PREDICTING JUSTICE CONTACT IN VETERANS WITH PTSD: THE INCREMENTAL VALIDITY OF SPECIFIC RISK FACTORS

_____

A Dissertation

Presented to

The Faculty of the Department of Psychology and Philosophy

Sam Houston State University

_____

In Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

_____

by

Joshua S. Camins

August, 2020

PREDICTING JUSTICE CONTACT IN VETERANS WITH PTSD: THE INCREMENTAL VALIDITY OF SPECIFIC RISK FACTORS

by

Joshua S. Camins

_____

APPROVED:

Jorge G. Varela, PhD
Dissertation Co-Director

Bryann B. DeBeer, PhD
Dissertation Co-Director

Craig E. Henderson, PhD
Committee Member

Marcus T. Boccaccini, PhD
Committee Member

Abbey Zink, PhD
Dean, College of Humanities and Social Sciences

DEDICATION

This dissertation is dedicated to the service members and their families that have been forever changed by the conflicts that have plagued our nation. In the last 15 years, over 1.5 million troops have deployed in support of conflicts abroad. The available evidence suggests return to the United States following deployment is seldom smooth. It is my hope that this research will act as one catalyst to inform resource availability for returning veterans. You served this country honorably and well. You fought, and often died as heroes. Thank you for your service. It is now our turn to serve you.

ABSTRACT

Camins, Joshua S., *Predicting justice contact in veterans with PTSD: The incremental validity of specific risk factors*. Doctor of Philosophy (Clinical Psychology), August, 2020, Sam Houston State University, Huntsville, Texas.

A small, but significant, portion of veterans are involved in the legal system. Recent efforts have created Veteran Treatment Courts, veteran-specific jail units, and veteran homeless outreach programming to address veteran justice-involvement. Further, there is an emerging body of literature identifying empirically supported risk factors for criminal activity in veterans, but additional research is needed. The extant literature highlights a series of general factors (i.e., socio-demographic, criminogenic, and mental health) and military-specific factors (e.g., traumatic brain injury, combat exposure, rank) that are generally associated with veteran anger, aggression, and criminal justice involvement. The current study examined whether socio-demographic, mental health, and deployment-related factors were associated with law enforcement contact in a sample of PTSD diagnosed veterans (N = 98) recruited for a larger study on social cognition and suicide. Participants were all receiving services through the Veteran Affairs Healthcare System, and the majority had previous deployments (83%). The present study examined the impact of general factors (i.e., age, education, financial difficulties, substance use, and PTSD/Depression) and veteran-specific (i.e., TBI and combat exposure) on past 6-month criminal justice contact. Prior to conducting analyses, data were transformed, and principal component analysis (PCA) was used to create a composite mental health score for PTSD/Depression. In a regression model of sociodemographic factors and mental health symptoms, only age was independently associated with legal contact. Additional regression analyses on military service-related factors were not significant but still

yielded notable effect sizes. The findings suggest prevention efforts should focus on younger veterans.

KEY WORDS: Veterans, Legal contact, Posttraumatic Stress Disorder, Justice-involved veterans

ACKNOWLEDGEMENTS

This dissertation was developed with the support and assistance of many phenomenal mentors. I would like to express my utmost gratitude to Dr. Bryann DeBeer for her unwavering assistance as an expert on veteran research, as my dissertation co-chair, and as my mentor. Your willingness to share access to your data and continued commitment to my development as a researcher and psychologist is amazing. Further, I want to express my greatest appreciation to Dr. Jorge Varela for acting as my co-chair and providing a bridge between the forensic and military realms. I would also like to thank both Dr. Craig Henderson and Dr. Marcus Boccaccini for their insight and expertise as members of my dissertation committee.

The data used in this dissertation was part of the Observation and Assessment of Social Interaction and Suicide (OASIS) study, funded by a VISN 17 Center of Excellence for Research on Returning War Veterans Pilot Funds Award and a VISN 17 New Investigator Award. Data was used with the permission of Dr. Bryann DeBeer, Principal Investigator and grant awardee. Drs. Sandra Morissette, Eric Meyer, and Nathan Kimbrel acted as mentors for the OASIS study and played an instrumental role in the creation and support of the parent study.

The collaboration between Sam Houston State University and the VISN 17 Center of Excellence for Research on Returning War Veterans (CoE) would not have been possible without the steadfast support of Drs. Jorge Varela and Craig Henderson. Thank you both for the untold pages of paperwork, unending conferences calls, and road trips across Texas. I also want to express my gratitude to Dr. Joseph Mignona for connecting

me with the CoE, and Dr. Richard Seim for his assistance in formalizing the collaboration.

TABLE OF CONTENTS

Page

LIST OF TABLES

Table **Page**

CHAPTER I

Introduction

Current data suggests that 1 in 37 adults, or 2.7% of the United State population is being supervised by the criminal justice system (Kaeble & Glaze, 2016). Although this number reflects a decrease from previous years, the revolving door of justice continues to have a negative impact on society. Some estimate the cost of incarceration alone may exceed $500 billion per year (McLaughlin, Pettus-Davis, Brown, Vech & Renn, 2016). To decrease recidivism and better utilize government resources, a new focus on subpopulations within the criminal justice system has emerged. This has resulted in the creation of problem-solving courts (i.e., drug court, mental health court, veteran court) and additional diversionary programs (i.e. treatment focused programs (Lange, Rehm & Popova, 2011).

Veterans comprise 7.4% of the population (U.S. Census Bureau, 2016) and are at higher risk for poor outcomes including mental health problems (Seal et al., 2009), homelessness (Tsai & Rosenheck, 2013), physical health problems (Oster, Morello, Venning, Redpath & Lawn, 2017), and criminal justice involvement (Elbogen, Johnson & Beckham, 2011). Recent data from the Bureau of Justice Statistics indicates approximately 181,500 (8%) of all inmates in U.S. jails and prisons are military veterans (Bronson, Carson, Noonan & Berzofsky, 2015). This represents a decline from previous years; however, these individuals still represent a sizable subgroup of the incarcerated population. It should be noted that the exact number of veterans incarcerated as of 2018 is unknown. Notwithstanding this, similar rates of veteran justice involvement have been

observed in England and Wales (Wainwright, Lennox, McDonnell, Shaw & Senior, 2017).

Despite research documenting higher rates of substance use, medical problems, mental illness, and homelessness (LePage et al., 2016), policies often interfere with Department of Veteran Affairs services being provided to incarcerated veterans. For example, although the Department of Veteran Affairs is tasked with providing care to servicemembers, incarcerated veterans are not able to access most of these services until release. Federal and state agencies have attempted to address this gap with the implementation of the Veterans Justice Outreach (VJO) and Health Care for Reentry Veterans (HCRV) as well as veteran-specific housing units (Blue-Howells, Clark, Berk-Clark & McGuire, 2013; Tsai & Goggin, 2017).

There are identified points at which offenders contact the justice system (i.e., intercepts) that can be the focus of intervention (Munetz & Griffin, 2006). These points include pre-arrest (e.g., contact with law enforcement/emergency services), post-arrest/initial detention (e.g., arrest, pre-adjudication, initial hearings), jail/court (e.g., specialty courts, psychological evaluations), reentry (e.g., mental health services), and community corrections (e.g., probation and parole). Former servicemembers involved with the Department of Veterans Affairs receive a wide range of medical, mental health, and social support from the government. This support makes them uniquely positioned for potential interventions using this framework (Blue-Howells, Clark, Berk-Clark & McGuire, 2013). One method for decreasing the rate and associated costs of criminal justice involvement is early detection and intervention. Therefore, exploration of pre-arrest predictors warrants further study.

The literature typically explores risk factors for re-offense (i.e., post-initial contact) rather than first-time offending (i.e., Douglas, Hart, Webster, Belfrage, Guy & Wilson, 2014). The literature rarely identifies individual characteristics that predict first-time adulthood justice contact. Nonetheless, the data on risk factors for re-offense can provide a framework for the exploration of the associations between individual factors and contact with the legal system. Although research has begun to explore these factors in veterans, gaps in the literature remain. More research is needed regarding risk factors for veteran justice involvement to develop prevention programs and assist with determinations of resource allocation. Therefore, the current study identifies individual factors highlighted in the re-offense literature that may impact veteran contact with the justice system (i.e., pre-arrest predictors).

Criminogenic Risk Factors

When considering risk factors for assessing risk for future offending, there are both static/stable and dynamic/changing factors that are either specific to the individual or situational/environmental. A comprehensive assessment examines risk factors present within all domains. Broadly speaking, the domains include dispositional, historical, clinical, and contextual variables (Elbogen et al., 2010). In working with veterans, it is especially important to consider the presence or absence of risk factors during pre-service, during service, and post-service. (Elbogen, Fuller, Johnson, Brooks, Kinner, Calhoun & Beckham, 2010; Wainwright, McDonnell, Lennox, Shaw & Senior, 2016). The risk factors described below reflect some of the most robust indicators in the literature on veteran-specific risk factors. The risk factors are separated into static non-military specific factors (i.e., Sociodemographic risk factors), dynamic non-military

specific factors (i.e., Mental Health-Related risk factors), and static military specific factors (i.e., Military Specific Factors).

Sociodemographic Risk Factors

One set of factors that influences risks are an individual's sociodemographic characteristics. Various static factors such as age, education, and financial strain/socioeconomic status have been found to have negative sequala particularly regarding justice-related issues (i.e., offending, violence, and aggression; Stainbrook, Hartwell & James, 2016; May, Stives, Wells & Woods, 2016; Elbogen, Fuller, Johnson, Brooks, Kinneer, Calhoun & Beckham, 2010; (Blakey, Love Linquist, Beckham & Elbogen, 2018). The variables highlighted below represent factors that are particularly relevant for veterans in the current study.

Age. Research connects lower age with higher levels of impulsivity (e.g., Stevenson, Meares, & Comerford, 2003), aggression (e.g., Liu, Lewis & Evans, 2013), and risk for criminal offending (e.g.., Steffensmeier, Allan, Harer, & Streifel, 1989). Consistent with this literature, researchers have found that active duty military and veterans are more likely to be incarcerated or commit an aggressive act at a young age (Blakely, Love, Linquist, Beckham & Elbogen, 2017; Elbogen, Johnson Beckham, 2011 Rosellini et al., 2016; Rosellini et al. 2017). In addition, there is evidence that lower military rank, also associated with youth, is indicative of misconduct and aggression (Rosellini et al., 2016; Rosellini et al. 2017).

Education. Low levels of educational attainment are common in the offender population (Ford & Schroeder, 2011) and are often related to aggressive behavior in civilians (Elbogen, Fuller, Johnson, Brooks, Kinneer, Calhoun & Beckham, 2010).

Similarly, lower education level predicts general violence in veterans (Elbogen et al., 2010) and major physical violence in active duty soldiers (Rosellini et al., 2016).

Financial Instability. Economic disadvantage has several negative sequelae. In veterans, financial strain increases likelihood of violence/aggression (Blakey, Love Linquist, Beckham & Elbogen, 2018). In fact, Elbogen and Colleagues (2014) observed such a significant impact that they included an item assessing financial instability in their veteran-specific risk assessment screener (Elbogen et al., 2014). Financial strain appears to be a consistent predictor of violence/aggression in veterans (Blonigen et al., 2016; Elbogen, Johnson, Wagner, Sullivan, Taft & Beckham, 2014; Elbogen et al., 2010).

Mental Health-Related Risk Factors

The role of mental illness in assessing risk, specifically serious mental illness has been the subject of significant study (Elbogen, Dennis, & Johnson, 2016). Although findings are mixed, the literature suggests an examination of mental health factors is relevant in the assessment of risk. Servicemembers experience high levels of certain mental health disorders (e.g., substance use, depression, and posttraumatic stress disorder). Therefore, exploring the role of mental health disorders in this population is particularly salient.

Substance Use. Substance use is prevalent among justice-involved individuals, with rates of substance use disorders ranging from 58% to 63% (Bronson, Stroop, Zimmer & Berzofsky, 2017). Further, research has consistently described substance use as a risk factor for criminal offending and violence (e.g., Boden, Fergusson & Horwood, 2013). Consistent with non-veteran samples, veterans involved in the justice system have higher rates of substance use and related diagnoses (LePage, Bradshaw, Cipher, Crawford

& Parish-Johnson, 2016). These individuals often develop co-occurring mental health diagnoses including, PTSD, depression, and anxiety (Drug Policy Alliance, 2012). Veterans with substance use histories often have more significant legal histories and are incarcerated at higher rates (Blonigen et al., 2016). Weaver, Trafton, Kimmerling, Timko & Moos (2013) suggested substance use is one of the strongest predictors of offending in veterans. For example, 85% of individuals in a VA substance use program reported past criminality and co-occurring alcohol and drug diagnoses increase a veterans' likelihood of having a violent criminal offense (Weaver et al., 2013). Substance use is often a coping strategy for individuals with PTSD, with as many as one-third of veterans in substance use treatment meeting criteria for PTSD (Drug Policy Alliance, 2012). Given the frequent co-occurrence and the clear links between substance use and offending, there is no disputing the value of accounting for substance use in an exploration of aggressive or violent behavior (Elbogen et al., 2010).

Posttraumatic Stress Disorder. Perhaps one of the most well-known sequelae of combat exposure, the prevalence and impact of PSTD in justice-involved populations has been consistently observed in the literature both in civilian and veteran populations (Barrett, Teeson & Mills, 2014; Blakey, Love, Linquist, Beckham & Elbogen, 2018; Skarupski et al., 2016). In one study, Donley and Colleagues (2012) observed civilians with PTSD were more likely to have contact with the criminal justice system and violent charges were significantly associated with a trauma history and PTSD symptoms (Donley, Habib, Jovanovic, Kamkwalala, Evces, Egan, Bradley & Ressler, 2012). In veterans, PTSD is a well-established as a predictor of anger, aggression (verbal and physical), violence, and criminal justice involvement (Blakey, et al., 2018; Elbogen,

Johnson & Beckham, 2011; Elbogen et al., 2012; Elbogen, Johnson, Newton, Timko, Van Male, Vasterling, 2014). Although the role of PTSD cannot be refuted, the symptoms and the latent content construct elevating risk is less clear. For example, hyperarousal symptoms are consistently linked with aggression and negative outcomes while numbing and avoidance have had both a negligible and negative association with aggression depending on the sample (Elbogen et al., 2010). There is also some evidence to suggest hostility mediates the association between PTSD and aggressive behavior (Van Voorhees, Dennis, Neal, Hicks, Calhoun, Beckham & Elbogen, 2016). Regardless of the route, PTSD has been found to increase justice-related outcomes. In some cases, the risk of re-arrest increases by 1.5 (Sadeh & McNiel, 2015). Another study found individuals with PSTD have higher rates of both severe violence (20% vs. 6%) and physical aggression (48% vs. 21%) relative to veterans without PTSD (Elbogen, Johnson, Wagner, Sullivan, Taft & Beckham, 2014). These findings give credence to the continued use of PTSD as a risk factor for future aggression in veterans (Blonigen et al., 2016).

Depression. Previous research (Elbogen, Wagner, Kimbrel, Brancu, Naylor, Graziano & Crawford, 2017) identified depression as increasing odds of both suicidal and violent thoughts both independently and combined. Further, scores on the Patient Health Questionnaire (PHQ), an instrument measuring depressive symptoms, predicted aggression in a sample of post-deployment soldiers (Wilk, Quartana, Clarke-Walper, Kok & Riviere, 2015). However, it should be noted that posttraumatic stress disorder (PTSD) is associated with, and often co-occurs with depression (Elbogen, Johnson & Beckham, 2011). Further, there is evidence of a higher-order factor in the exploration of PTSD and depression (Miller et al., 2008). This connection makes it more difficult to parse out the

importance of depression above and beyond that of PTSD. Despite this, veterans with a combination of PTSD and depression are four times more likely to engage in domestic violence (Elbogen, Fuller, Johnson, Brooks, Kinneer, Calhoun & Beckham, 2010).

Military Specific Risk Factors

Researchers have explored the impact of military experiences on anger, aggression, and criminal offending (e.g., Blonigen et al., 2014; Elbogen et al., 2014; Elbogen, Johnson, & Beckham, 2011; Rosellini et al., 2017). while many of the general factors are predictive, researchers have also identified characteristics such as rank, combat exposure, and traumatic brain injury as having an impact on these outcomes (Blonigen et al., 2014; Rosellini et al., 2017). The variables identified below reflect the more robust military-specific risk factors relevant to the current study.

Combat Exposure. There is evidence to suggest civilians exposed to the atrocities of war have higher rates of violence and aggression (Hecker, Fetz, Ainamani & Elbert, 2015). In veterans, researchers have observed that many externalizing behaviors are higher following a combat tour (Wright, Foran, Wood, Eckford & McGurk, 2012). Thus, it is unsurprising that similar associations between war-time trauma (combat exposure) and aggression are found in veterans. For example, Tsai and Colleagues observed that incarcerated Operation Enduring Freedom (OEF)/Operation Iraqi Freedom (OIF)/ Operation New Dawn (OND) veterans are more likely to report combat exposure (Tsai, Rosenheck, Kasprow & McGuire, 2013b). Research in several studies of veterans has identified combat exposure as increasing risk for aggression (Elbogen, Johnson, Wagner, Sullivan, Taft & Beckham, 2014), violent thoughts (Elbogen, Wagner, Kimbrel, Brancu, Naylor, Graziano & Crawford, 2017) and violence (Sullivan & Elbogen, 2014).

There is ample research supporting the association between combat exposure and anger (Wilk, Quartana, Clarke-Walper, Kok & Riviere (2015). However, Novaco & Chemtob (2015) suggest the association between combat exposure and violence is accounted for by PTSD. Although the reason for the association is unclear, combat exposure appears to be a relevant factor in predicting the risk of criminal offending (Blonigen et al., 2016).

Traumatic Brain Injury. Physical or concussive insult to the head, often known as traumatic brain injury (TBI) is a condition with a plethora of negative sequelae. Meta-analytic findings suggest rates of TBI are significantly higher in civilian incarcerated samples (Farrer & Hedges, 2011). Although researchers have found an association between TBI and violence (O'Sullivan, Glorney, Sterr, Oddy & da Silva Ramos, 2015), direct causality between TBI and criminal offending has not been established (Durand, Chevignard, Ruet, Dereix, Jourdan & Pradat-Diehl, 2017). Research with veterans has identified TBI with loss of consciousness as a risk factor for aggression (Elbogen, Johnson, Newton, Timko, Van Male & Vasterling, 2014). In fact, in a sample of male OEF/OIF veterans, those with TBI had more physical aggression, higher levels of revenge planning, and increased urge to engage in aggression (Backhaus, Gholizadeh, Godfrey, Pittman & Afari, 2016). Although TBI appears to be a consistent predictor of violence and aggression in veterans (Blonigen et al., 2016), research with active duty soldiers suggests it is not a strong predictor of criminal offending (Rosellini et al., 2017). Regardless, the available research suggests an association between justice contact and traumatic brain injury. Therefore, any exploration of veteran legal contact should incorporate an assessment of TBI.

CHAPTER II

Current Study

As mentioned above, multiple risk factors identified in the general population have been found to predict criminal offending in veterans. The current study examined whether both general (i.e., age, education, financial difficulties, substance use, and PTSD/Depression) and veteran-specific (i.e., TBI, and combat exposure) risk factors for criminal offending are associated with criminal justice contact during the previous six months in a sample of PTSD-diagnosed veterans. This study also tested the incremental validity of veteran-specific risk factors in exploring factors associated with veteran criminal justice contact.

Hypotheses

This study explored three hypotheses using participants who reported past 6-month perpetration of a criminal or motor vehicle offense. The hypotheses are outlined below.

Hypothesis 1. General factors for criminal offending such as age, lower education level, substance use (both alcohol and drug use), financial instability, PTSD, and depression will be associated with perpetration-related contact with law enforcement.

Hypothesis 2. There is evidence linking veteran-specific factors such as combat exposure and TBI, to aggression and incarceration. Consistent with the literature, it is hypothesized these factors will be associated with perpetration-related contact with law enforcement.

Hypothesis 3. The extant literature highlights that the best prediction of military and veteran criminal justice involvement incorporates both general and specific risk

factors. It is hypothesized that veteran-specific risk factors will incrementally account for variance in contact with the justice system beyond the aforementioned general risk factors.

CHAPTER III

Method

Participants

Veterans receiving services through the Central Texas Veterans Healthcare System were recruited to participate in a study on social functioning and suicide risk. The study, Observation and Assessment of Social Interaction and Suicide (OASIS) recruited veterans through a variety of advertising mediums. Inclusion criteria included: being between age 18 and 60, enrollment in local (Veterans Health Administration) VHA, diagnosis of either PTSD or schizophrenia/schizoaffective disorder, ability to consent to research, ability to complete extended assessment battery. Exclusionary criteria included: primary diagnosis of bipolar disorder, a recent change in psychiatric medication (less than one month stabilized on medication), and imminent risk of suicide. Several participants (N = 15) were excluded for the following reasons: no PTSD diagnosis (n = 10), a diagnosis of bipolar disorder (n = 1), a recent medication change (n = 1), incomplete study participation (n = 1), and severe TBI (n = 2). The final sample of PTSD-diagnosed veterans (N = 100) was predominantly male (n = 76) with an average age of 42.85 (SD = 9.48). Although not categories were not mutually exclusive, the sample was 47% White/Caucasian, 39% Black/African American, 7% American Indian/Alaska Native, 1% Hawaiian/Pacific-Islanders, and 9% Other. Thirteen percent of the sample reported being of Hispanic/Latino descent. Over one third the sample (38%) reported earning a post-high school degree. Most participants (n = 82) reported a previous combat deployment. Information pertaining to military history is included in Table 1.

Table 1

Military History

Demographics	Mean (*SD*)/Percentage	Range
Age Enlisted (*n* = 98)	*M* = 2.33 (3.9)	17 - 33
Age Discharged (*n* = 95)	*M* = 31.73 (7.8)	18 - 50
Years Active Duty (*n* = 90)	*M* = 3.55 (3.59)	1 - 27
Years Reserves (*n* = 21)	*M* = 3.42 (4.64)	0 - 20
Years National Guard (*n* = 15)	*M* = 5.13 (3.75)	1 - 12
Mental Health Service-Connected Disability (*n* = 95)	70%	N/A
Number of Deployments (*n* = 98)	*M* = 1.92 (1.7)	0 - 12
Deployment Locations (*n* = 82)		
Afghanistan	14%	N/A
Iraq (OIF)	57%	N/A
Vietnam	1%	N/A
Desert Shield/Storm	23%	N/A
Bosnia	11%	N/A
Somalia	2%	N/A
Other	15%	N/A

Measures

Community Adjustment Form (CAF; Test et al., 1991). The CAF is a semi-structured interview encompassing contact with a range of agencies of the past year. Sections included institutionalization, employment/school, activity involvement, family contact, contact with friends, social support, socio-sexual status, legal involvement, and miscellaneous agency involvement. Modules were administered regardless of responses from previous sections. The current study used items from the legal system contact module (see Appendix A for relevant CAF section).

Demographics Questionnaire. The current study used a demographics questionnaire created for the OASIS study. The questionnaire gathered information on participant characteristics including age, gender, race/ethnicity, relationship status, education level, employment, income, and military services. Income was assessed based a six-category income bracket. The current study collapsed the groups into two categories. Participants who made $0-29,999 and those that made more than $30,000. Description of select demographic characteristics listed in the participant section. (see Appendix B for measure).

Alcohol Use Disorders Identification Test (AUDIT; Babor, Higgins-Biddle, Saunders & Monteiro, 2001). The AUDIT is a screening instrument used to identify individuals with problematic patterns of alcohol misuse. Possible scores range from 0 to 40. Scores in the current sample range from 0 to 27 (M = 5.45, *SD* = 6.15). Six percent of the sample (*n* = 6) were missing scores on the AUDIT. Mean scores were substituted to address missing data. A log transformation was performed to address the kurtotic distribution in the sample. The measure demonstrated appropriate reliability in the sample (α = .845; see Appendix C for AUDIT).

Drug Abuse Screening Test (DAST- 20; Skinner, 1982). The DAST is a 20-item self-report instrument of past or current drug use. Items assess the impact of drug use on a variety of domains including social, family, employment and medical. Items are scored 0 (absent) or 1 (present). Measure scores range from 0 to 20. Responses in the current study ranged from 0 to 18 (*M* = 2.60, *SD* = 4.33). Data for one participant was missing. The mean score was used to replace the missing value. A log transformation was performed to address the kurtotic distribution. Prior research indicates good reliability

and validity (Skinner, 1982) with acceptable internal consistency (α = .928) in the current sample (see Appendix D for DAST-20).

Posttraumatic Stress Disorder Checklist for DSM-5 (PCL-5; Weathers, Litz, Keane, Palmieri, Marx & Schnurr, 2013). The PCL-5 is a 20-item self-report measure that assesses symptoms of PTSD. Participants score items on a Likert scale from 0 to 4. Scores range from 0 to 80. In the sample, scores ranged from 11 to 80 (*M* = 45.85, *SD* = 16.91, Skew = -.138, Kurtosis = -.718). Two participants had missing data in the sample. The mean score was used to replace the missing values. The PCL-5 has been shown to have strong validity, internal consistency, and test-retest reliability in the literature (Blevins, Weathers, Davis, Witte & Domino, 2015). Reliability in this sample was within the accepted range (α = .945). The current study used a composite factor score combining the PCL-5 and BDI-II (See Appendix E for PCL-5).

Beck Depression Inventory-II (BDI-II; Beck et al., 1996). The BDI-II is a 21-item measure of current depressive symptoms. Participants rate symptoms on a Likert scale from 0 to 3. Total scores can range from 0 to 63. In the sample, scores ranged from 1 to 51 (*M* = 25.22, *SD* = 12.46, Skew = .260, Kurtosis = -.770). Eleven percent of the sample (*n* = 11) had missing values. The BDI-II item and total means replaced missing values. The BDI-II has high internal consistent and test-retest reliability in other samples (Beck et al., 1996). Reliability within the sample was within (α = .932) an acceptable range. The current study created a composite factor score using the PCL-5 and BDI-II (see Appendix F for BDI-II).

Full Combat Experiences Scale (FCES; Guyker et al., 2013). The FCES is a 34-item self-report instrument measuring potentially traumatic events related to

deployment. Scores on items range from "Never" to "10+ times." Scores in the sample ranged from 3 discrete experiences to 136 (M = 56.46, SD = 29.10, Skew = .408, Kurtosis = .230). Individuals who had no history of military deployments (n = 18) were coded as having no deployment-related traumas. The FCES was developed using data from a scale of the Deployment Risk & Resilience Inventory-2 (DRRI-2; Vogt, Smith, King & King, 2012). The DRRI scales have been well-validated with veterans from the recent conflicts (Vogt et al., 2008). Internal consistent in the sample (α = .954) was acceptable. (see Appendix G for FCES).

Traumatic Brain Injury Interview. (TBI Interview; Vasterling, 2008). The TBI interview is a clinician structured assessment that collects information on the number, recency, type of injury and sequelae of potential head injuries. Clinicians provide tentative TBI diagnoses and specify severity based on symptom endorsement. The current study used the item specifying presence of TBI (positive or negative). Individuals who denied experiencing any head injuries (i.e., not applicable data) were recoded to reflect an absence of TBI (see Appendix H).

Structured Clinical Interview for DSM-5 (SCID-5, First, Williams, Karg & Spitzer, 2015). The SCID-5 is a structured clinical interview that assesses psychopathology based on DSM-5 criteria. The current study used the PTSD module of the SCID-5 to assess the presence of a posttraumatic stress disorder diagnosis. The SCID-5 is a proprietary measure and is thus not included in the appendices.

Outcome Variable

The outcome variable for the current study was criminal justice contact over the six months preceding the administration of the aforementioned measures. A total of 35

participants endorsed criminal justice contact; however, 16 individuals reported being the victim of a crime or observing a crime in progress. These individuals were deemed qualitatively different and not included in the outcome variable. The previously described hypotheses were tested with individuals who reported any non-victim/observer contact with the criminal justice system (N = 19) in the past 6-months.

Procedures

VHA Institutional Review Board (IRB) approval was obtained by the investigators prior to OASIS data collection. As part of the OASIS study, veterans completed telephone screens with VHA personnel to assess eligibility. Individuals were then scheduled for an in-person assessment that lasted between two and three hours. Final eligibility was confirmed, and informed consent completed prior to the assessment. OASIS testing procedures included semi-structured interviews, self-report measures, and computerized social cognition measures. Local IRB approval was obtained from Sam Houston State University prior to conducting secondary analysis on OASIS data.

CHAPTER IV

Results

Missing Data and Variable Transformations

Missing data across variables was examined using the SPSS Missing data function. Mean values were subsequently substituted for the missing responses. Two participants were removed from the sample because they were missing several scores on multiple measures of interest. Two participants were missing income information. The modal response was substituted to address the missing values. All continuous variables were within acceptable range for parametric procedures with respect to skew, kurtosis, and homoscedasticity, with the exception of AUDIT (skew = 2.13, kurtosis = 3.68) and DAST-20 (skew = 1.73, kurtosis = 2.66) scores. Log 10 transformations were applied resulting in acceptable parameters for AUDIT (*M* = .637, *SD* = .396, Skew = .006, Kurtosis = -.758) and DAST-20 (*M* = .350, *SD* = .389, Skew = .936, Kurtosis = -.202).

Given the high comorbidity of depression and PTSD and evidence of a higher-order factor (Miller et al., 2008), the authors created a PTSD-depression composite. The literature on functional outcomes in veterans suggests the combination of PTSD and depressive symptomology is a more robust predictor of negative outcomes, as there is significant covariation. As supported in the literature (e.g., DeBeer et al., 2014), Principal Component Analysis (PCA) was used to create a factor using the total (summed) BDI-II score and the total (summed) PCL-5 score. The two scores were combined into a single factor, accounting for 86.14% of the variance in the measures. Component loading for both measures was .932. This composite score was used in all subsequent analyses

Preliminary Analyses

Prior to conducting the analyses for hypothesis testing a series of bivariate and point-biserial correlations were run to examine the relationship between the variables of interest. Examination of the data indicated the relationship between law enforcement contact and traumatic brain injury trended towards marginal significance (r = .193, p = .057). Similarly, the relationship between law enforcement contact and AUDIT scores also trended towards significance (r = .188, p = .064). Lastly, participant income (r = -.211, p = .037) and age (r = -.301, p = .003) were significantly related to law enforcement contact. Associations between other relevant variables were also examined (see Table 2). To remain consistent with the proposed analyses, all variables, regardless of the univariate relationship, were included for hypothesis testing. A hierarchical logistic regression was selected as the appropriate analysis to determine predictors of veteran justice contact. A logistic regression permits the inclusion of both independent interval and categorical variables.

Table 2

Pairwise Correlations between Relevant Variables

Variables	1	2	3	4	5	6	7	8
1. Age	-							
2. Income	.097	-						
3. BDI-PCL	-.077	-.105	-					
4. AUDIT	-.133	-.171	.091	-				
5. DAST	-.066	-.221*	.152	.152	-			
6. TBI	-.012	.007	-.063	.221*	.126	-		
7. Combat	-.396**	.152	.205*	.128	-.101	.231*	-	
8. Law Enforcement Contact	-.301**	-.211*	.091	.188	.087	.193	.121	-

Note. BDI-PCL = Composite score based on PCA, AUDIT = Alcohol Use Disorder Identification Test, DAST = Drug Abuse Screening Test, TBI = Presence of TBI, Combat = Rating of combat related experiences.

** $p < .05$ level (2-tailed)*
*** $p < .01$ level (2-tailed)*

Hypothesis 1: Predicting Law Enforcement Contact with General Risk Factors

To test the overall prediction of the general risk factors, law enforcement contact was regressed onto the general factors (age, income, mental health symptoms, and substance use) in the first block of a two-block hierarchical logistic regression. The identified general factors significantly predict the outcome in the overall model, χ^2 (5) = 15.052, p = .010. Result indicated that age (b = -.084, SE = 1.411, χ^2 = 6.855, p = .009) was a significant individual factor, such that younger age is associated with law enforcement contact. Although income trended towards significance (p = .119), none of the other individual predictors in the model were significant (See Table 3). Results from the Hosmer and Lemeshow Test [χ^2 (8) = 3.443, p = .904] indicate acceptable fit in the

model. Although a logistic regression does not yield an indicator of variance accounted for (i.e., r^2), Nagelkerke R^2 acts as a rough estimate. The findings from this model suggest approximately 22.7% of outcome change is accounted for in the model.

Table 3

Results of Logistic Regression Using General Factors to Predict Contact with Law Enforcement

	B	S.E.	Wald	Sig.	OR	95% CI
BDI-PCL	.172	.282	.370	.543	1.187	.683 – 2.065
DAST	.102	.723	.020	.887	1.108	.269 – 4.566
AUDIT	.960	.772	1.546	.214	2.613	.575 – 11.870
Income	.910	.584	2.432	.119	2.485	.792 – 7.798
Age	-.084	.032	6.855	.009	.920	.864 – 0.979

Note. BDI-PCL = Composite score based on PCA, AUDIT = Alcohol Use Disorder Identification Test, DAST = Drug Abuse Screening Test.

Hypothesis 2: Predicting Law Enforcement Contact with Veteran-Specific Risk Factors

To evaluate the second hypothesis (i.e., impact of veteran-specific factors), a hierarchical logistic regression, containing only the veteran-specific risk factors (TBI presence and combat exposure) was examined. Although approaching significance, the specific factors did not predict contact with law enforcement, χ^2 (2) = 5.181, p = .075. Neither history of TBI nor combat exposure was significant (see Table 4). However, the effect size (i.e., odds ratio) suggests an association such that the odds recent legal contact are five times greater for a veteran with TBI when compared to a veteran without TBI. However, the 95% confidence interval indicates both a protective and detrimental

relationship fall within the estimated true score, indicating sample characteristics and sample size make definitive conclusions impossible. The Hosmer and Lemeshow Test [χ^2 (7) = 5.555, p = .593] indicated the prediction model was appropriately suited to the data. Examination of Nagelkerke R^2 suggests that approximately 8.2% of outcome change is accounted for in the model.

Table 4

Results of Logistic Regression Using Specific Factors to Predict Contact with Law Enforcement

	B	S.E.	Wald	Sig.	OR	95% CI
TBI	1.698	1.070	2.516	.113	5.462	.670 – 44.508
Combat	.011	.014	.572	.449	.1011	.983 – 1.038

Note, TBI = Presence of TBI, Combat = Rating of combat-related experiences

Hypothesis 3: Exploring the incremental impact of Veteran-Specific Risk Factors

To examine the impact of the addition of veteran-specific risk factors over general risk, hierarchical logistic regression was used. BDI-PCL Composite, DAST, AUDIT, Income, and age were entered in the first model and TBI and combat exposure was entered in the second model. Results from model 1 were used as the basis for Hypothesis 1. The overall significance of the final model (Block 1 + Block 2) was significant, χ^2 (7) = 19.505, p = .007, Nagelkerke R^2 = .288. Further, examination of individual factors (see Table 5) indicate a continued significant ratio associated with age (b = -.095, SE = .307, χ^2 = 6.667, p = .010), such that younger age is associated with increased odds of contact with law enforcement. Additionally, income continued to trend towards significance (p = .097). Although there was a similar trend towards significance observed in TBI (p =

.077), neither specific factor (i.e., TBI and combat exposure) appeared to individually add significantly to the overall model.

Table 5

Hierarchical Logistic Regression: Final Model

	B	S.E.	Wald	Sig.	OR	95% CI
BDI-PCL	.325	.318	1.042	.307	1.384	.742 – 2.583
DAST	-.178	.776	.053	.818	.837	.183 – 3.827
AUDIT	.640	.797	.645	.422	1.896	.398 – 9.039
Income	1.007	.607	2.755	.097	2.738	.834 – 8.994
Age	-.095	.037	6.667	.010	.909	.846 – 0.977
TBI	-2.074	1.172	3.133	.077	.126	.013 – 1.249
Combat	-.013	.019	.457	.499	.987	.951 – 1.025

Note. BDI-PCL = Composite score based on PCA, AUDIT = Alcohol Use Disorder Identification Test, DAST = Drug Abuse Screening Test, TBI = Presence of TBI, Combat = Rating of combat-related experience

CHAPTER V

Discussion

The current study explored the nature of veteran legal contact in a sample of veterans diagnosed with PTSD. This study extends research suggesting both general and military-specific risk factors can help predict legal involvement in veteran samples (Blongien et al., 2014; Elbogen et al., 2010). The current findings were consistent with previous research in some respects, but were inconsistent with previous finding in other respects, highlighting several areas for additional research.

Examination of associations between variables of interested provided some interesting insight into veteran characteristics and functioning. An inverse association between age and combat exposure was observed in the sample. This relation can be explained by the high rates of combat exposure experienced in the early years of the Iraq and Afghanistan war. A large proportion of the sample reported deployments within this window and likely were exposed to many traumatic wartime experiences. Similarly, the association between combat exposure and TBI can be explained by wartime experiences, as many service members have returned from deployments with head injuries (Terrio et al., 2009). Further, the mental health composite was positively associated with combat exposure, showing increasing combat experiences were associated with affective distress and posttraumatic stress symptoms. Lastly, there was an inverse relationship between drug abuse and income. This finding suggests individuals more likely to experience problematic drug use reported lower income. These findings, although not the focus of the paper, provide additional insight into the functioning of military veterans.

Are General Risk Factors Associated with Justice Contact among Veterans with PTSD?

The first hypothesis, the impact of general risk factors for violence and legal involvement was partially supported. That is, age and income were individually associated with legal contact while mental health symptoms (depression-PTSD composite), alcohol use, and drug use were unrelated. Moreover, when these variables were examined in combination, although the overall model was significant, only age was individually associated with legal involvement. Specifically, age was inversely associated with legal involvement; younger veterans were more likely than older veterans to have had contact with the criminal justice system as the perpetrator of a crime over the preceding six months. The significance of the total model is consistent with the literature on general offenders (Otto & Douglas, 2010) and the literature with veteran-offenders (Blonigen et al., 2016). However, the lack of individual value of highly relevant factors (e.g., PTSD symptoms, drug use, and alcohol use) was surprising.

Across crime types, rates of offending decrease as individuals age (Sampson & Laub, 2003). The association between younger age and higher risk of violence and offending has been routinely observed in the risk assessment literature (Heilbrun, 2009). Similarly, lower age is also a risk factor for perpetrating sexual violence and recidivism (Phenix, Fernandez, Harris, Helmus, Hanson & Thornton, 2016). The increased odds of justice contact for younger veterans in the current study highlights the pervasive nature of this risk factor across contexts.

There is extensive research suggesting PTSD is associated with justice involvement (Blakey, et al., 2018; Elbogen et al., 2012; Elbogen et al., 2014). However,

these studies often encompass individuals without PTSD diagnoses. All participants in the current sample were SCID-5 diagnosed with PTSD. Thus, the underlying psychopathology was present in all participants. Moreover, as all individuals met diagnostic criteria for PTSD, scores reflected general symptom distress from the past two weeks (BDI) and month (PCL-5) respectively. The symptoms endorsement may not accurately represent symptoms experienced at the time of legal contact. Therefore, it is possible the diagnostic homogeneity of the sample influenced the impact of this variable.

The non-significance of both alcohol and drug use may also be partially attributed to sample characteristics. The mean scores for both measures placed participants in the lowest substance use risk categories. Therefore, there was an overabundance of low-risk substance use. Specifically, most of the veterans in the sample did not report substance use problems. In a VA newly enrolled patient healthcare sample, approximately 11% of veterans met criteria for an alcohol, drug use, or co-occurring substance use disorder (Seal, Cohen, Waldrop, Cohen, Maguen, & Ren, 2011). However, contextualizing substance use rates within a combat PTSD sample of Vietnam era veterans, 74% also met criteria for a substance use disorder (Kulka et al., 1990). The low rates of problematic alcohol use (75% low risk or below) and drug use (86% low risk or below) in the current sample may have decreased the strength of the association between legal contact and substance use.

Income was associated with legal contact at a univariate level, such that lower income was associated with a greater chance of contact with the legal system. However, this association was not significant in subsequent analyses. The lack of individual impact,

although surprising, may stem from the sample size, or the dichotomous nature of the variable.

Are Veteran-Specific Risk Factors Associated with Justice Contact among Veterans with PTSD?

The hypothesis that veteran-specific factors would be able to predict justice contact was unsupported. These findings are largely inconsistent with the literature. Specifically, the role of combat exposure (Elbogen, et al., 2017; Sullivan & Elbogen, 2014) and TBI (Blonigen et al., 2016) as risk factors are documented. It is hypothesized the lack of significance can be attributed to specific sample characteristics. There is an established association between PTSD and combat exposure (Blonigen et al., 2016). As the current sample was exclusively PTSD-diagnosed veterans, this may have acted as a confound. Additionally, veterans with TBI are at an increased risk for PTSD (Stein et al., 2015). The current sample was comprised of PTSD-diagnosed veterans, with high rates of TBI (77%). Studies on TBI in VHA samples of veterans range from 22.8% to 45% (Brenner et al., 2013; Terrio et al., 2009). Therefore, there may have been insufficient heterogeneity in PTSD, combat exposure, and TBI in the current sample to detect an effect.

Do Veteran-Specific Risk Factors Account for Justice Contact Beyond General Risk Factors?

While veteran-specific risk factors were associated with justice involvement in the univariate analyses, they did not incrementally account for variance in justice contact when combined with the general risk factors.

Implications

The present study contributes to a growing body of literature on veteran-related legal system involvement. These findings are particularly relevant for case management and systems interventions. VHA case management personnel are tasked with managing a significant number of high-risk veterans. Personnel managing criminal justice involvement should be aware that younger veterans with PTSD are more likely to be coming into contact with the legal system. Additionally, study findings support the use of criminogenic psychosocial interventions with young PTSD-diagnosed veterans. Although there are a range of potential treatments (e.g., Moral Reconation Therapy), widespread implementation of these interventions has not been undertaken by the VHA (Blonigen et al., 2018).

Limitations

The study has several specific and general limitations. First, the data used for this study was part of an existing study on suicide risk and social functioning. Legal or criminal justice contact was one component of social functioning examined in the larger study (i.e., OASIS). This project represented secondary data analysis. There are additional variables relevant to criminal justice involvement (e.g., psychopathy, antisocial associates, childhood conduct problems) that were not included in the parent study. The outcome variable in the current study (i.e., contact with criminal justice) was part of an instrument measuring legal functioning. The information collected did not reflect an exhaustive list of legal contact or include anything that had occurred greater than six months prior. Therefore, the reported percentage of individuals with perpetrating contact (19%) did not reflect lifetime rates and is likely an underrepresentation of the true legal

contact in the sample. Rates of legal contact in the current sample are higher than arrest rates observed in other samples (Elbogen et al., 2012). The higher rate is likely due to differing definitions (e.g., contact vs. arrest).

In addition to the above-mentioned limitations, there are several broader concerns. The rate of veteran justice involvement is still relatively low. There are many methodological concerns with predicting low base-rate phenomenon. Many of the existing studies attempt to mitigate this concern by using large samples (e.g., Roselini et al., 2016). Many of the risk factors identified in the extant literature were identified in heterogeneous samples (e.g., large epidemiology samples). The current study had strict inclusion/exclusion criteria consistent with the parent-study objectives. These criteria may have decreased the heterogeneity in some of the variables of interest.

Future Research

The findings in the current study highlight several areas of future inquiry. Future research should focus on how to better predict legal involvement with PTSD-diagnosed veterans. Much of the current literature (i.e., Elbogen et al., 2012) focuses on a more heterogeneous sample of veterans. Nevertheless, understanding specific groups of veterans (i.e., those with PTSD) is highly relevant. As was observed in the current study, although PTSD has previously been identified as a risk factor (see. Blonigen et al., 2016), not all individuals with PTSD will have contact with the justice system. Further, prediction based on PTSD symptoms is insufficient in such a homogeneous sample. Future studies should examine both the role of criminal justice characteristics such as psychopathy, antisocial peers, and the impact of broader traits such as impulsivity in samples of veterans with PTSD.

Conclusions

The current study highlights that a significant portion of veterans experience recent contact with the legal system. Although not all hypotheses were confirmed, there is further evidence that individual demographic characteristics can help identify veterans at greatest risk for contact with the legal system. Future research should elucidate specific risk factors for justice contact in veterans with PTSD. Researchers and policymakers armed with a thorough understanding of veteran justice involvement can enact systemic changes for the early detection and prevention of veteran legal involvement and recidivism.

REFERENCES

Backhaus, A. a., Gholizadeh, S. s., Godfrey, K. k., Pittman, J. j., & Afari, N. n. (2016). The many wounds of war: The association of service-related and clinical characteristics with problems with the law in Iraq and Afghanistan veterans. *International Journal Of Law & Psychiatry*, *49*205-213.

Barrett, E. L., Teesson, M., & Mills, K. L. (2014). Associations between substance use, post-traumatic stress disorder and the perpetration of violence: A longitudinal investigation. *Addictive Behaviors*, *39*(6), 1075-1080. doi:10.1016/j.addbeh.2014.03.003

Blakey, S. M., Love, H., Lindquist, L., Beckham, J. C., & Elbogen, E. B. (2018). Disentangling the link between posttraumatic stress disorder and violent behavior: Findings from a nationally representative sample. *Journal Of Consulting And Clinical Psychology*, *86*(2), 169-178. doi:10.1037/ccp0000253

Blevins, C. A., Weathers, F. W., Davis, M. T., Witte, T. K., & Domino, J. L. (2015). The Posttraumatic Stress Disorder Checklist for *DSM-5* (PCL-5): Development and initial psychometric evaluation. *Journal of Traumatic Stress, 28*, 489-498. doi: 10.1002/jts.22059

Blonigen, D. M., Bui, L., Elbogen, E. B., Blodgett, J. C., Maisel, N. C., Midboe, A. M., & ... Timko, C. (2016). Risk of Recidivism Among Justice-Involved Veterans. *Criminal Justice Policy Review*, *27*(8), 812-837. doi:10.1177/0887403414562602

Blonigen, D. M., Rodriguez, A. L., Manfredi, L., Nevedal, A., Rosenthal, J., McGuire, J. F., & ... Timko, C. (2018). Cognitive–behavioral treatments for criminogenic

thinking: Barriers and facilitators to implementation within the Veterans Health Administration. *Psychological Services, 15*(1), 87-97. doi:10.1037/ser0000128

Blue-Howells, J. H., Clark, S. C., van den Berk-Clark, C., & McGuire, J. F. (2013). The U.S. Department of Veterans Affairs Veterans Justice programs and the sequential intercept model: case examples in national dissemination of intervention for justice-involved veterans. *Psychological Services, 10*(1), 48-53. doi:10.1037/a0029652

Boden, J. M., Fergusson, D. M., & Horwood, L. J. (2013). Alcohol misuse and criminal offending: Findings from a 30-year longitudinal study. *Drug And Alcohol Dependence, 128*(1-2), 30-36. doi:10.1016/j.drugalcdep.2012.07.014

Brenner, L. A., Homaifar, B. Y., Olson-Madden, J. H., Nagamoto, H. T., Huggins, J., Schneider, A. L., … Corrigan, J. D. (2013). Prevalence and screening of traumatic brain injury among veterans seeking mental health services. *The Journal of Head Trauma Rehabilitation, 28*(1), 21–30. https://doi-org.ezproxy.shsu.edu/10.1097/HTR.0b013e31827df0b5

Bronson, J., Carson, E.A., Noonan, M., & Berzofsky, M. (2015). *Veterans in prison and jail* (NCJ 249144). Retrieved from http://www.bjs.gov/index.cfm?ty=pbdetail&iid=5479

Bronson, J., Stroop J., Zimmer, S., & Berzofsky, M. (2017). *Drug Use, Dependence, and Abuse Among State Prisoners and Jail Inmates, 2007-2009* (NCJ 250546). Retrieved from http://www.bjs.gov/index.cfm?ty=pbdetail&iid=5966

DeBeer, B. B., Kimbrel, N. A., Meyer, E. C., Gulliver, S. B., & Morissette, S. B. (2014). Combined PTSD and depressive symptoms interact with post-deployment social

support to predict suicidal ideation in Operation Enduring Freedom and Operation Iraqi Freedom veterans. *Psychiatry Research, 216*(3), 357-362. doi:10.1016/j.psychres.2014.02.010

Drug Policy Alliance (2012). *Healing a Broken System: Veterans and the War on Drugs*. Retrieved from http://www.drugpolicy.org/resource/healing-broken-system-veterans-and-war-drugs

Donley, S., Habib, L., Jovanovic, T., Kamkwalala, A., Evces, M., Egan, G., & ... Ressler, K. J. (2012). Civilian PTSD symptoms and risk for involvement in the criminal justice system. *Journal Of The American Academy Of Psychiatry And The Law*, *40*(4), 522-529.

Douglas, K. S., Hart, S. D., Webster, C. D., Belfrage, H. Guy, L. S., & Wilson, C. M. (2014). Historical-Clinical-Risk Management-20, Version 3 (HCR-20V3): Development and overview. *International Journal of Forensic Mental Health, 13*, 93-108. doi:10.1080/14999013.2014.906519

Durand, E., Chevignard, M., Ruet, A., Dereix, A., Jourdan, C., & Pradat-Diehl, P. (2017). History of traumatic brain injury in prison populations: A systematic review. *Annals Of Physical And Rehabilitation Medicine*, *60*(2), 95-101. doi:10.1016/j.rehab.2017.02.003

Elbogen, E. B., Cueva, M., Wagner, H. R., Sreenivasan, S., Brancu, M., Beckham, J. C., & Van Male, L. (2014). Screening for violence risk in military veterans: predictive validity of a brief clinical tool. *The American Journal Of Psychiatry*, *171*(7), 749-757. doi:10.1176/appi.ajp.2014.13101316

Elbogen, E. B., Dennis, P. A., & Johnson, S. C. (2016). Beyond mental illness: Targeting stronger and more direct pathways to violence. *Clinical Psychological Science*, *4*(5), 747-759. doi:10.1177/2167702615619363

Elbogen, E. B., Fuller, S., Johnson, S. C., Brooks, S., Kinneer, P., Calhoun, P. S., & Beckham, J. C. (2010). Improving risk assessment of violence among military veterans: an evidence-based approach for clinical decision-making. *Clinical Psychology Review*, *30*(6), 595-607. doi:10.1016/j.cpr.2010.03.009

Elbogen, E. B., Johnson, S. C., & Beckham, J. C. (2011). Anger, aggression, and violence. In B. A. Moore, W. E. Penk, B. A. Moore, W. E. Penk (Eds.) , *Treating PTSD in military personnel: A clinical handbook* (pp. 305-324). New York, NY, US: Guilford Press.

Elbogen, E. B., Johnson, S. C., Newton, V. M., Straits-Troster, K., Vasterling, J. J., Wagner, H. R., & Beckham, J. C. (2012). Criminal justice involvement, trauma, and negative affect in Iraq and Afghanistan war era veterans. *Journal Of Consulting And Clinical Psychology*, *80*(6), 1097-1102. doi:10.1037/a0029967

Elbogen, E. B., Johnson, S. C., Newton, V. M., Timko, C., Vasterling, J. J., Van Male, L. M., & ... Beckham, J. C. (2014). Protective mechanisms and prevention of violence and aggression in veterans. *Psychological Services*, *11*(2), 220-228. doi:10.1037/a0035088

Elbogen, E. B., Johnson, S. C., Wagner, H. R., Sullivan, C., Taft, C. T., & Beckham, J. C. (2014). Violent behaviour and post-traumatic stress disorder in US Iraq and Afghanistan veterans. *The British Journal Of Psychiatry*, *204*(5), 368-375. doi:10.1192/bjp.bp.113.134627

Elbogen, E. B., Wagner, H. R., Kimbrel, N. A., Brancu, M., Naylor, J., Graziano, R., & Crawford, E. (2017). Risk Factors for Concurrent Suicidal Ideation and Violent Impulses in Military Veterans. *Psychological Assessment*, doi:10.1037/pas0000490

Farrer, T. J., & Hedges, D. W. (2011). Prevalence of traumatic brain injury in incarcerated groups compared to the general population: A meta-analysis. *Progress In Neuro-Psychopharmacology & Biological Psychiatry*, *35*(2), 390-394. doi:10.1016/j.pnpbp.2011.01.007

Ford, J. A., & Schroeder, R. D. (2011). Higher education and criminal offending over the life course. *Sociological Spectrum*, *31*(1), 32-58. doi:10.1080/02732173.2011.525695

Hecker, T., Fetz, S., Ainamani, H., & Elbert, T. (2015). The cycle of violence: Associations between exposure to violence, trauma-related symptoms and aggression—Findings from Congolese refugees in Uganda. *Journal Of Traumatic Stress*, *28*(5), 448-455. doi:10.1002/jts.22046

Heilbrun, K. (2009). *Evaluation for risk of violence in adults*. New York, NY: Oxford University Press.

Kaeble, D., & Glaze, L., (2016). *Correctional Populations in the United States, 2015* (NCJ 250374). Retrieved from http://www.bjs.gov/index.cfm?ty=pbdetail&iid=5870

Lange, S., Rehm, J., & Popova, S. (2011). The effectiveness of criminal justice diversion initiatives in North America: A systematic literature review. *The International*

Journal Of Forensic Mental Health, *10*(3), 200-214. doi:10.1080/14999013.2011.598218

Kulka, R. A., Schlenger, W. E., Fairbank, J. A., Hough, R. L., Jordan, B. K., Marmar, C. R., & Weiss, D. S. (1990). *Trauma and the Vietnam war generation: Report of findings from the National Vietnam Veterans Readjustment Study*. Philadelphia, PA: Brunner/Mazel.

LePage, J. P., Bradshaw, L. D., Cipher, D. J., Crawford, A. M., & Parish-Johnson, J. A. (2016). The association between recent incarceration and inpatient resource use and death rates: evaluation of a US veteran sample. *Public Health*, *134*109-113. doi:10.1016/j.puhe.2016.01.009

Liu, J., Lewis, G., & Evans, L. (2013). Understanding aggressive behaviour across the lifespan. *Journal Of Psychiatric And Mental Health Nursing*, *20*(2), 156-168.

Lurigio, A. J., & Harris, A. J. (2009). Mental illness, violence, and risk assessment: An evidence-based review. *Victims & Offenders*, *4*(4), 341-347. doi:10.1080/15564880903260561

May, D. C., Stives, K. L., Wells, M. J., & Wood, P. B. (2017). Does Military Service Make the Experience of Prison Less Painful? Voices From Incarcerated Veterans. *Criminal Justice Policy Review*, *28*(8), 770-789. doi:10.1177/0887403416628600

McLaughlin, M., Pettus-Davis, C., Brown, D., Veeh, C., Renn, T, (2016) *The Economic Burden of Incarceration in the U.S.* Working Paper #AJI072016. Institute for Advancing Justice Research and Innovation

Miller, M. W., Fogler, J. M., Wolf, E. J., Kaloupek, D. G., & Keane, T. M. (2008). The internalizing and externalizing structure of psychiatric comorbidity in combat veterans. *Journal Of Traumatic Stress, 21*(1), 58-65. doi:10.1002/jts.20303

Novaco, R. W., & Chemtob, C. M. (2015). Violence associated with combat-related posttraumatic stress disorder: The importance of anger. *Psychological Trauma: Theory, Research, Practice, And Policy, 7*(5), 485-492. doi:10.1037/tra0000067

Otto, R. K., & Douglas, K. S. (2010). *Handbook of violence risk assessment*. New York, NY: Routledge/Taylor & Francis Group.

Oster, C., Morello, A., Venning, A., Redpath, P., & Lawn, S. (2017). The health and wellbeing needs of veterans: A rapid review. *BMC Psychiatry, 17*doi:10.1186/s12888-017-1547-0

O'Sullivan, M., Glorney, E., Sterr, A., Oddy, M., & da Silva Ramos, S. (2015). Traumatic brain injury and violent behavior in females: A systematic review. *Aggression And Violent Behavior, 25*(Part A), 54-64. doi:10.1016/j.avb.2015.07.006

Phenix, A., Fernandez, Y., Harris, A. J. R., Helmus, M., Hanson, K., R., & Thornton, D. (2016). *Static-99R coding rules: Revised 2016.* Ottawa, Canada: Department of the Solicitor General of Canada

Rosellini, A. J., Monahan, J., Street, A. E., Hill, E. D., Petukhova, M., Reis, B. Y., & ... Kessler, R. C. (2017). Using administrative data to identify U.S. Army soldiers at high-risk of perpetrating minor violent crimes. *Journal Of Psychiatric Research, 84*128-136. doi:10.1016/j.jpsychires.2016.09.028

Rosellini, A. J., Monahan, J., Street, A. E., Heeringa, S. G., Hill, E. D., Petukhova, M., & ... Kessler, R. C. (2016). Predicting non-familial major physical violent crime

perpetration in the US Army from administrative data. *Psychological Medicine, 46*(2), 303-316. doi:10.1017/S0033291715001774

Sadeh, N., & McNiel, D. E. (2015). Posttraumatic stress disorder increases risk of criminal recidivism among justice-involved persons with mental disorders. *Criminal Justice and Behavior, 42*(6), 573-586. doi:10.1177/0093854814556880Sampson, R. J., & Laub, J. H. (2003). Life-course desisters? Trajectories of crime among delinquent boys followed to age 70. *Criminology*, *41*(3), 555-592.

Seal, K. H., Cohen, G., Waldrop, A., Cohen, B. E., Maguen, S., & Ren, L. (2011). Substance use disorders in Iraq and Afghanistan veterans in VA healthcare, 2001–2010: Implications for screening, diagnosis and treatment. *Drug And Alcohol Dependence*, *116*(1-3), 93-101. doi:10.1016/j.drugalcdep.2010.11.027

Seal, K. H., Metzler, T. J., Gima, K. S., Bertenthal, D., Maguen, S., & Marmar, C. R. (2009). Trends and risk factors for mental health diagnoses among Iraq and Afghanistan veterans using Department of Veterans Affairs health care, 2002–2008. *American Journal Of Public Health*, *99*(9), 1651-1658. doi:10.2105/AJPH.2008.150284

Skarupski, K. A., Parisi, J. M., Thorpe, R., Tanner, E., & Gross, D. (2016). The association of adverse childhood experiences with mid-life depressive symptoms and quality of life among incarcerated males: Exploring multiple mediation. *Aging & Mental Health, 20*(6), 655-666. doi:10.1080/13607863.2015.1033681

Stainbrook, K., Hartwell, S., & James, A. (2016). Female Veterans in Jail Diversion Programs: Differences From and Similarities to Their Male Peers. *Psychiatric Services (Washington, D.C.), 67*(1), 133-136. doi:10.1176/appi.ps.201400442

Steffensmeier, D. J., Allan, E. A., Harer, M. D., & Streifel, C. (1989). Age and the distribution of crime. *American Journal Of Sociology, 94*(4), 803-831. doi:10.1086/229069

Stein, M. B., Kessler, R. C., Heeringa, S. G., Jain, S., Campbell-Sills, L., Colpe, L. J., & ... Ursano, R. J. (2015). Prospective longitudinal evaluation of the effect of deployment-acquired traumatic brain injury on posttraumatic stress and related disorders: Results from the Army Study to Assess Risk and Resilience in Servicemembers (Army STARRS). *The American Journal Of Psychiatry, 172*(11), 1101-1111. doi:10.1176/appi.ajp.2015.14121572

Stevenson, J., Meares, R., & Comerford, A. (2003). Diminished impulsivity in older patients with borderline personality disorder. *The American Journal Of Psychiatry, 160*(1), 165-166. doi:10.1176/appi.ajp.160.1.165

Sullivan, C. P., & Elbogen, E. B. (2014). PTSD symptoms and family versus stranger violence in Iraq and Afghanistan veterans. *Law And Human Behavior, 38*(1), 1-9. doi:10.1037/lhb0000035

Terrio, H., Brenner, L. A., Ivins, B. J., Cho, J. M., Helmick, K., Schwab, K., … Warden, D. (2009). Traumatic brain injury screening: Preliminary findings in a US Army brigade combat team. *The Journal of Head Trauma Rehabilitation, 24*(1), 14–23. https://doi-org.ezproxy.shsu.edu/10.1097/HTR.0b013e31819581d8

Tsai, J., & Goggin, E. (2017). Characteristics, needs, and experiences of U.S. veterans on a specialized prison unit. *Evaluation & Program Planning*, *64*44-48. doi:10.1016/j.evalprogplan.2017.05.016

Tsai, J., & Rosenheck, R. A. (2013). Homeless veterans in supported housing: Exploring the impact of criminal history. *Psychological Services*, *10*(4), 452–458. https://doi-org.ezproxy.shsu.edu/10.1037/a0032775

Tsai, J., Rosenheck, R. A., Kasprow, W. J., & McGuire, J. F. (2013a). Risk of incarceration and clinical characteristics of incarcerated veterans by race/ethnicity. *Social Psychiatry And Psychiatric Epidemiology*, *48*(11), 1777-1786. doi:10.1007/s00127-013-0677-z

Tsai, J., Rosenheck, R. A., J Kasprow, W., & McGuire, J. F. (2013b). Risk of incarceration and other characteristics of Iraq and Afghanistan era veterans in state and federal prisons. *Psychiatric Services (Washington, D.C.)*, *64*(1), 36-43. doi:10.1176/appi.ps.201200188

Van Voorhees, E. E., Dennis, P. A., Neal, L. C., Hicks, T. A., Calhoun, P. S., Beckham, J. C., & Elbogen, E. B. (2016). Posttraumatic stress disorder, hostile cognitions, and aggression in Iraq/Afghanistan era veterans. *Psychiatry: Interpersonal And Biological Processes*, *79*(1), 70-84. doi:10.1080/00332747.2015.1123593

Wainwright, V., Lennox, C., McDonnell, S., Shaw, J., & Senior, J. (2017). Offending Characteristics of Male Ex-Armed Forces Personnel in Prison. *Howard Journal Of Crime & Justice*, *56*(1), 19-33. doi:10.1111/hojo.12189

Wainwright, V., McDonnell, S., Lennox, C., Shaw, J., & Senior, J. (2016). Soldier, civilian, criminal: identifying pathways to offending of ex-armed forces personnel in prison. *Psychology, Crime & Law*, *22*(8), 741-757.

Weaver, C. M., Trafton, J. A., Kimerling, R., Timko, C., & Moos, R. (2013). Prevalence and nature of criminal offending in a national sample of veterans in VA substance use treatment prior to the Operation Enduring Freedom/Operation Iraqi Freedom conflicts. *Psychological Services, 10*(1), 54-65. doi:10.1037/a0030504

Wilk, J. E., Quartana, P. J., Clarke-Walper, K., Kok, B. C., & Riviere, L. A. (2015). Aggression in US soldiers post-deployment: Associations with combat exposure and PTSD and the moderating role of trait anger. *Aggressive Behavior, 41*(6), 556-565. doi:10.1002/ab.21595

Wright, K. M., Foran, H. M., Wood, M. D., Eckford, R. D., & McGurk, D. (2012). Alcohol problems, aggression, and other externalizing behaviors after return from deployment: Understanding the role of combat exposure, internalizing symptoms, and social environment. *Journal Of Clinical Psychology*, *68*(7), 782-800. doi:10.1002/jclp.21864

APPENDIX A

Community Adjustment Form (CAF; Select items)

11. Legal

A. *"Have you had any **contact with the police** in the last **6 months**?"*

	What happened:	**Dates:**	**Which Police Department:**	**Jailed: (Dates)**	**Charged:**
Instance 1					
Instance 2					
Instance 3					
Instance 4					
Instance 5					
Instance 6					

B. *"Have you had any **court appearances** in the last **6 months**?"*

	Charges:	**What happened to charges: (outcome)**	**Sentences:**	**For traffic violations: (speeding, etc.)**	**What happened: (outcome: fined, dropped)**	**Other charges: (charges pending?)**
Instance 1						
Instance 2						
Instance 3						
Instance 4						

APPENDIX B

Demographics Questionnaire

What is your gender?

O Female O Male O Transgender (F to M) O Transgender (M to F)

How old are you? _____ years

What is your month and year of birth (MM/YYYY)? _____/_____

Which of the following best describes your <u>current</u> relationship status?

O Single, not dating	O Engaged to be married	O Married, separated
O Single, in casual relationship	O Married, living with spouse	O Divorced
O Single, in serious relationship	O Married, geographically separated	O Widowed

Do you currently live with your intimate/romantic partner?

O No O Yes O Not applicable (not currently in intimate/romantic relationship)

Which of the following best describes your highest level of education?

O some High School	O High School Diploma or GED	O some College, no degree
O Associates Degree	O Technical School Certification	O Bachelor's Degree
O some Graduate School	O Graduate Degree (please specify): _____	

How many years of education have you <u>completed</u>? _____
(Note: HS/GED = 12; AA = 14; BA/BS = 16; MA/MS = 18) years

Which of the following best describes your <u>current</u> employment status (check all that apply)?

O Employed (Full-Time)	O Employed (Part-Time)	O Disabled	O Retired
O Full-Time Student	O Full-Time Homemaker	O Unemployed (looking for work)	

O Unemployed (not actively looking for work)

On average, how many hours per week have you worked in the last 3 months? _____ hours

What is your current (or most recent if not currently employed) occupation?

_____

What is your current annual income (last 12 months)?

O $0 - $14,999 O $15,000 - $29,999 O $30,000 - $44,999 O $45,000 - $59,999
O $60,000 - $74,999 O $75,000 - $89,999 O $90,000 or higher

Are you Hispanic/Latino? O No O Yes (please specify below, select all that apply)

O Cuban O Dominican O Mexican/Mexican American/Chicano O Puerto Rican
O Spanish/Basque O other (please specify): _____

What is your Race? (please select all that apply)

O American Indian or Alaska Native
O Asian or Asian-American
O Black or African-American
O Native Hawaiian or other Pacific Islander
O White or Caucasian
O Other (please specify): _____

1. When did you enlist in the military? _____ Age
Date: _____/_____*(month/year)*

2. In which branch(es) of the military did you serve? (select all that apply)
O Air Force O Army O Marine Corps O National Guard O Navy

3. How long have you served in the military? Please complete the table below:

			Years	Months
Active Duty	O YES	O NO		
Reserves	O YES	O NO		
National Guard	O YES	O NO		

4. When were you discharged from the military?_____ Age

Date: _____/_____ *(month/year)*

5. Was there a period of time in between your original enlistment and final discharge dates listed above that you were not in the military (i.e., did you re-enlist after taking time off)?

O NO O YES – how long? _____ Years & _____ Months

6. What is your discharge status? (select all that apply)

O Honorable O General O Medical O Retired O Dishonorable

O Other (please specify): _____

7. What was your discharge rank?

O E1-E4 O E5-E6 O E7-E9 O O1-O3 O O4-O9 O WO1-WO5

8a. Have you ever been deployed? If no, skip to question 13

8b. How many times were you deployed? _____

9. To what military theatres/countries/war zones were you deployed to?

(select all that apply)

O Afghanistan O Iraq O Vietnam O Desert Storm/Shield

O Bosnia O Somalia O Others (please specify): _____

10. Please list dates (month/year) and areas of deployment below (if more than 6, continue on back of form):

Deployment #1: Left: ____/____ Returned: ____/____

Country(ies):_____

Deployment #2: Left: ____/____ Returned: ____/____

Country(ies):_____

Deployment #3: Left: ____/____ Returned: ____/____

Country(ies):_____

Deployment #4: Left: ____/____ Returned: ____/____

Country(ies):_____

Deployment #5: Left: ____/____ Returned: ____/____

Country(ies):_____

Deployment #6: Left: ____/____ Returned: ____/____

Country(ies):_____

13. Have you been granted a Physical Service-Connected disability?

O No O Yes _____ %

14. Have you been granted a Mental Health Service-Connected disability?

O No O Yes _____ %

15. Are you currently seeking a Service-Connected disability?

O No O Yes

APPENDIX C

AUDIT

INSTRUCTIONS: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential so please be honest. Fill in the circle that best describes your answer to each question

		Never	Monthly or less	2-4 per month	2-3 times per week	4+ times a week
1.	How often do you have a drink containing alcohol?	O	O	O	O	O

		1 or 2	3 or 4	5 or 6	7 to 9	10 or more
2.	How many drinks containing alcohol do you have on a typical day when you are drinking?	O	O	O	O	O

		Never	Less than monthly	Monthly	Weekly	Daily or almost daily
3.	How often do you have six or more drinks on one occasion?	O	O	O	O	O
4.	How often during the last year have you found that you were not able to stop drinking once you started?	O	O	O	O	O
5.	How often during the last year have you failed to do what was	O	O	O	O	O

	normally expected of you because of drinking?					
6.	How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	O	O	O	O	O
7.	How often during the last year have you had a feeling of guilt or remorse after drinking?	O	O	O	O	O
8.	How often during the last year have you been unable to remember what happened the night before because of your drinking?	O	O	O	O	O

		No	**Yes, but not in the last year**	**Yes, during the last year**
9.	Have you or someone else been injured because of your drinking?	O	O	O
10.	Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	O	O	O

APPENDIX D

DAST-20

INSTRUCTIONS: The following questions concern information about your involvement and abuse of drugs. Drug abuse refers to (1) the use of prescribed or "over the counter" drugs in excess of the directions and (2) any non-medical use of drugs. Carefully read each statement and decide whether your answer is yes or no, then fill in the appropriate bubble.

In the **PAST YEAR**, …

		No	Yes
1.	Have you used drugs other than those required for medical reasons?	O	O
2.	Have you abused prescription drugs?	O	O
3.	Did you abuse more than one drug at a time?	O	O
4.	Could you get through the week without using drugs (other than those required for medical reasons)?	O	O
5.	Were you always able to stop using drugs when you want to?	O	O
6.	Did you have "blackouts" or "flashbacks" as a result of drug use?	O	O
7.	Did you feel bad about your drug abuse?	O	O
8.	Did your spouse (or parents) complain about your involvement with drugs?	O	O
9.	Did drug abuse create problems between you and your spouse or your parents?	O	O
10.	Did you lose friends because of your use of drugs?	O	O
11.	Did you neglect your family or missed work because of your use of drugs?	O	O
12.	Did you get into trouble at work because of drug abuse?	O	O
13.	Did you lose a job because of drug abuse?	O	O
14.	Did you get into fights when under the influence of drugs?	O	O
15.	Did you engage in illegal activities to obtain drugs?	O	O
16.	Did you get arrested for possession of illegal drugs?	O	O
17.	Did you experience withdrawal symptoms (felt sick) when you stopped taking drugs?	O	O
18.	Did you have any medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?	O	O
19.	Did you go to anyone for help for a drug problem?	O	O
20.	Did you get involved in a treatment program specifically related to drug use?	O	O

APPENDIX E

PCL-5

INSTRUCTIONS: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

		Not at all	**A little bit**	**Moderately**	**Quite a bit**	**Extremely**
1.	Repeated, disturbing, and unwanted memories of the stressful experience?	O	O	O	O	O
2.	Repeated, disturbing dreams of the stressful experience?	O	O	O	O	O
3.	Suddenly feeling or acting as if the stressful experience were actually happening again *(as if you were actually back there reliving it)?*	O	O	O	O	O
4.	Feeling very upset when something reminded you of the stressful experience?	O	O	O	O	O
5.	Having strong physical reactions when something reminded you of the stressful experience *(for example, heart pounding, trouble breathing, sweating)?*	O	O	O	O	O
6.	Avoiding memories, thoughts, or feelings related to the stressful experience	O	O	O	O	O
7.	Avoiding external reminders of the stressful experience *(for example, people, places, conversations, activities, objects, or situations)?*	O	O	O	O	O
8.	Trouble remembering important parts of the stressful experience?	O	O	O	O	O

9.	Having strong negative beliefs about yourself, other people, or the world *(for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?*	O	O	O	O	O	
10.	Blaming yourself or someone else for the stressful experience or what happened after it?	O	O	O		O	O
11.	Having strong negative feelings such as fear, horror, anger, guilt, or shame?	O	O	O	O	O	
12.	Loss of interest inactivities that you used to enjoy?	O	O	O	O	O	
13.	Feeling distant or cut off from other people?	O	O	O	O	O	
14.	Trouble experiencing positive feelings *(for example, being unable to feel happiness or have loving feelings for people close to you)?*	O	O	O	O	O	
15.	Irritable behavior, angry outbursts, or acting aggressively?	O	O	O	O	O	
16.	Taking too many risks or doing things that could cause you harm?	O	O	O	O	O	
17.	Being “superalert” or watchful or on guard?	O	O	O	O	O	
18.	Feeling jumpy or easily startled?	O	O	O	O	O	
19.	Having difficulty concentrating?	O	O	O	O	O	
20.	Trouble falling or staying asleep?	O	O	O	O	O	

APPENDIX F

BDI-II

INSTRUCTIONS: This questionnaire consists of 21 groups of statements. Please read each group of statements carefully, and then pick out the **one statement** in each group that best describes the way you have been feeling during the **past two weeks, including today**. Circle the number beside the statement you have picked. If several statements in the group seem to apply equally well, circle the highest number for that group. Be sure that you do not choose more than one statement for any group, including Item 16 (Changes in Sleeping Pattern) or Item 18 (Changes in Appetite).

1. Sadness

0 I do not feel sad.

1 I feel sad much of the time.

2 I am sad all the time.

3 I am so sad or unhappy that I can't stand it.

2. Pessimism

0 I am not discouraged about my future.

1 I feel more discouraged about my future than I used to be.

2 I do not expect things to work out for me.

3 I feel my future is hopeless and will only get worse.

3. Past Failure

0 I do not feel like a failure.

1 I have failed more than I should have.

2 As I look back, I see a lot of failures.

3 I feel I am a total failure as a person.

7. Self-Dislike

0 I feel the same about myself as ever.

1 I have lost confidence in myself.

2 I am disappointed in myself.

3 I dislike myself.

8. Self-Criticalness

0 I don't criticize or blame myself more than usual.

1 I am more critical of myself than I used to be.

2 I criticize myself for all my faults.

3 I blame myself for everything bad that happens.

9. Suicidal Thoughts or Wishes

0 I don't have any thoughts of killing myself.

1 I have thoughts of killing myself, but I would not carry them out.

2 I would like to kill myself.

3 I would kill myself if I had the chance.

4. Loss of Pleasure

0 I get as much pleasure as I ever did from the things I enjoy.

1 I don't enjoy things as much as I used to.

2 I get very little pleasure from the things I used to enjoy.

3 I can't get any pleasure from the things I used to enjoy.

5. Guilty Feelings

0 I don't feel particularly guilty.

1 I feel guilty over many things I have done or should have done.

2 I feel quite guilty most of the time.

3 I feel guilty all of the time.

6. Punishment Feelings

0 I don't feel like I am being punished.

1 I feel I may be punished.

2 I expect to be punished.

3 I feel I am being punished.

10. Crying

0 I don't cry anymore than I used to.

1 I cry more than I used to.

2 I cry over every little thing.

3 I feel like crying, but I can't.

11. Agitation

0 I am no more restless or wound up than usual.

1 I feel more restless or wound up than usual.

2 I am so restless or agitated that it is hard to sit still.

3 I am so restless or agitated that I have to keep moving or doing something.

12. Loss of Interest

0 I have not lost interest in other people or activities.

1 I am less interested in other people or things than before.

2 I have lost most of my interest in other people or things.

3 It's hard to get interested in anything.

13. Indecisiveness

0 I make decisions about as well as ever.

1 I find it more difficult to make decisions than usual.

2 I have much greater difficulty in making decisions than I used to.

3 I have trouble making decisions.

17. Irritability

0 I am no more irritable than usual.

1 I am more irritable than usual.

2 I am much more irritable than usual.

3 I am irritable all the time.

18. Changes in Appetite

0 I have not experienced any changes in my appetite.

14. Worthlessness

0 I do not feel I am worthless.

1 I don't consider myself as worthwhile and useful as I used to.

2 I feel more worthless as compared to other people.

3 I feel utterly worthless.

14. Loss of Energy

0 I have as much energy as ever.

1 I have less energy than I used to have.

2 I don't have enough energy to do very much.

3 I don't have enough energy to do anything.

16. Changes in Sleeping Patterns

0 I have not experienced any changes in my sleeping pattern.

1a I sleep somewhat more than usual.

1b I sleep somewhat less than usual.

2a I sleep a lot more than usual.

2b I sleep a lot less than usual.

3a I sleep most of the day.

3b I wake up 1-2 hours early and can't get back to sleep.

1a My appetite is somewhat less than usual.

1 b My appetite is somewhat greater than usual.

2a My appetite is much less than before.

2 b My appetite is much greater than before.

3a I have no appetite at all.

3 b I crave food all the time.

19. Concentration Difficulty

0 I can concentrate as well as ever.

1 I can't concentrate as well as usual.

2 It's hard to keep my mind on anything for very long.

3 I find I can't concentrate on anything.

20. Tiredness or Fatigue

0 I am no more tired or fatigued than usual.

1 I get more tired or fatigued more easily than usual.

2 I am too tired or fatigued to do a lot of the things I used to do.

3 I am too tired or fatigued to do most of the things I used to do.

21. Loss of Interest in Sex.

0 I have not noticed any recent change in my interest in sex.

1 I am less interested in sex than I used to be.

2 I am much less interested in sex now.

3 I have lost interest in sex completely.

APPENDIX G

FCES

Have you ever experienced combat/ a combat-like situation? (i.e. deployed to a war zone, other peace keeping missions, etc.)
If no, skip to next page.

Yes O **No O** *(If not, skip to next page)*

		Never	1 Time	2-4 Times	5-9 Times	10+ Times
1.	Being attacked or ambushed	O	O	O	O	O
2.	Seeing destroyed homes and villages	O	O	O	O	O
3.	Receiving small arms fire	O	O	O	O	O
4.	Seeing dead bodies or human remains	O	O	O	O	O
5.	Handling or uncovering human remains	O	O	O	O	O
6.	Witnessing an accident which resulted in serious injury or death	O	O	O	O	O
7.	Witnessing violence within the local population or between ethnic groups	O	O	O	O	O
8.	Seeing dead or seriously injured Americans	O	O	O	O	O
9.	Knowing someone seriously injured or killed	O	O	O	O	O
10.	Participating in de-mining operations	O	O	O	O	O
11.	Working in areas that were mined	O	O	O	O	O
12.	Having hostile reactions from civilians	O	O	O	O	O
13.	Disarming civilians	O	O	O	O	O
14.	Being in threatening situations where you were unable to respond because of rules of engagement	O	O	O	O	O
15.	Shooting or directing fire at the enemy	O	O	O	O	O
16.	Calling in fire on the enemy	O	O	O	O	O
17.	Engaging in hand-to-hand combat	O	O	O	O	O
18.	Clearing/searching homes or buildings	O	O	O	O	O
19.	Clearing/searching caves or bunkers	O	O	O	O	O
20.	Witnessing brutality/mistreatment toward non-combatants	O	O	O	O	O
21.	Being wounded/injured	O	O	O	O	O
22.	Seeing ill/injured women or children who you were unable to help	O	O	O	O	O
23.	Receiving incoming artillery, rocket, or mortar fire	O	O	O	O	O
24.	Being directly responsible for the death of an enemy combatant	O	O	O	O	O
25.	Being directly responsible for the death of a non-combatant	O	O	O	O	O
26.	Being responsible for the death of US or ally personnel	O	O	O	O	O
27.	Having a member of your own unit become a casualty	O	O	O	O	O
28.	Had a close call: dud land near you	O	O	O	O	O
29.	Had a close call: was shot or hit but protective gear saved you	O	O	O	O	O
30.	Had a buddy shot or hit who was near you	O	O	O	O	O
31.	Improvised explosive device (IED)/booby trap explode near you	O	O	O	O	O
32.	Provided aid to the wounded	O	O	O	O	O
33.	Saved the life of a soldier or civilian	O	O	O	O	O
34.	Other: _____	O	O	O	O	O

APPENDIX H

TBI- Lifetime

I am going to ask some questions about any injury to your head or close exposure to explosive blasts that you might have experienced at any time during your life. Have you ever had a head injury or exposure to a blast in which you experienced at least one of the following problems?

○ **Altered consciousness (by altered consciousness, I mean that you "saw stars", were "dazed", or were knocked out altogether)**

○ **No Head Injury**

If "no" DISCONTINUE INTERVIEW

Did you have more than one head injury resulting in one of these problems

Yes_____ If yes, how many? _____

No _____

Have you had any of the following symptoms on the PAST WEEK?

Select **ALL** that apply by filling in the circle

○ Memory problems/lapses ○ Balance problems or dizziness ○ Headache

○ Sensitivity to bright light ○ Irritability ○ Sleep Problems ○ NONE OF THESE

I'm going to ask you now about your worst injury.

WORST HEAD INJURY

1. **How old were you at the time?** _____

2. **Date of Injury:** / / (*mm/dd/yyyy*)

3. **Was this the most serious head injury you've ever had?** ○ Yes ○ No

4. **How were you injured?**

○ Blast or explosion (RPG, landmine, IED, grenade) ○Vehicular accident/crash(include aircraft)

○ Fragment or bullet wound above the shoulder ○ Fall ○ Knocked out by another person

○ Object Hitting Head or Head Hitting Object ○ Other (specify): _____

5. **Did this injury happen during deployment?** ○ Yes ○ No

6. **Did you lose consciousness or did you get "knocked out"?** ○ Yes ○ No

If YES, how long were you unconscious? ○ less than 1 min ○ 1-15 min ○ 16-30 min ○ 30+ minutes ○ unknown

7. **List all the following symptoms IMMEDIATELY afterward or after you regained consciousness (if you got "knocked out")?**

○ Being dazed, confused, or "seeing stars" ○ Dizziness ○ Blurred Vision

○ Loss of coordination ○ Ruptured ear drums ○ NONE OF THESE

8. Did any of the following problems begin or get worse afterward?

*Select **ALL** that apply by filling in the circle*

○ Memory problems/lapses ○ Balance problems or dizziness ○ Headaches ○ Sensitivity to bright light

○ Irritability ○ Sleep Problems ○ NONE OF THESE

9. a. Immediately after the injury or upon regaining consciousness, were you unable to recall the event? ○ Yes ○ No ○ Unknown

b. If yes, **are you still unable to recall the event**? ○ Yes ○ No ○ Partially

If no to both Q9a or Q9b skip to Q11

10. How long after the injury was it before you started remembering new things again? ○ Less than 1 hour ○ 1-24 hours ○ More than 24 hours to 7 days ○ More than 7 days ○ Unknown

11. Did injury result in a skull fracture? ○ Yes ○ No ○ Unknown

12 Did you need brain surgery after the injury? ○ Yes ○ No ○ Unknown

13. Does this head injury qualify for a positive TBI screen according to the following (DVBIC Criteria)?:

□□Yes (Positive TBI Screen) □□No (Negative TBI Screen)

Presence of head injury event (Q4) plus any of the following:
Any loss of consciousness (Q6)

Any other alteration of consciousness (Being dazed, confused, or "seeing stars") (Q7)

Not remembering the injury (Q9a)

14. If positive, categorize according to the following (ACRM Criteria):

□□Mild □□Moderate □□Severe

Mild: loss of consciousness for less than 30 minutes or Post-traumatic amnesia for less than 24 hours.	**Moderate: loss of consciousness for 30 min-1 week or Post-traumatic amnesia for 24 hrs- 1 week.**	**Severe: loss of consciousness for more than 1 week or Post-traumatic amnesia for more than 1 week.**

IF MODERATE OR SEVERE, PARTICIPANT IS INELIGIBLE

VITA

JOSHUA S. CAMINS, M.A.

EDUCATION

Present
Doctor of Philosophy in Clinical Psychology
Sam Houston State University
Huntsville, Texas
Dissertation: Predicting Justice Contact in Veterans with PTSD: The Incremental Validity of Specific Risk Factors
Co-Chairs: Jorge G. Varela, Ph.D. and Bryann B. DeBeer, Ph.D.

August 2016
Master of Arts in Clinical Psychology
Sam Houston State University
Huntsville, Texas
Thesis: Early childhood externalizing behavior types and late adolescent delinquent behavior: The role of exposure to community violence
Chair: Marcus T. Boccaccini, Ph.D.

May 2013
Master of Arts in Clinical Psychology
Towson University
Towson, Maryland

May 2011
Bachelor of Arts in Psychology &
Bachelor of Science in Criminal Justice
Magna Cum Laude
University of New Haven
West Haven, Connecticut
Thesis: Treatment motivation, engagement, and working alliance in community clinics (Psychology)
Chair: W. Amory Carr, Ph.D.

CLINICAL & PRACTICA EXPERIENCE DURING DOCTORAL STUDY

July 2018 – Present
Student Clinician
Rusk State Hospital
Rusk, Texas

Duties:
- Participate in multi-disciplinary treatment team meetings, behavioral interventions, and treatment plan review
- Provide individual therapy to patients, implementing a variety of empirically supported treatments, including: cognitive behavioral therapy, dialectical behavioral therapy, interpersonal psychotherapy, motivational interviewing
- Administer, score, and interpret psychological instruments of malingering and neuropsychological functioning to assist in treatment planning

- Conduct both inpatient competence to stand trial evaluations and violence risk assessments
- Co-author forensic and psychodiagnostic evaluation reports
- Lead competency restoration groups

Supervisor: Sarah Rogers, Ph.D.

May 2018 – Present

Research Therapist
Center of Excellence for Research on Returning War Veterans (CoE), VISN 17, Veterans Affairs Administration
Waco, Texas

Duties:
- Act as therapist and treatment team member for a multisite study of a novel intensive form of prolonged exposure (PE) designed for military members and veterans conducted by the Consortium to Alleviate PTSD (PI: Peterson, Co-PI: Foa, Site PI: DeBeer)
- Provide manualized prolonged exposure (PE) to enrolled study participants
- Participate in group consultation/supervision with Edna Foa, Ph.D.
- Document encounters in the VA Computerized Patient Record System (CPRS) files

Supervisor: Bryann DeBeer, Ph.D.

October 2015 – Present

Assistant Forensic Evaluator
Psychological Services Center, Sam Houston State University
Huntsville, Texas

Duties:
- Conduct court-ordered, pre-trial evaluations with adults (e.g., competency to stand trial, mental state at the time of the offense) and juveniles (e.g., fitness to proceed, criminal responsibility, waiver/transfer to adult court)
- Co-author forensic evaluation reports to be submitted to the courts, documenting diagnoses, psycholegal opinions, and recommendations

Supervisors: Mary Alice Conroy, Ph.D., ABPP & Wendy Elliott, Ph.D.

September 2015 – Present

Student Clinician
Psychological Services Center, Sam Houston State University
Huntsville, Texas

Duties:
- Complete intake interviews and treatment plans for clients
- Conduct individual therapy employing empirically-supported treatments including: cognitive behavioral therapy, motivational interviewing, and dialectical behavior therapy
- Engage in suicide risk assessments and client safety planning

- Conduct comprehensive psychodiagnostic and psychoeducational evaluations for self-referred individuals, academic institutions, and other treating professionals.
- Assessment procedures include clinical and psychosocial interviews psychological testing, collateral data collection, and behavioral observations
- Complete necessary clinical documentation including intake reports, treatment plans, progress notes, and integrated reports
- Consult with community providers and agencies as needed to ensure client safety and continuity of care

Supervisors: Darryl Johnson, Ph.D., Craig Henderson, Ph.D., Jorge G. Varela Ph.D., David Nelson, Ph.D., ABPP, Chelsea, Ratcliff, Ph.D., & Jaime Anderson, Ph.D.

May 2018 ***Assistant Evaluator***
Texas Department of Criminal Justice
Huntsville, Texas

Duties:
- Participated in behavioral abnormality and risk assessment of inmate being considered for civil commitment as a Sexually Violent Predator
- Assisted with administration, scoring, and interpretation of risk assessment measures (i.e., Static-99R, Psychopathy Checklist-Revised).
- Assisted with report submitted to the Texas Department of Criminal Justice.

Supervisor: Jorge G. Varela, Ph.D.

January 2018 – July 2018 ***Practicum Student - Therapist***
Health for All Primary Care Clinic
Bryan, Texas

Duties:
- Provided individual, evidence-based therapy, including motivational interviewing, cognitive behavioral therapy, acceptance and commitment therapy, dialectical behavior therapy, and interpersonal psychotherapy
- Provided couples therapy from an interpersonal process framework
- Co-facilitated a mediation group
- Conducted brief targeted interventions with medical patients focused on addressing behavioral health concerns
- Provided consultation services to providers at a medical clinic
- Conducted suicide risk assessment and engaged in safety planning as needed

Supervisor: Kevin Tarlow, Ph.D.

June 2017 – January 2018 ***Practicum Student –Therapist***
Telehealth Counseling Clinic, Texas A&M University

College Station, Texas

Duties:
- Conducted intake evaluations and authored intake reports
- Provided individual, evidence-based interventions, including cognitive behavioral therapy, interpersonal psychotherapy, cognitive processing therapy, and dialectical behavior therapy via videoconferencing and telephone sessions
- Collaborated with clients on treatment plan development and implementation
- Conducted suicide risk assessment and implement safety plan interventions as required
- Monitored treatment progress through self-report measures and behavioral observations
- Participated in weekly didactic and group supervision meetings

Supervisors: Carly McCord, Ph.D. & Kevin Tarlow, Ph.D.

August 2016 – June 2017 ***Pre-Doctoral Practicum Student Clinician***
Montgomery County Juvenile Probation Department
Conroe, Texas

Duties:
- Co-facilitated adolescent anger management group with clinical staff
- Conducted court-ordered and probation-referred psychodiagnostic and psychoeducational evaluations
- Completed semi-structured interviews with minors and their legal guardians
- Reviewed collateral information (i.e., court report information summary, probation supervision reports, etc.)
- Administered, scored, and interpreted measures assessing cognitive abilities, academic achievement, psychopathology, and personality
- Authored integrated reports of clinical findings and recommendations to assist probation department and the court in placement and probation requirement decisions

Supervisors: Darryl Johnson, Ph.D. & Wendy Elliott, Ph.D.

RESEARCH EXPERIENCE

March 2018 – Present ***Graduate Research Assistant / Co-Investigator / Investigator***
Sam Houston State University
Huntsville, Texas

Duties: *Mental Health Profiles Among Justice-Involved Veterans*
- Collaborate with graduate student investigators on data collection and study implementation procedures
- Administer a range of psychological tests to incarcerated offenders across two Texas counties
- Collect data with incarcerated specialty court participants

Criminal Culpability and Risk: Does Military Status Matter?
- Design and conduct online study exploring juror perceptions of veteran and non-veteran defendants diagnosed with posttraumatic stress disorder

Supervisor: Jorge G. Varela, Ph.D.

October 2017 – Present
Graduate Research Assistant (Dissertation Research)
Center of Excellence for Research on Returning War Veterans (CoE), VISN 17, Veterans Affairs Administration
Waco, Texas

Duties: *Predicting Justice Contact in Veterans with PTSD:*
- Investigate the association between empirically supported risk factors and criminal justice contact in Veterans to complete required doctoral dissertation
- Conduct data management and analysis
- Engage in professional development activities including publication reviews and VAMC/CoE department meetings

Supervisor: Bryann DeBeer, Ph.D.

April 2016 – Present
Graduate Research Assistant
Youth and Family Studies Laboratory
Sam Houston State University
Huntsville, Texas

Duties: *Violence Risk Assessment and Externalizing Symptoms among Recently Immigrated Adolescents*
- Assist with grant-funded study examining recently immigrated adolescents' attachment styles, preparedness to participate in immigration court procedures, immigration experience, and trauma related symptoms.
- Conduct semi-structured interviews with youth
- Provide supervision for junior doctoral students

Psychosocial Assessment of Justice Involved Youth
- Co-develop research project examining emotional and behavioral factors including psychopathy, psychopathology, emotional functioning and trauma in justice-involved adolescents
- Administer a wide range of psychological assessments to detained juveniles as part of ongoing research

Supervisor: Amanda Venta, Ph.D.

January 2016 – August 2016
Graduate Research Assistant (Thesis Research)
Sam Houston State University
Huntsville, Texas

Duties:
- Completed master's thesis using data acquired from the National Data Archive on Child Abuse and Neglect (NDACAN)

- Conducted secondary analysis on the Longitudinal Studies of Child Abuse and Neglect (LONGSCAN) examining whether latent classes of externalizing behavior in early childhood predicted adolescent delinquency
- Conducted additional exploratory analyses examining the moderating effect of community violence on latent class and adolescent delinquency

Supervisor: Marcus Boccaccini, Ph.D.

June 2015 ***Graduate Research Assistant***
Sam Houston State University
Huntsville, Texas

Duties:
- Assisted in Hogg Foundation of Mental Health Grant research project on the effects of parental incarceration on adolescents' psychological functioning
- Interviewed and assessed adolescents' executive functioning, achievement, and trauma-related symptoms

Supervisor: Adam Schmidt, Ph.D.

August 2014 – December 2015 ***Graduate Research Assistant***
Sam Houston State University
Huntsville, Texas

Duties:
- Completed literature reviews on a range of juvenile-focused topics including trauma, psychopathy, and cortisol levels
- Reviewed legal cases related to the Millon Clinical Multiaxial Inventory (MCMI)
- Developed thesis project examining impact of exposure to community violence on juvenile delinquency

Supervisor: Melissa Magyar, Ph.D.

February 2014 – June 2014 ***Research Specialist A***
University of Pennsylvania
Philadelphia, Pennsylvania

Duties:
- Managed NIH funded study examining associations between sociodemographic characteristics (specifically socioeconomic status) and brain structure
- Conducted participant recruitment, screening, and scheduling
- Coordinated data collection, including administration of questionnaires/interviews and functional MRI scan
- Managed IRB and institutional compliance for MRI imaging study
- Supervised undergraduate student

Supervisor: Martha Farah, Ph.D.

REFEREED PUBLICATIONS

Venta, A., Bailey, C., Muñoz, C., Godinez, E., Colin, Y., Arreola, A., Abate, A., **Camins, J.**, Rivas, M., & Lawlace, S. (2018). Contribution of Schools to Mental Health and Resilience in Recently Immigrated Youth. *School Psychology Quarterly*. Advance online publication. http://dx.doi.org/10.1037/spq0000271

Lawson G.M., **Camins, J.S.**, Wisse, L., Wu, J., Duda, J.T., Cook, P.A., Gee, J.C., & Farah, M.J. (2017). Childhood socioeconomic status and childhood maltreatment: Distinct associations with brain structure. *PLOS ONE, 12*(4): e0175690. https://doi.org/10.1371/journal.pone.0175690

Loewenstein, R.J., Brand, B., Gilbert, L.E., Dressel, C.E., **Camins, J.S.**, & Pyne, Z. J. (2014). Treating complex trauma survivors. *Psychiatric Times*. Retrieved from http://www.psychiatrictimes.com/cme/treating-complex-trauma-survivors

NON-REFEREED PUBLICATIONS

Camins., J. (In Press). Military PTSD and Violence: A review of the evidence. *Trauma Psychology News.*

Camins, J.S. (2017, December 19). Soldier or Psychologist: Why not both? [Blog post]. Retrieved from http://deploymentpsych.org/blog/Soldier-or-psychologist-why-not-both.

Katz, E.C., Dunne, E., Lookatch, S., & **Camins, J.** (2014). Prevention of mental and behavioral health problems. In D. L. Katz, J. G. Elmore, S. C. Lucan & D. G. Wild (Eds.), *Jekel's epidemiology, biostatistics, preventive medicine, and public health* (pp. 252-263). Philadelphia, PA: Saunders.

UNPUBLISHED INTERVENTION MANUALS

DeBeer, B.B., Matthieu, M., Degutis, L., Clafferty, S., **Camins, J.**, & Morissette, S. (2018). *LOOP (Loved One On safety Plan) Manual.* Center of Excellence for Research on Returning War Veterans.

DeBeer, B.B., Bryan, C. J., Monteith, L., Clafferty, S., Cassidy, R., Heise, J., Baack, S., Williams, M., Keene, R., **Camins, J.**, Synett, S., & Benzer, J. B. (2018). *Transit: A Transitional Care Program for Suicide Prevention Among Veterans Not Connected to VHA Care Manual*. Center of Excellence for Research on Returning War Veterans.

CONFERENCE PRESENTATIONS

Camins, J.S., Varela, J.G., Henderson, C.E., Kimbrel, N.A., Meyer, E.C., Morissette, S.B., & DeBeer, B.B. (2018, November). *Predicting Justice Contact in Veterans with PTSD: The Incremental Validity of Specific Risk Factors.* Invited Paper to be presented at the annual convention of the Texas Psychological Association, Frisco, TX.

Camins, J.S., Varela, J.G., Henderson, C.E., Kimbrel, N.A., Meyer, E.C., Morissette, S.B., & DeBeer, B.B. (2019, March). *Predicting Justice Contact in Veterans with PTSD.* Paper submitted for consideration to the Annual American Psychology-Law Society Conference, Portland, OR.

Camins, J.S., Holdren, S., & Varela, J.G., Waymire, K., A., & Schiafo, M.C. (2019, March). *Criminal culpability: Does military status matter?* Poster submitted for consideration to the Annual American Psychology-Law Society Conference, Portland, OR.

Camins, J.S., Varela, J.G., Henderson, C.E., Kimbrel, N.A., Meyer, E.C., Morissette, S.B., & DeBeer, B.B. (2018, August). *Veteran criminal justice involvement: Examining individuals diagnosed with PTSD or Schizophrenia.* Poster presented at the annual convention of the American Psychological Association, San Francisco, CA.

Muñoz**,** C. G., Abate, A., **Camins, J. S.**, Venta, A.C., & Sharp, C. (2018, March). *Psychometric properties of the Youth Psychopathy Inventory in a psychiatric inpatient sample and in a probation sample of juvenile offenders.* Poster presented at the Annual American Psychology-Law Society Conference, Memphis, TN.

Camins, J.S., Henderson, C.E., Varela, J.G., Kimbrel, N.A., Meyer, E.C., Morissette, S.B., & DeBeer, B.B. (2017, August*). Associations between justice involvement and social functioning in veterans diagnosed with posttraumatic stress disorder.* Poster presented at the annual convention of the American Psychological Association, Washington, D.C.

Camins, J.S., LaDuke, C., DeMatteo, D., & Heilbrun, K. (2017, August). *The role of trauma in predicting risk of future offending among incarcerated men.* Poster presented at the annual convention of the American Psychological Association, Washington, D.C.

Bailey, C.A., Muñoz, C.G., **Camins, J.S.**, Abate, A.A., Varela, J.G., Boccaccini, M.T. & Venta, A. (2017, March). *The effect of unpreparedness for immigration court on psychopathology in recently immigrated adolescents*. Poster presented at the Annual American Psychology-Law Society Conference, Seattle, WA.

Camins, J.S., Henderson, C.E., Magyar, M.S., Schmidt, A.T., Crosby, J., Ridge, B.E., & Kurus, S.J. (2017, March). *Predicting adolescent delinquency from a behavior typing model: The role of exposure to community violence.* Paper presented at the annual American Psychology-Law Society Conference, Seattle, WA.

Camins, J.S., Henderson, C.E., Magyar, M.S., Schmidt, A.T., Crosby, J., Reinhard, E.E., & Boland, J.K., (2017, March). *Adolescent behavior typing in at-risk youth: Validation using a latent variable approach.* Paper presented at the annual American Psychology-Law Society Conference, Seattle, WA.

Muñoz**,** C. G., M., Bailey, C. A., **Camins, J.**, Abate, A., Varela, G. J., Lyons, P., Boccaccini, M., & Venta, A. (2017, March). *Acculturation stress and criminal attitudes as risk factors for externalizing behaviors in recently immigrated adolescents.* Poster presented at the Annual American Psychology-Law Society Conference, Seattle, WA.

Muñoz**,** C. G., Bailey, C. A., **Camins, J.**, Abate, A., & Venta, A., (2017, March). *When does perception of the justice system relate to rule breaking among immigrant adolescents? Examining the role of criminal attitudes.* Poster presented at the Annual American Psychology-Law Society Conference, Seattle, WA.

Waymire, K.A., Varela, J.G., Schiafo, M.C., Holdren S.M., Miller, R.S., Lawrence, J.M., Ibarra, D.A. & **Camins, J.S.** (2017, March). *Do race and ethnic identity influence perceptions of law enforcement officers after traffic stops?* Poster presented at the Annual American Psychology-Law Society Conference, Seattle, WA.

Camins, J., & Tomei, J. (2016, November*). Lawyers and laypeople: Posttraumatic stress disorder and the insanity defense*. Poster presented at the annual meeting of the International Society of Traumatic Stress Studies, Dallas, TX.

Hart, J. R., Magyar, M. S., Ball, E. M**., Camins, J.**, Ridge, B., & Edens, J. (2016, March). *Using the Personality Assessment Inventory-Adolescent to predict high-risk Behaviors among juvenile male offenders.* Paper presented at the annual convention of the American Psychology- Law Society, Atlanta, GA.

Ricardo, M., Magyar, M., Abate, A., **Camins, J**., & Edens, J. (2016, March). *Personality Assessment Inventory-Adolescent (PAI-A) substance use-related scales' predictive validity within a justice-involved youth sample*. Paper presented at the annual convention of the American Psychology-Law Society, Atlanta, GA.

Colbourn, S., Magyar, M., **Camins, J**., & Edens, J. (2015, March*). The exploration of the mediating effects of substance use on the relation between exposure to community violence and aggressive behaviors among justice-involved youth*. Poster presented at the annual convention of the American Psychology-Law Society, San Diego, CA.

Formon, D., Schmidt, A., Marshall, K., & **Camins, J.S.** (2015, August). *Dollars-and-cents differences in ex-offender employment outcomes.* Poster presented at the annual convention of the American Psychological Association, Toronto, Canada.

Lawson G.M., **Camins, J.S.**, Wu, J., Duda, J.T., Cook, P.A., Gee, C.G., & Farah, M.J. (2015, March). *Associations between childhood socioeconomic status, childhood maltreatment, and hippocampal volume in young adulthood.* Poster presented at the annual convention of the Society for Research in Child Development, Philadelphia, PA.

Camins, J.S., LaDuke, C., & DeMatteo, D. (2014, May). *Violence and trauma: Exploring the military in the 21st century*. Poster presented at the annual convention of the Association for Psychological Science, San Francisco, CA.

Camins, J.S., Brodsky, C., Fletcher, C., Hildebrand, A., & Katz, E.C. (2013, April). *College students in the 21st century: Multimedia usage and problematic use.* Poster presented at the annual meeting of the Maryland Psychological Association Graduate Student Convention, Columbia, MD.

Camins, J.S., Katz, E.C., Rhodes, A.G., Taxman, F.S., & Friedmann, P.D. (2012, November). *Predictors of parole officer and substance use counselor working alliance among drug-involved offenders.* Poster presented at the annual convention of the Association for Behavioral and Cognitive Therapies, National Harbor, MD.

August 2018 – Present
Peer Supervisor
Doctoral Practicum I/Capstone
Sam Houston State University
Huntsville, Texas

Duties:
- Co-supervise junior doctoral student providing psychotherapy and conducting psychological assessments in psychology training clinic
- Review session videos with supervisee and provide feedback related to interviewing and therapy techniques
- Review and provide feedback on progress notes, treatment plans, and assessment reports

Supervisor: Darryl Johnson, Ph.D.

January 2017 – May 2017
Peer Supervisor
Theory and Research in Psychotherapy
Sam Houston State University
Huntsville, Texas

Duties:
- Supervised first-year clinical psychology doctoral students' simulated therapy sessions
- Provided feedback consistent with designated therapeutic modalities

Supervisor: Craig Henderson, Ph.D.

October 2016 – May 2017
Peer Supervisor
Doctoral Practicum I/Capstone
Sam Houston State University
Huntsville, Texas

Duties:
- Co-supervised junior doctoral students conducting comprehensive psychoeducational and psychodiagnostic evaluations
- Provided feedback related to interviewing and testing techniques
- Reviewed protocols and provided feedback on scoring of psychodiagnostic instruments
- Provided feedback on clinical documentation.

Supervisors: Darryl Johnson, Ph.D., & David Nelson, Ph.D., ABPP

June 2016 – August 2016
Peer Supervisor
Introduction to Doctoral Practicum
Sam Houston State University
Huntsville, Texas

Duties:
- Supervised first-year clinical psychology doctoral student conducting simulated interviews
- Provided feedback related to the use of foundational clinical skills and assisted with progress evaluation

Supervisor: Mary Alice Conroy, Ph.D., ABPP

TEACHING EXPERIENCE

August 2013 – May 2014
Adjunct Professor of Sociology & Psychology
William Patterson University
Wayne, New Jersey

Duties:
- Developed and served as instructor for Forensic Social Psychology
- Developed and served as instructor for Personality Theory

Supervisor: Gennifer Furst, Ph.D.

August 2013 – December 2013
Adjunct Professor of Psychology
The College of New Jersey
Ewing, New Jersey

Duties:
- Developed and served as instructor for Personality Theory and Research

Supervisor: Arthur Hohmuth, Ph.D.

PROFESSIONAL DEVELOPMENT

SEMINARS & TRAININGS

October 2018	STRONG STAR Consortium Cognitive Processing Therapy Workshop Katherine Dondanville, Psy.D., ABBP
September 2018	Neurobiology of Trauma Train-The-Trainer Workshop Hilary Hodgdon, Ph.D. & Shavonne J. Moore, PhD.
May 2018	Critical Thinking in Forensic Psychological Evaluations Terry Kukor, Ph.D., ABPP
May 2018	Controversies in Forensic Mental Health Assessment Terry Kukor, Ph.D., ABPP
September 2017	STRONG STAR Consortium Prolonged Exposure Workshop Brooke Fina, LCSW, BCD
July 2017	Motivational Interviewing: Clinical Skills Workshop Joseph Mignogna, Ph.D.
June 2017	Center for Deployment Psychology Summer Institute Paula Domenici, Ph.D.
March 2017	Developments in Risk Assessment and Risk Reduction: Classification, Intervention Planning, Intervention, and Communication Kirk Heilbrun, Ph.D., ABPP
April 2016	Advancing Recidivism Reduction Efforts: RNR Simulation Tool Faye S. Taxman, Ph.D.
March 2015	Evidence-Based Trauma-Specific Services for Youth in the Juvenile System: Bringing the TARGET Model to Youth, Staff, and Key Stakeholders Julian Ford, Ph.D., ABPP

PROFESSIONAL SERVICE AND LEADERSHIP

February 2018 – Present	***Graduate Student Committee Member*** Social Media Committee, APA Division 56: Trauma Psychology
April 2015 – March 2018	***Sam Houston State University Campus Representative*** APA Division 19: Military Psychology
August 2016 – July 2017	***Sam Houston State University Campus Representative*** APA Division 41: American Psychology-Law Society

REVIEWING EXPERIENCE

2018	American Psychology-Law Society Conference Proposals
2018	Psychiatric Research, Ad-Hoc Co-Reviewer
2017	APA Annual Convention, American Psychology-Law Society Proposals
2017	Association for Psychological Science, Student Grant Competition
2017	American Psychology-Law Society Conference Proposals
2017	Journal of Clinical Psychology, Ad-Hoc Co-Reviewer
2017	Association for Psychological Science, Student Research Award
2017	Association for Psychological Science, RISE Research Award
2016	APA Annual Convention, Trauma Psychology Proposals
2016	APA Annual Convention, American Psychology-Law Society Proposals

PROFESSIONAL MEMBERSHIPS

2016 – Present	International Society for Traumatic Stress Studies
2015 – Present	Military Psychology (APA Division 19)
2015 – Present	Trauma Psychology (APA Division 56)
2010 – Present	Association for Psychological Science
2009 – Present	American Psychological Association
2009 – Present	American Psychology-Law Society (APA Division 41)

AWARDS AND SCHOLARSHIPS

2018	Mary Alice Conroy Award for Best Paper in Forensic Psychology ($500)
2018	Division 19 Student Travel Grant Award ($750)
2017	Division 19 Student Travel Grant Award ($750)
2017	American Psychology-Law Society CE Workshop Grant ($100)
2016	Division 19 Student Travel Grant Award ($750)
2015	Daniel Lee Mattis Scholarship ($1,500)
2015	American Psychology-Law Society CE Workshop Grant ($100)