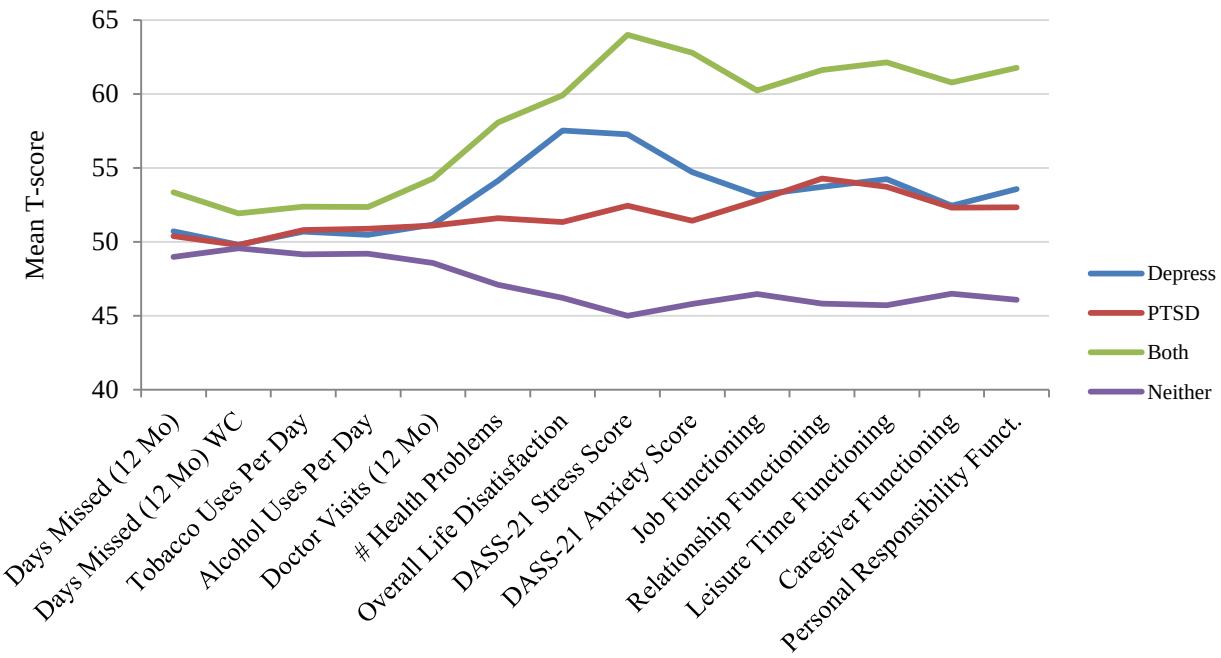


The frequent co-occurrence of PTSD and Depression is well established in the literature (Erickson et al. 2001; Pietrzak et al. 2011). The same co-occurrence was found in the DWCO Initiative study, where 17% of the sample demonstrated PTSD and Depression simultaneously and had more negative health statuses, conditions, and levels of functioning. The co-occurrence of the two disorders appears particularly debilitating and is known to increase suicide risk (Pietrzak et al. 2011; Sareen et al. 2007). The association between comorbidity (having more than one disorder simultaneously) and suicide risk helps explain why correctional security staff have been found to have a particularly elevated suicide rate relative to other professions, including law enforcement, and relative to the general population (New Jersey Police Suicide Task Force 2009; Stack and Tsoudis 1997).

An array of health-related variables were found to be impacted by the presence of PTSD and/or Depression among corrections professionals in the study, including: work days missed, substance use, doctor visits, total number of health problems, life satisfaction, stress level, anxiety level, and functioning in a variety of contexts. Figure 2 illustrates how disorder-free individuals compared with individuals who screened positive for PTSD alone, Depression alone, or both conditions. As shown, the presence of PTSD, Depression, or both, was associated with

worse status (i.e., higher T-scores) across numerous health-related conditions and behaviors. (Data from the different measures are presented as T-scores, also known as standardized scores, in order to make their magnitudes directly comparable, side by side. T-scores are transformations of raw scores that set the mean to 50 and the standard deviation to 10.) DASS-21 on the chart below refers to scores on the Depression, Anxiety and Stress Scale (Lovibond and Lovibond, 1995). A notable observation was that individuals who screened positive for both PTSD and Depression concurrently—17% of the sample studied—demonstrated distinctively worse health statuses, conditions, and levels of functioning across a wide range of health-related measures.

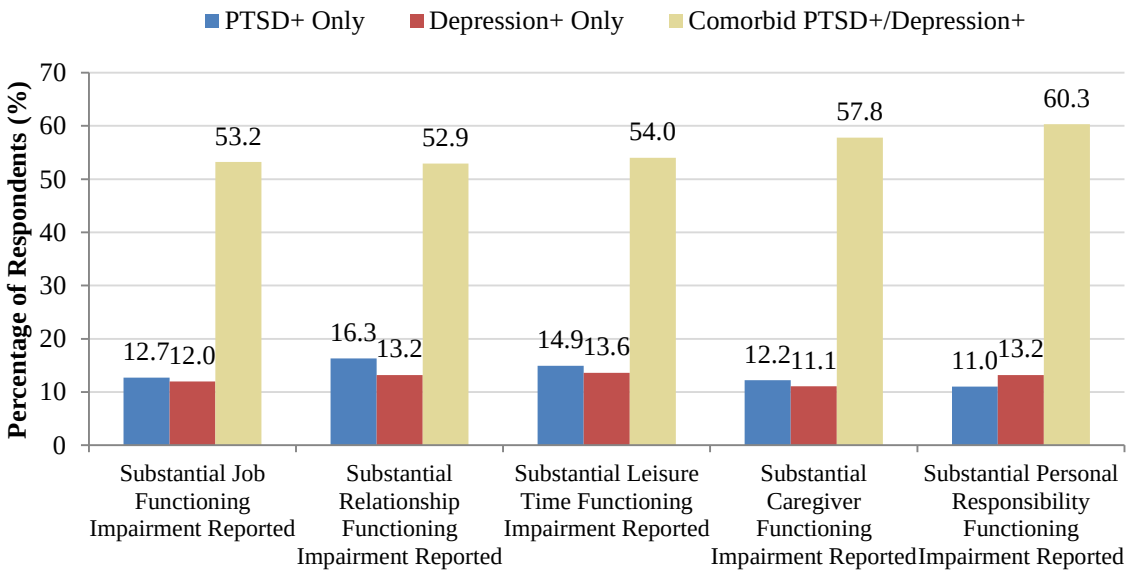
Figure 2. PTSD, Depression, Comorbidity and Other Health-Related Measures



*Higher scores reflect worse status/greater impairment.

Figure 3 contrasts reported levels of impact regarding behavioral functioning in various life contexts on study participants with PTSD alone and Depression alone versus those demonstrating both conditions concurrently. Approximately 50 to 60% of participants who screened positive for both conditions reported that exposure to events in the correctional setting or due to their correctional role substantially and negatively affected their ability to function in five different contexts: job functioning, relationship functioning, leisure time functioning, caregiver functioning, and personal responsibility functioning. This is in contrast to the much lower percentage of approximately 11% to 16% of individuals who screened positive for PTSD alone or for Depression alone who reported being adversely impacted by events in the correctional setting or while performing their correctional role.

Figure 3. Impairment in Functioning According to Disorder Status



Data from other studies provide additional evidence of the detrimental effects of corrections work upon security staff in particular, including negatively skewing personality, emotions, and outlook over time for a sample of Australian security staff (Dollard and Winefield

1998), as well as increased substance use, sick leave use, and physical and psychological symptoms in U.S. corrections professionals (Bierie 2012). Stadnyk (2003) reported a 26% PTSD prevalence rate among Canadian corrections officers, and a French study (David et al. 1996) estimated a 24.0% Depression rate for corrections staff of several disciplines. In that study, 24.9% of male security staff and 19.5% of female security staff met criteria for Depression. This finding again points to a gender effect reversal in Depression prevalence among corrections staff.

Job-specific detriments have been found to extend to corrections professionals working not only in locked facilities but also in community settings. Lewis, Lewis and Garby (2013), for example, found that probation officers who reported experiencing specific high-stress/traumatic incidents in the line of duty scored significantly higher on measures of traumatic stress and burnout than did officers who did not experience such incidents. These individuals also exhibited higher rates of self/personality changes characteristic of Corrections Fatigue, such as mistrust, anger, distorted worldview, and social/emotional isolation. Similarly, a positive relationship was found between length of career in the probation field and: safety concerns, family problems, anger, distorted worldview, mistrust, and identification with offenders. Additional traumatic symptoms that increased with career length were social/emotional isolation, physical symptoms, depression and escape/avoidance behaviors, with the highest number of symptoms being reported by probation officers who had worked in the field for 9-12 years. These findings support the notion of the cumulative negative impact of high stress/traumatic exposure over time.

Many, if not all, of the findings cited above support the concept of Corrections Fatigue as an umbrella term that encompasses detrimental consequences to corrections professionals of exposure to high-stress events, including traumatic events. Detrimental outcomes include negative personality, perceptual, and attitudinal changes; and physical and psychological health-

related conditions, including elevated PTSD and Depression rates, concurrent multiple physical health problems, increased substance use, elevated anxiety, functional impairments, increased use of sick days, and lower life satisfaction.

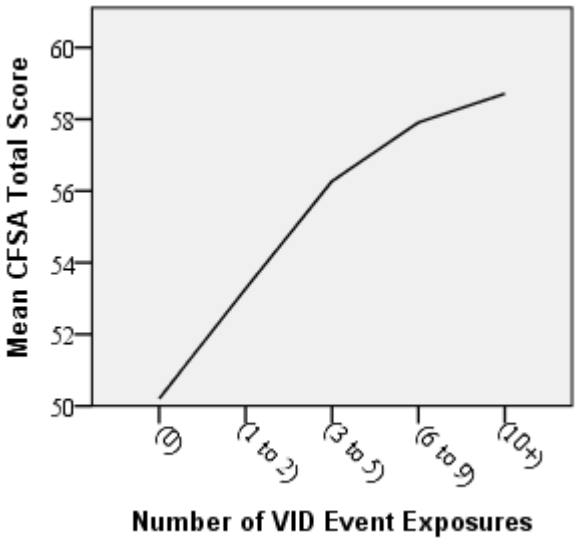
To more directly and precisely measure the extent of Corrections Fatigue and related workplace conditions, two web-based assessment instruments have been developed—*The Corrections Fatigue Status Assessment (CFSA),* and the *Workplace Climate Assessment (WCA).* These instruments were specifically designed for use online with corrections professional populations. They were developed based on review of relevant literature and theory, implementation of contemporary statistical analysis techniques for clinical assessment instrument development, and use of data from a large number of corrections professional participants from multiple locations across the United States. Both of these instruments have been found to have good foundational psychometric properties, that is, that they validly and reliably measure what they are purported to measure (Denhof and Spinaris 2013b; Denhof and Spinaris 2013c).

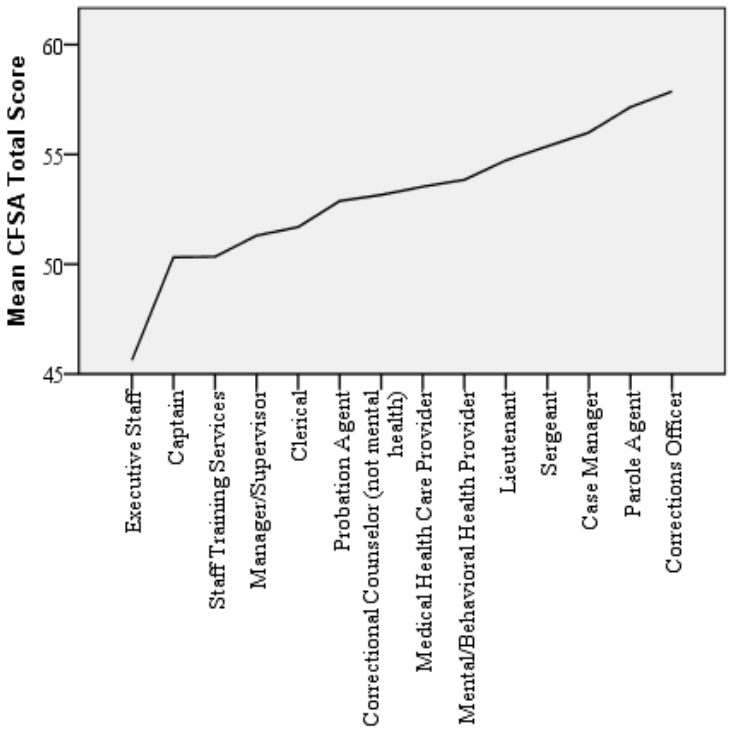
The CFSA is an assessment and report generation tool that was developed to detect and quantify the extent of Corrections Fatigue. The WCA was designed to assess and quantify critical facets of the workplace culture/climate. The CFSA measures Corrections Fatigue in terms of the extent of its presence. The WCA is an instrument that provides distinctive assessment of seven critical content areas which are systemically affected by Corrections Fatigue, and which, depending on their status, can either promote workplace health or further promote Corrections Fatigue. The seven content areas are Physical Safety, Psychological Safety, Trust, Respect, Power, Connection, and Meaning.

Both the CFSA and WCA offer efficient web-based administration and useful assessment of both Corrections Fatigue and workplace conditions that represent both the organizational/systemic outcomes of Corrections Fatigue and circumstances with potential to further promote and sustain it—or reverse it. Both assessment tools can be used for gauging the extent or magnitude of Corrections Fatigue within entire facilities or community-based agencies and/or within individuals. As such they provide a quantitative approach to discerning the need for workplace health-related intervention or prevention programs, as well as a basis for assessing the effectiveness of such programs through potential pre- and post-test measurements.

Figure 4 illustrates the relationship that exists between CFSA scores and the number of Violence, Injury and Death (VID) exposures during the past 12 months, as well as between CFSA scores and corrections job roles involving varying degrees of VID exposure. As illustrated in the charts, the CFSA demonstrates measurement sensitivity in the expected ways. Individuals with more VID exposures show higher CFSA scores. Individuals with more front-line job roles (i.e., typically involving more frequent high-risk and/or high-stress contact with justice-involved individuals) also show higher CFSA scores.

Figure 4. CFSA Scores versus Number of VID Event Exposures and Job Role





SECTION 6: REASONS FOR IMPLEMENTING PROGRAMS THAT ADDRESS CORRECTIONS FATIGUE

There is compelling evidence concerning the reality and harmful effects of psychological trauma on correctional staff. Understanding the nature and impact of both direct and indirect traumatic exposure on staff, and taking active and ongoing steps to counter its effects, is a necessity in corrections organizations. The alternative—addressing staff symptoms alone, such as through taking disciplinary action for presumed sick leave misuse—is not sufficient to bring about lasting, positive changes in employees who are continually immersed in an inherently difficult and detrimental correctional work environment. The cumulative effect of workplace

stressors, especially traumatic stressors and the changes they generate within corrections professionals must be addressed as a deeper source of persistent maladaptive[**] behaviors and functioning impairments among staff.

Corrections systems need to be equipped with data-driven information and strategies to manage and counter the influence of traumatic work-related events and conditions upon both individual employees and organizations. In the absence of effective strategies and interventions, the build-up of Corrections Fatigue will most likely continue to take its toll in the form of substandard or impaired work performance, lowered morale, and elevated rates of sick leave, disability and staff turnover. Corrections Fatigue will also likely continue to contribute to stress-related physical ailments, substance abuse, relationship problems, difficulty with leisure time and other areas of life functioning, lowered life satisfaction, and elevated staff suicide rates.

While it is a fact that the budgets in correctional organizations are often strained, data also make clear that the absence of effective health and wellness maintenance programming for corrections employees results in high financial costs for correctional agencies and institutions. Corrections staff with unaddressed components of Corrections Fatigue—such as negative changes in thinking and mood, Depression and PTSD—demonstrate lower levels of life satisfaction, use more sick days, have more doctor visits, and experience a long list of detrimental health and functioning-related statuses and conditions.

The following is an example of costs associated with one outcome of Corrections Fatigue. Using the data from the DWCO Initiative, and based on a) the estimated prevalence rates for Depression and/or PTSD, b) the average number of sick days per year used by

[**] These are types of behaviors that inhibit a person's ability to adjust well or adequately to taxing situations.

employees with Depression and/or PTSD, c) subsequent overtime pay at a time and a half to provide replacement coverage, and d) an average employee salary of $22.00/hour, the cost of sick time due to these two disorders for a correctional facility or agency of 1000 employees is approximately $590,000.00 per year. But the consequences of PTSD and Depression clearly manifest in a range of other ways as well, such as impaired work performance, unhappy employees, and elevated turnover, among other negative outcomes. Thus total agency or institutional costs of the unaddressed elements of Corrections Fatigue are in reality going to cost organizations considerably more than just sick days and overtime pay.

Unhealthy and unhappy employees also constitute the building blocks of unhealthy work environments—environments lacking positive leadership, ethical professional conduct, humane treatment of justice-involved individuals, supportiveness of coworkers, acknowledgement of emotionally and mentally taxing circumstances, and sensitivity to human suffering and health maintenance needs. The investment in individual and/or systemic staff intervention and wellness-maintenance programs can thus offer much more than immediate financial rewards. Rather, it can also result in improved workplace climates, job performance, and quality of life for all parties concerned. Most importantly perhaps for correctional workplaces, investment in staff intervention programs can improve safety and security for both staff and the justice-involved individuals they manage while also maximizing opportunities for pro-social interactions between members of these two groups, ultimately improving rehabilitation outcomes.

Indeed, healthy employees are a mission-critical asset when it comes to the task of positively influencing justice-involved individuals. Just as hospitals constantly strive for a hygienic environment so that patients are given every opportunity to regain their health,

corrections agencies also have an implied social responsibility to create environments that support the well-being and moral development of justice-involved individuals. Employees whose behaviors and attitudes have been negatively shaped by Corrections Fatigue are unlikely to be effective role models. Employees whose job performance and functioning have been eroded due to symptoms of Corrections Fatigue are also less likely to respond optimally in dangerous or other high-stress situations. Staff who demonstrate negative thinking, negative mood, reckless behavior or unhealthy professional boundaries due to the effects of unaddressed trauma will be particularly ill-suited to effectively manage justice-involved individuals who often also have been negatively influenced by unaddressed trauma (Wolff et al. 2013).

While there is always a concern among corrections administrators that increased openness and education about the nature of health risks inherent to corrections work will provide some employees with excuses to justify poor work performance or absenteeism, or even promote malingering, it is plausible and logical to expect that, on the contrary, healthier and more positive work climates will help deter such behaviors.

In addition, the liability associated with negative working conditions is in fact reduced for an agency that is taking active and transparent steps to assess and address associated problems, such as through formal assessments and specialized staff training programs. Providing the necessary cautionary guidance to staff about the inherent challenges of the corrections profession and encouraging effective and positive coping strategies is both ethical and wise. Healthy and sustainable workplace cultures require a combination of trauma awareness throughout the workplace, the teaching of effective adaptation strategies, and leaders who consistently model and reinforce informed, health-promoting, and ethical conduct to subordinates.

While it is true that individual employees ultimately must take responsibility for their health and well-being, given the pervasive cultural influence found in 24/7 workplaces, individual employees cannot be reasonably expected to maintain personal health and well-being against the grain of potentially toxic and dysfunctional workplace cultures. Thus employee health and functioning must be addressed both by individuals and also systemically on the organizational and cultural levels.

In summary, it is in the best interest of corrections agencies to implement available data-driven strategies and programs to ensure that their employees and work environments are healthy and configured in ways that promote and maintain individual and group health and wellness. Prevailing work conditions in corrections workplaces impact employee health and overall well-being, which in turn affect work performance and the treatment of justice-involved individuals (Bierie 2012). Therefore, employee health maintenance and overall well-being are prerequisites for safe and secure working conditions in corrections. This is true in general for all types of work communities, but arguably especially true for correctional work environments, given the inherent dangerousness and negativity of these environments, and given the inherent traumatizing potential of corrections work.

Decision-makers in correctional organizations will be best served by not only taking into account what available research literature is saying about the negative consequences of traumatic experiences, but also what their personal experience and judgment are saying, what the consensus judgment of their peers and employees are saying, what the history of events in the organization suggests regarding staff interactions with justice-involved individuals and also with other staff, along with any other sources of evidence about what is really happening in

employees' lives, such as feedback from their families. The consequences of a default to the status quo are just too costly in corrections environments. Suicide rates for corrections staff, for instance, will continue to be shockingly high, and sick leave abuse and staff misconduct will continue to be significant correctional realities unless changes are made in correctional environments—changes designed to promote and maintain employee and workplace health and well-being. To that end, corrections administrators and leaders need the tools and reassurance that lasting workplace improvement is possible and within their reach.

SECTION 7: WAYS TO IMPLEMENT TRAUMA-INFORMED PROGRAMS TO ADDRESS CORRECTIONS FATIGUE

According to SAMHSA (2012b), a trauma-informed approach refers to "how a program, agency, organization, or community thinks about and responds to those who have experienced or may be at risk for experiencing trauma; *it refers to a change in the organizational culture."* (Emphasis added.) When implementing such an approach, all components of the organization receive ongoing education regarding the prevalence of trauma and the nature of its impact, the ways in which trauma can affect operations, and the various complex ways in which people recover from the effects of trauma. An agency that addresses the effects of trauma also provides those at risk and those affected with strategies and resources for countering its effects. Such organizational strategies include:

a) Implementation of trauma-informed approaches that educate all concerned about the nature of trauma, its signs and symptoms, means of prevention, and means of healing and recovery;
b) Countering of mind-sets and behaviors that result from trauma through education and practice of corrective ways of thinking and behaviors;
c) Promotion and facilitation of individual self-care;
d) Education in the area of resilience;
e) Promotion and practice of enlightened Positive Leadership (Cameron 2008; Quinn 2004) and Transformational Leadership (Bass and Bass 2008);
f) Incorporation of knowledge about trauma into policies and procedures; and
g) Application of these practices in all settings.

Experts in the field (Harris and Fallot 2001; SAMHSA 2012b) propose that an organizational trauma-informed approach involves the implementation of strategies that promote the application of the following principles in a workplace, among others:

a) Staff's physical and psychological safety;
b) Transparency and trustworthiness;
c) Interactions based on mutual agreement, respect, and collaboration;
d) Empowerment; and
e) Inclusiveness and shared purpose.

These targeted areas involve a substantial overlap with the seven content areas proposed earlier as crucial for healthy and functional correctional workplace cultures–physical safety, psychological safety in relation to other staff, trust, power, respect, connection and meaning.

When these elements are fulfilled, Corrections Fatigue can be expected to be deterred and professional fulfillment and personal growth—including post-traumatic growth—promoted.

Application of the above trauma-informed principles, such as transparency, empowerment and inclusiveness, presents unique challenges in corrections work settings. One reason for this is security concerns (i.e., staff's emphasis on safety and security while managing justice-involved individuals), and a resultant "us vs. them" adversarial perspective that divides the "keepers" and the "kept," the managers and the managed, and an inherent inequality of power. Because of this power differential, staff need to maintain appropriate professional boundaries, while combining the dual duties of law enforcer and helper, and investing themselves emotionally in the welfare of justice-involved individuals. When Corrections Fatigue is operating, changes in the thought processes of staff, such as negative expectations, can also make distrust or lack of transparency spread into the realm of inter-coworker relations, promoting adversarial "camps" and "cliques," such as administrators vs. line staff, and security vs. non-security staff, among others. As a result, some of the prescribed principles, such as transparency, may not universally apply and/or may require modification before implementing in correctional settings.

Trauma-informed and trauma-countering practices in corrections settings—be it institutions or community-based work environments—are likely to include at least the following key components:

a) Acknowledgement of the occurrence of trauma, its pervasiveness, its multi-faceted signs, and its consequences among even the "toughest of the tough" of corrections employees. Administrators and other leaders must repeatedly make concerted efforts,

through strategic communications, to lessen the stigma of acknowledging the impact and complexities of psychological trauma and its manifestations.

b) Administrators must promote use of mental health resources and other types of support, and ensure their availability and accessibility to staff and their families through EAP and other community-based services. This is particularly important in rural areas where such resources may be scant and problematic to access due to large geographic distances.

c) Administrators must provide staff with regular and frequent training opportunities and educational materials regarding countering the effects of trauma, practicing positive coping strategies, and practicing resilience-boosting behaviors while maintaining sound professional boundaries with the justice-involved individuals they manage.

d) Administrators must ensure that supervisors and other mid-level managers and executive staff are regularly trained in the areas of positive climate maintenance and positive leadership, especially in relation to interacting with potentially traumatized and otherwise highly stressed staff.

The above components are of paramount importance if notable and lasting progress is to be made in the areas of wellness and professionalism of corrections employees. But these are not exhaustive. Hiring practices need also be considered. The paramilitary structure of corrections facilities has traditionally drawn and continues to draw employees with prior military experience, because of the substantial skill set overlap that exists between military service and corrections work roles. However, data from the DWCO Initiative indicated that corrections professionals with prior military experience tended to have, on average, a 7.4% higher PTSD rate than

employees with no such prior experience, and a 5.4% higher Depression rate. Given the cumulative impact of traumatic stress, exposing military veterans to additional occupational trauma in corrections settings may be a topic that needs to be re-evaluated.

Since the 1980's high-trauma professions, such as the military and police, have addressed the effects of trauma in one or more of the following ways: recognition of the impact of critical incidents; debriefing of staff likely to have been affected using critical incident psychological debriefing models, such as Critical Incident Stress Management (Mitchell 1983); provision of training in the area of effective coping strategies; provision of resilience building trainings; provision of EAP and/or peer support services; provision of health insurance to staff that offers affordable coverage for behavioral health services; and provision of educational materials and services to family members.

Typically, debriefing interventions are delivered by a range of professionals, and are single sessions (individual or group) that include education about traumatic stress, expression of emotions and planning for the future. Recently, however, the effectiveness of psychological debriefing has been questioned. Based on analyses of debriefing studies by the National Institute for Clinical Evidence (2005), the World Health Organization (2012) strongly recommended that psychological debriefing not be used for people exposed recently to a traumatic event as an intervention to reduce the risk of post-traumatic stress, anxiety or depressive symptoms. Interestingly, despite the lack of notable effects following from measured attempts to prevent trauma-related mental health problems, there is evidence that recipients of psychological debriefing appreciate and value the intervention (Adler et al. 2008).

Currently, five intervention principles have been identified as best supported by evidence for the purpose of guiding practice and programs shortly after traumatic incidents and for a mid-term period following a disaster (Hobfoll et al. 2007). These five principles involve the promotion of: a) a sense of safety; b) calming down; c) self-efficacy and collective/group efficacy (i.e., effectiveness, which promote a sense of competence and confidence); d) connectedness with other important individuals and groups; and e) hope for the future. Programs, such as "Psychological First Aid" (Brymer et al. 2006) provide protocols to deliver interventions based on these five principles following traumatic exposure.

A systemic intervention, implemented by the Toronto Police Service (TPS), and described by Schaer (2004), serves as an illustration of a highly successful "culture" intervention.

The TPS intervention aimed to reduce the number of suicides and to increase the overall health of the police force. Between 1975 and mid-1992, TPS experienced a total of twenty-two officer suicides. After beginning a culture intervention in June 1992, TPS experienced zero suicides through 2004 (when data were last reported online)—an impressive outcome.

The TPS intervention was multi-faceted. It was acknowledged and supported by both administration at all levels and by the officers' union. The intervention started for officers at the time of their graduation from the training academy—thus helping counter the stigma of seeking mental health help which is often prevalent in law enforcement cultures. The intervention included the following components:

a) Staffing of a 24/7 off-site confidential assessment/referral center by trained referral agents (i.e., police officers and civilians)

b) A strong EAP program for officers, family members and retirees;
c) Use of screened community-based mental health providers and unlimited psychological treatment coverage for trauma therapy;
d) Multiple ongoing proactive educational initiatives for stress management within specialized units;
e) Supervisory education in managing troubled officers, maintaining balance in life, and critical incident stress management;
f) Provision of educational material for family members;
g) Implementation of a Critical Incident Stress Management use policy;
h) Use of a trained debriefing team;
i) Use of trained peer support providers; and
j) Provision of articles in monthly publications, brochures and activities to promote intervention program awareness.

The TPS intervention progress report stated that due to this multi-pronged and sustained approach a positive culture change took place through: positive peer pressure; educating a new generation of officers on the psychological occupational hazards of their job from the outset; family education and intervention; a labor union which proactively promoted the well-being of their membership; and multi-faceted support by management, including funding of all intervention efforts.

Over the past several years corrections agencies have increasingly used trained critical incident response teams in order to provide psychological debriefing to trauma-exposed staff. However, given the accumulation of evidence on the lack of usefulness of psychological

debriefing, the nature of such interventions can be expected to gradually shift toward more evidence-informed material, like the Psychological First Aid protocol (Brymer et al. 2006).

Over the past several years, EAP services have also been increasingly made available to corrections staff by their agencies, based either on peer support or professional mental health services, whether internal or community-based. This practice has gone a long way toward providing much needed and affordable services to corrections personnel and their families. However, EAP and behavioral health providers are not necessarily informed on the unique circumstances of corrections work and the dynamics of health and functioning related problems that are typical of corrections professionals working in facilities or within community supervision programs. Corrections employees often require more than just peer-support types of EAP intervention, or professional EAP services that typically allow for less than 10 sessions annually. This circumstance makes it crucial that corrections professionals are provided with affordable health care coverage so that individuals and their family members can continue addressing their mental health needs when limited EAP service offerings are exhausted. It also makes crucial the need for the behavioral health providers to be familiar with the potential impact of corrections work on employees' health and functioning and on their personal relationships. Effectively addressing Corrections Fatigue requires specialized, corrections-specific interventions, and in some cases professional trauma-focused mental health services.

Social support following traumatic exposure has been repeatedly identified as a protective factor that helps reduce the negative impact of trauma (Gates et al. 2012; Ozer et al. 2003). Social support in the corrections workplace can take many forms. Active role modeling of behaviors and styles of interaction by supervisors and administrators to support a positive workplace climate, such as targeting of critical need areas (e.g., physical safety, psychological

safety, trust, power, respect, connection and meaning) is paramount. Social support can also be provided through trained peer supporters, seasoned corrections professionals who are knowledgeable about the nature and sources of Corrections Fatigue and/or who have learned to effectively adapt to the common challenges of the corrections workplace. Educating family members and the general public on the nature of Corrections Fatigue and strategies for its deterrence represents a further means of providing social support to corrections staff, and potentially improving the public perception of corrections professionals and increasing appreciation and respect for the difficult and important functions they serve.

It is noteworthy that comprehensive wellness and functioning resources specific to public safety occupations are fairly rare at the present time. Those that do exist frequently come from the military (Bartone, Pastel, and Vaitkus 2010; Seligman 2011) or the law enforcement/police discipline. When undertaken on an agency-wide level, it is not unusual to find correctional agencies either designing home-grown methodologies, relying on a generic EAP service as mentioned above, or using the police officer-focused resources. Examples of such resources are the police officer-focused book and DVD course entitled *Emotional survival for law enforcement: A guide for officers and their families*. (Gilmartin 2002), and other materials (Paton et al. 2009; Paton, Violanti and Smith 2003).

While police officers and corrections professionals experience similar challenges and issues (such as, consequences of shift work, continuous hypervigilance, and a negative worldview), materials designed for police officers specifically are not going to be optimal for corrections professionals working in either locked facilities or community supervision programs.

Corrections-specific training programs (i.e., developed specifically for use with corrections professionals who work at either facilities or in the community) have been recently developed to address the impact of traumatic exposure. One such resource is KSL Research, Training, & Consultation, LLC, which conducts research and provides education and training customized to the needs of probation and parole officers with the goal to increase staff resilience and to promote recovery following traumatic exposure. DWCO has designed the psychoeducation training *From Corrections Fatigue to Fulfillment*™ which educates corrections professionals on the nature of Corrections Fatigue and individual and organizational strategies for deterring it, so that a context is set for dealing with it in an informed and systematic way. The training also equips corrections professionals to progress toward "Corrections Fulfillment"—a construct that represents positive transformations, post-traumatic growth, increased resilience, healthy functioning, and well-being that follow from successful implementation of effective coping and adaptation strategies. The training is available in the form of an Instructor Training course, so that individual trainers can be certified to deliver the training to employees at their agencies/facilities.

One corrections-specific publication, *The Manager's Guide to Stress, Burnout & Trauma in the Corrections Workplace* (Fisher 2000) presents material geared to assist corrections managers in managing stress, burnout and traumatic exposure of subordinates. Other corrections-specific resources available on the subject of corrections staff wellness include the booklet *Staying Well: Strategies for Corrections Staff* (Spinaris 2008), and the workbook *Processing Corrections Work* (Spinaris and Morton 2013).

In light of evidence-based practices in other high-trauma and high-stress occupations (e.g., Toronto Police Service, military), and taking into account existing literature on the nature

of corrections environments, the following set of actions are recommended for the purpose of addressing Corrections Fatigue and promoting professional fulfillment and effectiveness of corrections professionals.

Table 2. Some Model Agency Responses to Address Corrections Fatigue

EXECUTIVE AND CULTURAL SUPPORT
1. Director's/Executive Staff messaging: Acknowledgement of Corrections Fatigue and its complexities as a professional challenge by agency leadership; adoption of values and behaviors that mitigate Corrections Fatigue and promote staff wellness, sound professional boundaries, and professional fulfillment, particularly as they relate to countering the effects of traumatic exposure; no minimizing the issue or exhibiting indifference; development of resources that "match that message;" maintenance of the message on a continual basis; "walking the talk."
2. Labor support: Acknowledgement of Corrections Fatigue as a professional challenge by union leadership, adoption of values and behaviors that mitigate Corrections Fatigue and promote staff wellness, professional fulfillment and sound professional boundaries, particularly as they relate to countering the effects of traumatic exposure; maintenance of the message on a continual basis; "walking the talk;" no overstatement of the issue by attributing unrelated problems or professional misconduct to Corrections Fatigue.
3. Consistent support from first line supervisors, including daily, on-duty monitoring:

Acknowledgment of Corrections Fatigue as a professional challenge; no minimizing the issue or exhibiting indifference; adoption of values and behaviors that mitigate Corrections Fatigue and promote staff wellness, sound professional boundaries and professional fulfillment, particularly as they relate to countering the effects of traumatic exposure; "walking the talk."

4. Transparency of events, within privacy guidelines: Public acknowledgment by the agency of incidents related to Corrections Fatigue when they occur without violating the privacy of individuals; documentation and analysis by the agency of incidents thought to be related to and/or to contribute to Corrections Fatigue.

5. Support of self-help tool use: Encouragement of staff by colleagues and supervisors to use resources such as EAP, behavioral health treatment, peer support, and trainings for the purpose of health maintenance and ethical professional conduct.

6. Provision of evidence-based interventions and screening following critical incidents: Provision of evidence-based interventions as needed following direct or indirect traumatic exposure, including provision of social support, provision of anonymous psychological screening after an appropriate time period following the incident (e.g., 3-4 weeks) to promote the seeking of professional help by employees if indicated, incident reporting, designated responsible parties, time frames, documentation and privacy requirements, training standards, an agency policy statement, and use of available tools for providing social and other relevant types of assistance and resources to corrections professionals following exposure to traumatic events.

TREATMENT RESOURCES
1. Unlimited confidential treatment for psychological issues related to the job: Recognizing that Corrections Fatigue symptoms wax and wane given the proximity and recency of triggering events, provision of treatment resources that are need-based and not limited in scope or dependent on formal referral.
2. Formal, confidential peer support structure: Immediate availability of empathetic and trained peers to provide incident-specific or generalized social support.
3. Treatment professionals educated on corrections-specific wellness issues: Availability/provision of education services about the unique dynamics of the correctional environment to area mental health providers, religious and spiritual leaders, physical health care specialists, and community mentors.
4. Family member coverage: Availability of treatment resources to staff's family members.
JOB DESIGN
1. Clear role definition of security and responsibilities regarding management of justice-involved individuals : Training employees to balance punitive or disciplinary actions with corrective or supportive interactions in their management of justice-involved individuals.

2. Job assignment rotations: Encouraging or building in rotation among different job roles, stations and institution levels wherever possible to reduce amount and degree of exposure to trauma and other high-stress circumstances.

3. Decision-making encouraged and supported at the lowest possible level: Providing line-level staff with the opportunity and information necessary to make substantive decisions or to offer their input regarding matters related to their assignments.

4. Clear task/outcome identity: Ensuring that task design, as codified in Post Orders and Position Descriptions, reflects as much as possible the opportunity for employees (individually or collectively) to complete work assignments in full from beginning to end, so that a sense of accomplishment can be afforded, and to deter a sense that efforts are undermined by the relative follow-through of others.

5. Evidence-based tools for management of justice-involved individuals: Provision of tools or techniques for management of justice-involved individuals that are evidence-based, research-supported, or data-driven.

6. Temporary flexibility of job assignments for employees exposed to traumatic incidents: Following significant traumatic exposure of an employee, availability, at least temporarily, of an alternative job assignment intended to moderate and facilitate the employee's return to the correctional environment with optimal health and functioning.

7. Reduction of staff isolation in job assignments: Encouraging staff to communicate with each other while on duty, and providing staff with opportunities to interact with coworkers during their

work day.

STAFF TRAINING

1. Equipping of academy/new employees: Training instructors on the subject of Corrections Fatigue and strategies for countering it; introduction of the concepts of Corrections Fatigue, strategies for self-care, sound professional boundaries with justice-involved individuals, and professional fulfillment, and other evidence-based health-promoting individual and organizational practices to new employees; encouraging instructors to monitor new employees for signs of distress; using training design that involves guided practice sessions and job transfer mechanisms, such as Field Training Officers.

2. Educational materials: Provision to staff of relevant and up-to-date information resources pertaining to Corrections Fatigue, sound professional boundaries with justice-involved individuals, and health-maintenance, such as brochures, articles, DVDs and booklets.

3. In-services: Provision of training to veteran employees specifically to recognize Corrections Fatigue as a professional challenge in themselves and others; teaching content that emphasizes sound professional boundaries with justice-involved individuals and also with coworkers; teamwork, conflict resolution, problem solving and communications skills; encouraging instructors to monitor employees for signs of distress; using training design that uses guided practice sessions and job transfer mechanisms such as Field Training Officers and mentors.

4. Supervisors: Provision of training to managers and supervisors specifically to recognize

Corrections Fatigue as a professional challenge in themselves and others, especially in their direct reports; teaching Corrections Fatigue content that emphasizes sound professional boundaries with justice-involved individuals and also with coworkers, teamwork, conflict resolution, problem solving, and communications skills, and using training design that includes guided practice sessions and job transfer mechanisms such as mentors.
5. Trained instructors: Provision of Instructor training on evidence-based material that addresses Corrections Fatigue, stress reduction and the promotion of resilience, wellness, ethical professional conduct, professional fulfillment and growth.
6. Peer supporters: Provision of training to peer supporters to recognize Corrections Fatigue and to intervene successfully with distressed co-workers. Training content includes evidence-informed material, such as Psychological First Aid (Brymer et al. 2006).
7. Mentors: Provision of training to selected mentors so they can facilitate the professional growth of designated mentees through professional guidance and assistance.
FAMILY SUPPORT
1. Family involvement in training activities: Inviting family members specifically to attend trainings to help them understand the unique pressures of the correctional work environment and to describe effective coping strategies for their home life; training instructors to deliver this material; providing peer support services and professional resources.
2. Family educational materials: Providing to family members relevant and up-to-date information

resources pertaining to Corrections Fatigue, resiliency, communication skills, and health and wellness maintenance, such as brochures, articles, booklets, and links to online resources.

3. Family days: Developing an annual calendar of family days that include recreational and educational activities at the corrections workplace or off-site.

4. Use of health maintenance tools for family members: Encouraging family members to use available tools (e.g., EAP, peer support, trainings, educational materials) for the purpose of addressing issues related to Corrections Fatigue and increasing wellness.

5. Formal family peer support structure: Modeled after the employee peer support structure, providing a family peer support structure for incident-specific or for generalized social support in the case of issues related to Corrections Fatigue.

RESEARCH

1. Assessment of staff health and functioning: Performance of agency-wide, anonymous and confidential assessments of various measures of staff health and functioning. Baseline to be established for comparison with future repeat assessments, especially following systemic interventions designed to increase staff wellness and professional fulfillment, particularly as they relate to countering the effects of traumatic exposure. A variety of validated corrections-specific and non-corrections-specific assessment instruments can be used for this purpose.

2. Design and evaluation of systemic interventions to counter Corrections Fatigue and to promote professional fulfillment: Based on pre- and post-intervention data, corrections-specific and

system-wide interventions designed, implemented and evaluated for the purpose of promoting staff wellness and professional fulfillment, particularly as they relate to countering the effects of traumatic exposure. Interventions to include individual skill-building in the areas of self-care and interpersonal skills, resilience-promoting behaviors, and strategies to improve the workplace climate. A variety of valid corrections-specific and non-corrections-specific assessment instruments can be used to measure effectiveness of implemented interventions.

3. Establishment of supporting outcome variables from available agency, facility or department data, and from employee survey data collection: Appropriate outcome variables selected to examine system-wide impact of interventions. Department data might include such indicators as employee absences (sick leave use), use of long-term and short-term disability, instances of staff conflict, policy violations, performance errors, lawsuits filed against the agency for alleged staff misconduct or negligence, or turnover statistics. Baselines to be established for comparison with future repeat assessments, especially following systemic interventions.

4. Periodic generation of comprehensive analytical reports: Periodic generation of comprehensive analytical reports to summarize average levels of health and functioning-related statuses and conditions on the group level, to discern relationships between changeable circumstances and outcome variables, to estimate agency-wide or department-wide financial and health-related costs, and to generate data-driven strategies for structuring additional organization-wide improvement efforts.

SECTION 8: FUTURE DIRECTIONS

The study of the impact of traumatic stress and its interactions with operational and organizational stress in corrections workplaces is still very much in its infancy. Existing data clearly point to the need for further research, system-wide interventions, and foundational training and education on the nature of Corrections Fatigue, its manifestations, and ways of addressing and/or preventing it, while also promoting staff wellness and professional fulfillment.

Development of solutions and strategies for addressing and preventing Corrections Fatigue and its consequences require ongoing assessment of symptoms and workplace environmental characteristics. This includes exploration not only of the causes and negative manifestations of Corrections Fatigue, but also factors and conditions associated with resiliency and healthy individual and culture-wide functioning.

Systematic use of quantitative and psychometrically sound assessment and measurement tools is encouraged. Establishment of baseline measures is highly recommended, as there remains much uncharted territory and scarcity of reference standards for determining what is typical, normal, positive, healthy, or functional in corrections work environments.

Research and clinical work conducted in related high-stress occupational contexts are useful for the purpose of highlighting similar occupational hazards of corrections work related to traumatic exposure. However, corrections work also has distinctive and inherent difficulties, such as operating unarmed around large concentrations of convicted justice-involved individuals for the duration of a work shift, or visiting, often unarmed, such individuals in their homes. These and related circumstances make corrections work unique enough to justify the development of corrections-specific research inquiries, assessments, and solutions to common problems suffered by corrections personnel. Such problems include: the development of PTSD,

Depression, physical health conditions, degraded/negative outlook and worldview, functional impairments in various areas, life dissatisfaction, and lack of work-related fulfillment among other areas.

The organizational benefits of countering the negative, trauma-based forces that cause Corrections Fatigue cannot be overestimated. Agency-wide movement from Corrections Fatigue to professional fulfillment, informed by data-driven strategies, offers the potential to:

a) preserve staff's physical and psychological health;
b) boost staff morale, thus improving staff's overall work performance and retention;
c) upgrade staff's family life and community interactions;
d) lower agency costs associated with unaddressed sources of health conditions, functional impairments, and professional misconduct;
e) increase facility, agency and community security; and
f) increase the likelihood of effective pro-social staff interactions with justice-involved individuals, thus facilitating their journey toward rehabilitation.

The work that corrections employees do around the clock is difficult, dangerous and largely without much positive recognition. And yet day after day this work carries on, contributing to public safety and the rehabilitation of justice-involved individuals. The move towards evidence-based practices in staff health and well-being aims to facilitate these critical goals through the development, teaching and implementation of positive personal adaptations and effective organizational strategies for dealing with the demands of corrections work. It is our fervent hope that corrections organizations and corrections professionals alike will pursue and implement such practices to promote accomplishments that all in the profession collectively

desire: staff wellness, professional effectiveness in accomplishing the respective corrections agencies' mission, professional and career development, and healthy and functional families.

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