

**Working with trauma in forensic therapeutic communities:
Implications for clinical practice.**

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Working with trauma in Forensic Therapeutic Communities: Implications for clinical practice.

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Aims

- Brief outline of forensic therapeutic communities
- To explore whether forensic therapeutic communities could be effective in treatment symptoms of trauma
- To explore residents' experiences of treatment
- To consider the relevance of TCs as an intervention & social climate for those experiencing trauma



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Therapeutic Communities

- Origins from traditions of social psychiatry
- Refers to the culture within which treatment is delivered
- Participation, responsibility, collaborative relationships, shared goals and working
- Early TCs found to be effective in addressing trauma



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Why of interest to us?

- High number of referrals report a primary reason for referral being to resolve distressing childhood experiences
- 60% of population report history of physical abuse
- 40% report history of sexual abuse
- 69% loss or separation from key care giver



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Previous research at HMP Grendon (Shuker & Kennedy 2012)

- 70% experienced clinical significant traumatisation
- 52% clinically significant levels of trauma re-experiencing
- 48% clinically significant levels of post traumatic stress

- Negative relationship between levels of trauma and offence risk (OGRS)
- Post traumatic stress & severity of symptoms associated with certain thinking styles - *particularly self inward directed hostility & guilt*



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Trauma and risk - Overview

- Seems to be a well established connection between early adversity & aggressive behaviour
- Repeated experiences to threat & harm have an impact on functioning of the brain over time
- Child abuse & neglect – both associated with impaired cognition & academic functioning (*Mills et al 2011*)
- Exposure to violence results in pervasive psychological, affective and cognitive/learning deficits (*Streeck-Fischer et al*)
- Neurobiological development – abuse related to abnormal development in amygdala



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Trauma and risk (cont)

- Violent men convicted for domestic violence reported significantly higher levels of PTSD symptoms *Dutton (1995)*
- Non clinical samples – those with PTSD symptoms report elevated symptoms of aggression, hostility and anger *Jakupcak (2005)*
- Aversive childhood experiences feature in SRA tools *ie HCR 20*
- ‘Sexually abused – sexual abuser’ hypothesis – *association between experience of childhood sexual abuse & later sexual offending*
- Sex offenders more likely to have been sexually abused than non sex offenders – *Jespersion 2008*



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Suggested links between trauma & offending

- Primary trauma is a stressor which triggers maladaptive coping ie substance misuse
- Trauma & neurobiological abnormality
- PTSD – vulnerability to reactive aggression
- Abuse - insecure attachment – relating difficulties - offending
- Negative self concept leading to reckless, self defeating and irresponsible behaviour
- Hostile/hypervigilant appraisals leading to violent responding



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Method. Measures 1

- Detailed Assessment of Posttraumatic Stress (DAPS)
 - 104-item test of trauma exposure and posttraumatic response
 - 150 men tested on reception
 - Followed up at 9 and 18 months
 - Measures trauma-relevant parameters;
 - Lifetime exposure to traumatic events,
 - Immediate cognitive, emotional and dissociative responses to specified trauma
 - Symptoms of Post Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD; DSM-IV-TR, APA, 2000)
 - Likelihood of PTSD or ASD diagnosis
 - Associated features of PTSD; posttraumatic dissociation, suicidal thoughts/behaviours and substance abuse



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Change in DAPS Trauma scale scores 0-9, 0-18 and 9-18 mths

DAPS Scale	0-9 mths	0-18 mths	9-18 mths
Trauma Exposure	-.44	-1.97*	-2.64**
Peritraumatic Distress	1.36	.39	-.14
Peritraumatic Dissociation	2.23*	2.03*	1.11
Re-Experiencing	.77	2.05*	1.39
Avoidance	1.93*	2.82**	1.20
Hyper Arousal	1.95*	2.81**	.74
Post-Traumatic Stress	2.24*	2.65**	.21
Post-Traumatic Impairment	1.98*	2.96**	1.58
Trauma Specific Dissociation	-1.05	.69	1.40
Substance Abuse	.49	1.17	.74
Suicidality	-.50	.69	.57
Post Traumatic Stress Disorder	1.73	2.55**	1.61
Acute Stress Disorder	1.99*	2.18*	1.03

* $p < .05$; ** $p < .01$

Change in DAPS trauma scores

- Of the 13 DAPS scales there was significant change on:
 - 6 scales at 0-9 mths
 - 9 scales at 0-18 mths
 - 1 scale at 9-18 mths
- Suggests that 18 mths important for significant change
 - Consistent with previous literature which has shown that 18 months + in treatment is important in terms of a therapeutic career (Genders & Player, 1995; Taylor 2000; Shuker & Newton, 2007)



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Correlations between variables

Strong significant correlations between the following DAPS scales and personality variables at 0 months ($p < .01$):

- Trauma Specific Dissociation + Negative Impression Management ($r = .57$)
- Trauma Specific Dissociation + Anxiety ($r = .53$) + Anxiety-Related Disorders ($r = .50$)
- Trauma Specific Dissociation + Depression ($r = .55$) + Suicide ($r = .57$)
- Trauma Specific Dissociation + Schizophrenia ($r = .54$)
- Re-Experiencing + Anxiety Related Disorders ($r = .52$)
- Re-Experiencing + Depression ($r = .50$) + Suicide ($r = .55$)
- Hyper Arousal + Anxiety ($r = .50$), Anxiety Related Disorders ($r = .52$)
- Hyper Arousal + Suicide ($r = .50$)
- Suicide + Depression ($r = .56$) + PAI Suicide ($r = .58$).
- Avoidance + Suicide ($r = .55$).
- Post-Traumatic Stress + Suicide ($r = .51$)
- Post-Traumatic Impairment + Suicide ($r = .51$)

- Also a number of significant moderate correlations between 12 of the 13 DAPS trauma scales and PAI scales



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Mediational analysis

- Total effect between total trauma at 0 months and 18 months: $r = .61, p < .01$
- Explored whether any of the 31 personality/psychosocial/risk variables influenced reductions in trauma between 0 and 18 months
- 21 variables analysed using mediational analyses (Baron & Kenny, 1986)
- 11 had a significant indirect effect on the relationship between total trauma at 0 months and 18 months:
 - ▣ Suicidal Ideation
 - ▣ Depression
 - ▣ Anxiety + Anxiety Related Disorders
 - ▣ Negative Impression Management
 - ▣ Neuroticism
 - ▣ Schizophrenia
 - ▣ Somatic Complaints
 - ▣ Mania
 - ▣ Borderline Features
 - ▣ Treatment rejection



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Conclusions

- Reductions in trauma occur - usually following 18 mths in treatment
- Significant comorbidity with other conditions
- Identifies those factors which are associated with less likelihood of trauma reduction – *suicide, anxiety, depression, borderline traits, negative impression management, treatment rejection, somatic complaints*



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Qualitative research – Consistent Themes

- Safe place to discuss & explore problems from the past that contribute to offending behaviour
- Mutually supportive, caring & trusting relationships
- Responsibility & shared goals
- Real friendships – share painful life experiences
- Psychological vulnerability & change inextricably linked

Safety and Trust - key elements

- *“I think trust has played a massive part in, like specially about opening up about my childhood”* (cited in Dolan 2016)
- *“I admire him (Officer) I respect him. He’s a role model for me. I would like to have a father like that. He believed in this place and gives me the guidance to do the right thing’* (cited in A stevens 2013)

Open communication with staff

The way they (officers) are if I'm feeling down or I'm feeling good, talk about it and that's what I've never done before always bottled it all up, and end up spilt out on someone so innocent, and basically it's changed my life totally my whole outlook on life is.... it just feels good now (cited in Dolan, 2016)

Their (officers) desire to help people just sort of oozes out of them....they believe in change (cited in Stevens 2013)



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Mutually supportive relationships key to change

- *‘some of these fellas here that I spoke to, I’ve spoke to about things that I have never spoke to anybody. So you really do build that bond with people and you gain a lot or respect for each other.....’* (cited in Dolan 2016)
- *Getting this crap out does seem to enlighten you...its fucking horrible, its weird as well, because it gives you a lot more confidence. The first time I broke down in group I cried and (a group member) put his arm round me – and I thought, how powerful is this place to give me the confidence to talk and take that conform from him*

Vulnerability and change

- *I've broken down...I feel weak when I cry, I feel embarrassed and my image is gone and its not nice. But its better than holding it in and being angry all the time*
- *'Its OK to talk about your feeling here; in fact you're encouraged to do so. And if that means crying then cry'*
cited in A stevens 2013



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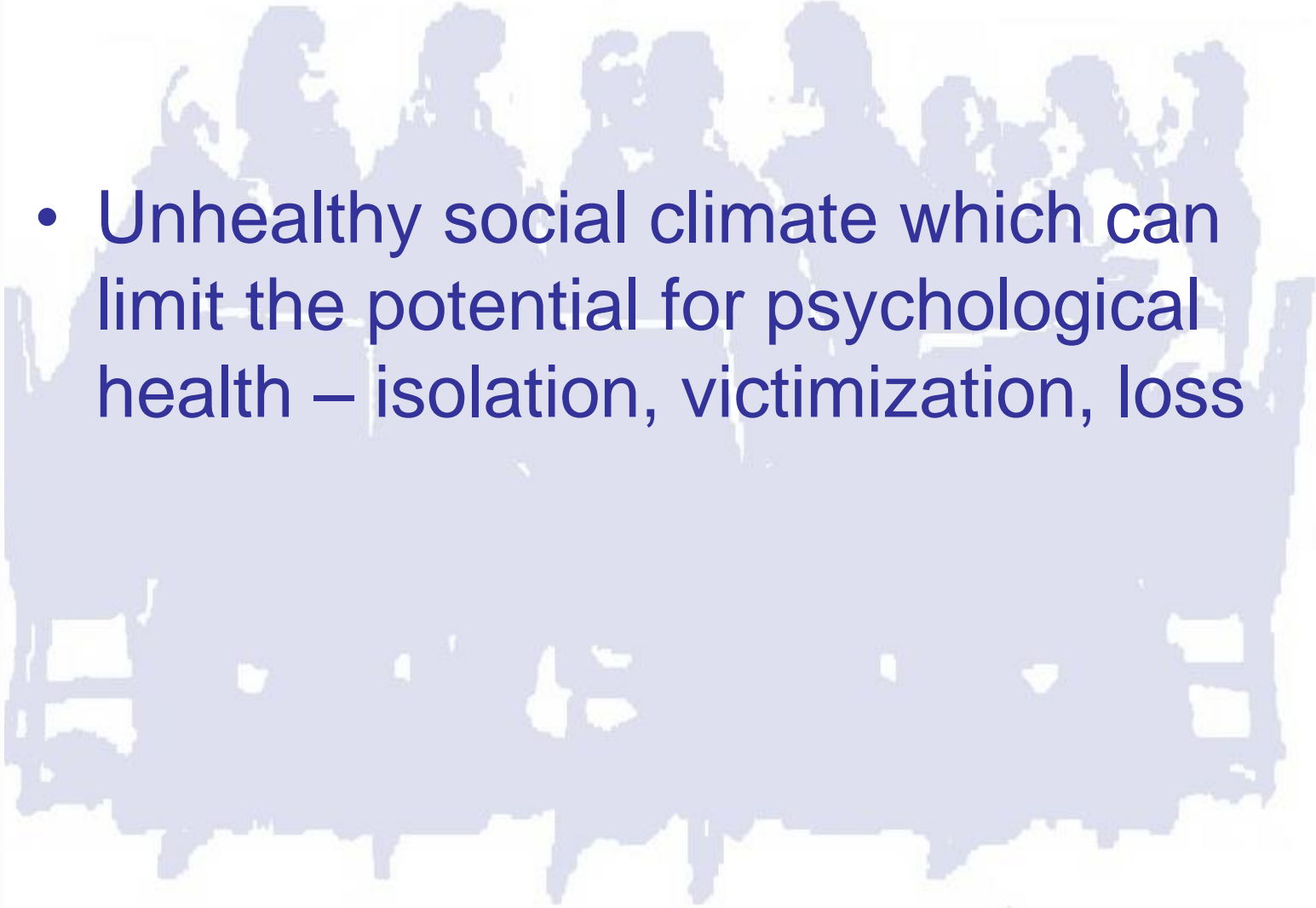
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Prison environment and impact on trauma (Jones 2015)

- Deprivation of mastery and autonomy or affirming experiences
- Contact with CJS can be traumatizing for those with PTSD
- How the institution responds to behavioural expression of trauma
- Witness of victim to extreme violence/acts of self harm

- 
- Unhealthy social climate which can limit the potential for psychological health – isolation, victimization, loss



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Trauma responsive social climate

- Safety and emotional containment
- Sharing/ disclosing, 'processing' traumatic experiences
- Choice & responsibility – empowerment & agency
- Developing secure attachment, trust, intimacy
- Authority legitimate & dependable



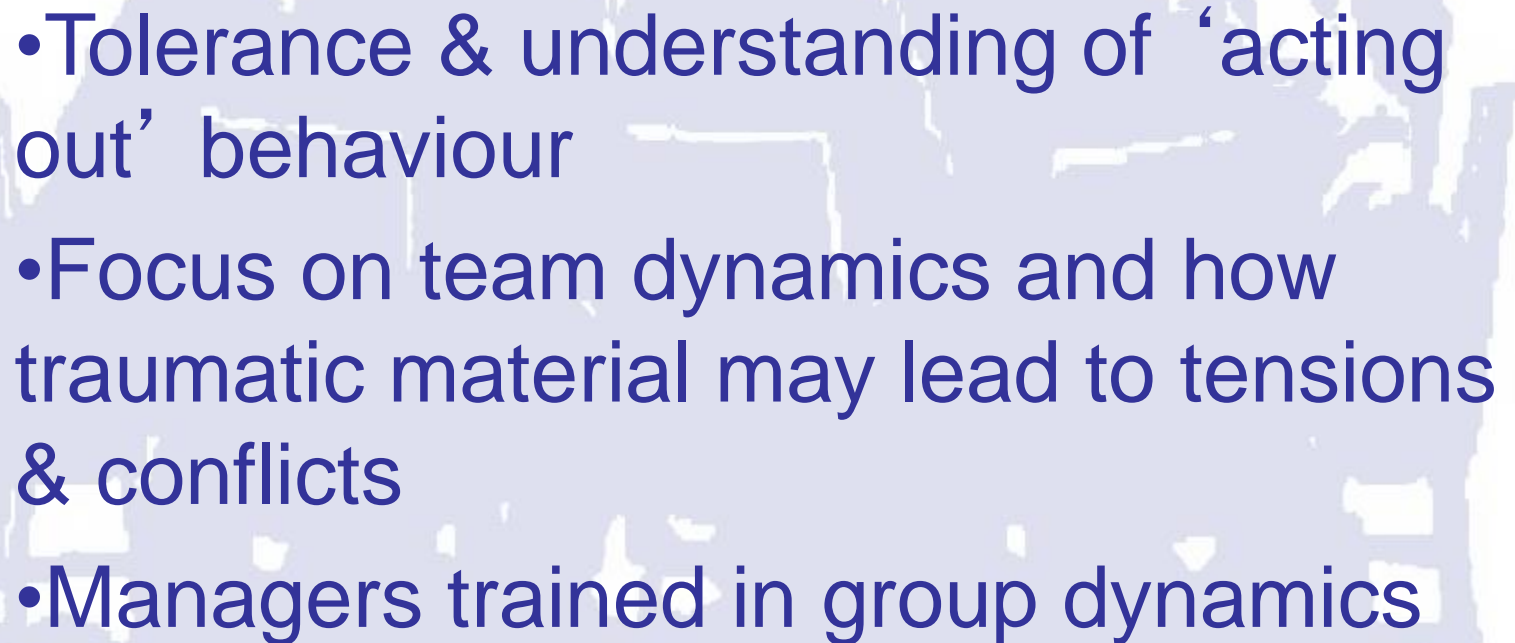
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- 
- Tolerance & understanding of ‘acting out’ behaviour
 - Focus on team dynamics and how traumatic material may lead to tensions & conflicts
 - Managers trained in group dynamics



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What can therapeutic communities offer in establishing the conditions for change?

Values based treatment

- Culture of responsibility, accountability & belonging - *self empowerment & affirming experiences*
- Shared goals & decision making
- Affirmation of worth and belief in intrinsic good



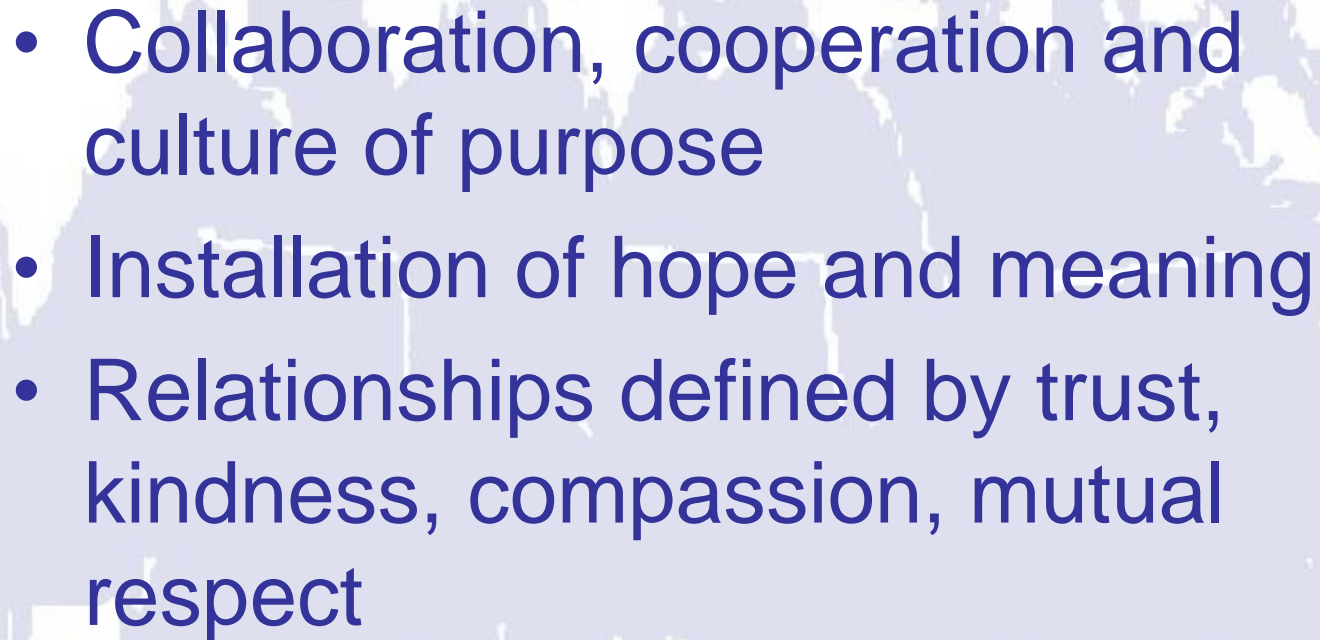
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- 
- Collaboration, cooperation and culture of purpose
 - Installation of hope and meaning
 - Relationships defined by trust, kindness, compassion, mutual respect



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To conclude....

- Provide an effective model for humane containment & treatment
- Efficacy in improved mental health, responding to trauma & risk reduction
- Values underpin the conditions for change
- Importance of how organization is integrated
- *Regime rather than therapy per se make the environment for change*




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