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“WHEN YOU HAVE GOT LIKE TWENTY THOUSAND THOUGHTS IN YOUR HEAD, THAT ONE LITTLE THING CAN JUST MAKE IT ALL GO AWAY”

Trauma and Non-Suicidal Self-Injury in Forensic Settings

Rachel Beryl and Jessica Lewis

Introduction

Within forensic settings the management of those causing harm to themselves presents a significant challenge to the services that look after them, particularly in women’s services (Uppal & McMurran, 2009). Trauma experiences, both in childhood and adulthood, and non-suicidal self-injury (NSSI) are highly correlated (Swannell et al., 2012) and the exact relationship between NSSI and trauma has been explored within the literature (see Serafini et al., 2017). This chapter will explore the relationship between trauma experiences and NSSI, and reflect on the responses within a high secure hospital setting to understanding, managing, and reducing the occurrence of NSSI, considering the impact of these on both staff and patients. We advocate trauma-informed treatment responses for this population, to compassionately respond to the distress and challenge of NSSI.

The lived experience of trauma and NSSI is woven as a narrative throughout, with three women (we called them Denise, Gina, and Emily) contributing to our understanding by reflecting on their own NSSI, what they felt were the functions of...
it, and how that might link to their traumatic experiences, commenting on staff and system responses to NSSI.

**Non-Suicidal Self-Injury**

The act of causing deliberate harm to oneself is given a number of labels such as NSSI, self-mutilation, or deliberate self-harm, and is viewed as a separate entity to suicidal behaviour. The definition of “intentionally causing physical harm to one’s own body, without the intent to die” (Ford & Gómez, 2015) is used, as it covers the broad range of behaviours. NSSI is highly associated with suicidal risk, particularly in forensic settings (Hawton et al., 2014), and both behaviours can be present in some individuals. However, many studies view them as being distinct entities, in that each can exist without the other, with the clear defining characteristic being the presence or absence of the intent to die (Ford & Gómez, 2015). In this chapter we focus on NSSI, without an intent to die.

**Trauma**

This chapter will consider trauma in its broadest sense to encompass exposure to psychologically traumatising experiences such as early traumatic experiences, e.g., abuse and neglect; adult traumatic experiences, such as sexual violence; racial trauma, seen as the “cumulative traumatising impact of racism on racialised individuals” (Williams, Haeny, & Holmes, 2021); sexual minority trauma, including interpersonal violence, victimisation, and discriminatory events (House, van Horn, Coppeans, & Stepleman, 2011); and, within forensic populations, the potential traumatising impact of their offending, and detainment (Gunter, Chibnall, Antoniak, Philibert, & Hollenbeck, 2011).

**Prevalence**

The rate of NSSI varies greatly when considering a range of different populations, such as adolescents, and those with various psychiatric diagnoses (Cipriano, Cella, & Cotrufo, 2017). There is also evidence that childhood sexual abuse, and other forms of maltreatment, including severe family dysfunction are risk factors for NSSI for a range of age groups and populations (Maniglio, 2011).

NSSI can be a particular challenge for the prison estate, with yearly NSSI rates recorded at 5–6% of male prisoners, and 20–24% of female prisoners (Hawton et al., 2014). In the 12 months up to September 2020 the Safety in Custody Statistics (Ministry of Justice, 2021) recorded self-harm incidents of 595 per 1,000 for male prisoners, in contrast to a rate of 3,597 per 1,000 for female prisoners. Within prison, NSSI rates are strongly associated with residing in solitary confinement, having disciplinary infractions and experiencing physical or sexual victimisation whilst in prison, as well as experience of childhood abuse, particularly sexual abuse (Favril, Yu, Hawton, & Fazel, 2020).

Rates of NSSI are similarly high within forensic hospital settings. Within a High Secure Hospital over a 16-month period, 30.9% of all incidents were self-harm, with
a staggering 54% of these carried out by the female patients who represented just 13.5% of the population. The rate of violence among female patients was also high, representing 36.2% of the hospital total (Uppal & McMurran, 2009). Longdon, Beryl, and Siddall (2020) reported that 98% of women in a high secure forensic population had experienced at least one form of childhood trauma, and 54% had experienced five forms of childhood trauma (physical, sexual, and psychological abuse, and physical and emotional neglect).

It is recognised that some populations are uniquely vulnerable to increased exposure to traumatic experiences, due to the long-term impact of systematic prejudice, discrimination, and targeting due to minority status (see Bhui et al., 2003; De Genna & Feske, 2013 for NSSI rates in different ethnic populations and House, van Horn, Coppeans, & Stepleman, 2011 for NSSI rates for gay, lesbian, bisexual, and/or transgender individuals).

Making Sense of the Links between Trauma and NSSI

The relationship between trauma and NSSI is complex and multifaceted, with many mediating variables, such as dissociation (Swannell et al., 2012; Ford & Gómez, 2015), alexithymia (Paivio & McCullock, 2004), and self-criticism (Glassman et al., 2007). Much of the existing literature is also cross-sectional in nature, further complicating the question of whether, and if so, how, trauma leads to NSSI (see Liu, Scopelliti, Pittman, & Zamora, 2018 for a review of the area). Throughout this section, the lived experience of individuals forms the narrative and provides opportunity for understanding the complexity of both the relationship between trauma and NSSI and NSSI and the individual. Yates’s (2009) Organisational Developmental Pathway model helps to illustrate different pathways/trajectories from trauma exposure to NSSI. These pathways also help illustrate the various “functions” of NSSI, as well as pointing to different areas of focus for therapeutic interventions.

Yates (2009) proposes that there are three key pathways from trauma to self-injury: regulatory, representational, and reactive; these can operate in isolation, or in conjunction with one another. In the regulatory pathway towards self-injury, childhood maltreatment can impact on the development of integrative, symbolic, and reflective affect-processing capacities. The thwarting of these capacities thus renders the individual less able to integrate thoughts and feelings, and to “know what they feel and to feel what they know” (Yates, 2009; p.125). It also results in reduced capacities to symbolise affect through language (i.e., to use language to share and communicate internal states), or to reflect on the feeling states of oneself or others. In this context, self-injury can become a means of communicating and regulating affect. Early caregiving experiences also shape patterns in physiological reactivity, and child “maltreatment may initiate neurobiological alterations and physiological cascades that contribute to a reactive path towards NSSI” (Yates, 2009; p.118). Self-injury can therefore represent a tool to alter biological reactivity/arousal. Thus, trauma exposure can result in both trauma-induced changes in arousal (reactive pathway) as well as reduced regulating capacities (regulatory pathway), demonstrating the inter-related and interactional nature of the pathways. The representational pathway relates to the negative representations (of
self, others, and relationships) that form as a consequence of maltreatment, and can lead to the enactment of NSSI (in isolation, or in co-existence with the other two pathways). The early caregiving milieu lays the foundation for a child’s core beliefs about themselves, their expectations of others, and of relationships. In the context of child maltreatment, the child develops representations of self as defective, unlovable, or bad; of others as malevolent and untrustworthy; and of relationships as dangerous. NSSI can therefore become a means of self-soothing (in the absence of relational soothing resources), and/or a means of self-punishment. Indeed, “self-harm can provide a paradoxical function that involves both attacking the self while simultaneously offering a self-soothing response to distress” (Grocutt, 2009; p.103).

Yates’s pathways can be viewed as synergistic and inter-related (Lang & Sharma-Patel, 2011), as can the functions and levels of meaning to a single act of NSSI. Our attempt to highlight some key themes in the functions NSSI is not to diminish the individualised and complex meanings of NSSI for a person, and indeed the reader is urged to hold in mind that “everyone self-harms for their own reason and they shouldn’t always be put like into one bubble” (Emily).

The Regulatory Pathway and Functions/Meanings of NSSI

Affect regulation is the most cited function of NSSI (Klonsky, 2007) garnering most empirical support and playing a prominent role in treatments for self-injury (Lang & Sharma-Patel, 2011). For some, NSSI offers a means of coping with emotional distress: “I’ve done it out of stress, anxiety to calm myself when I’m incredibly emotional/upset” (Chandler, 2014). It is also described as a means of “releasing all that tension and stuff” (Emily), and “feels good at the time and it makes them feel better” (Gina).

The act of NSSI can help the individual to “forget about something” (Young, van Beinum, Sweeting, & West, 2007) and “to get relief from a terrible state of mind” (Boergers, Spirito, & Donaldson, 1998). NSSI can thus offer a sense of distraction from emotional pain:

It just calms me down, like when you have got like 20,000 thoughts in your head, that one little thing can just make it all go away.

Emily

This distraction can also offer a physical focus for pain, distracting from emotional pain:

after I cut myself … it starts to hurt a little bit … and then I focus on that because it hurts. It’s like, oh God, I’ve got this to focus on now. Thank goodness. So it also kind of gives me something else to focus on rather than everything else, some- thing surface.

Himber, 1994

NSSI can represent an attempt to distance from emotional pain and “produce a feeling of numbness when my feelings are too strong” (Swannell, Martin, Scott, Gibbons, & Gifford, 2008).
It can also represent an attempt to generate feelings, to cope with the numbness brought about by a dissociative state (Klonsky & Muehlenkamp, 2007):

it's a way of getting myself awake again, it's a wakening experience.

_Himber, 1994_

I feel numb—physically and emotionally. I can’t feel my own skin. [after self-harming] I can physically feel again. My senses come back. I get a surge of energy and regain sensation.

_Horne & Csipke, 2009_

Indeed, NSSI can be a means of generating feeling (Nock & Cha, 2009), when you “want to feel something else for a change” (Gina), or want to disrupt a sense of derealisation or “psychic numbness” (Yates, 2009; p.30) and respond to or generate altered states of consciousness.

NSSI is also described as an anti-suicide survival strategy (Messner & Fremouw, 2008), where, for some people, NSSI can be a means of regulating intense emotional states and managing their risk of suicide (Edmondson, Brennan, & House, 2016): “I wouldn’t be here today if this hadn’t happened [self-harm]” (Demming, 2008).

The communicative function of NSSI is further acknowledged, where symbolic and reflective affect-processing are limited, such that acts of self-injury can be “a way of saying through gestures and acts of violence, that which cannot be put into words. Through self-harm the body speaks” (Motz, 2009; pp.21–22).

**The Representational Pathway and Functions/ Meanings of NSSI**

The role of self-criticism, negative self-image, and shame, in the association between trauma and self-injury is well evidenced in the literature (Klonsky, Oltmanns, & Turkheimer, 2003); and in the voices of individuals:

lack of self-esteem because that can play a big part for some people so if they don’t like themselves …, they might want … to destroy their own bodies or something … like if they hate themselves or people have made them feel shit about themselves over the years.

_Denise_

Self-injury is also described as inducing further self-criticism:

at the time you might think that you could feel better for a couple of minutes …, but then when that feeling goes – and it will go – and you’re just left feeling just as bad again or worse for like giving in to it, and you’ll be disappointed in yourself and upset people that love you.

_Gina_

Another related theme in the enactment of NSSI is the experience of self-blame and self-hatred. Trauma survivors may “blame themselves for what has happened in
the past” (Denise), and develop representations of themselves as defective and bad (Yates, 2009). NSSI (especially in the form of cutting or bloodletting) is described by some as a means of “cleansing” or “letting out badness” (Edmondson et al., 2016):

All the bad escapes in the blood and it’s like you can physically watch everything just wash away.

_Abrams & Gordon, 2003_

The self-punishment function of self-injury is also well documented in the literature (Klonsky & Muehlenkamp, 2007), and in service user accounts of their experience of NSSI (Edmondson et al., 2016).

In addition to negative self-representations, the negative representations of others and relationships are also evident in the various interpersonal functions of NSSI. Without other means of communicating needs for care and support, NSSI can “be a cry for help for some people, say like ‘something’s wrong and I don’t know how to ask for help’” (Denise). Through acts of self-injury, a relational need can be met:

Doing this [self-harm] I found … I received the warmth, love and attention I had been looking for.

_Harris, 2000_

if you have grown up like in a traumatic like home environment or grown up and not had the attention that you need like and the care and stuff, it might be the only way you have learnt to get that attention and …, even though it’s negative, it could be the only way that you know how to get like your needs met.

_Emily_

The description of “seeking attention” as a function of self-injury is not, however, endorsed by many (Gratz, 2003); the pejorative connotations of “self-harmers” being “attention seekers” may perhaps influence this. It is however recognised that NSSI can play a role in shaping one’s environment and influencing others (Nock & Cha, 2009). It can also offer a means of regaining some sense of control in one’s environment (Klonsky, 2007); and, in the context of secure/custodial settings, it can prompt a move in location (DeHart, Smith, & Kaminski, 2009). In forensic contexts, self-harm may further serve as a replacement for aggression (Daffern & Howells, 2009), and as an expression of aggression and revenge (Gallagher & Sheldon, 2010).

The long-term effects of NSSI on relationships is also acknowledged:

It can have an impact on your relationships with people especially if they don’t understand as to why you’re doing it in the first place, then it can scare another person cos they don’t know if that person’s going to take it too far one day, and so instead of waiting for that to happen they might just reject ‘em and that, cos it’s easier to reject someone than to losing someone completely.

_Denise_
Another proposed meaning of NSSI relates to the maintenance and exploration of boundaries (Edmondson et al., 2016), for instance “to create a symbolic boundary between myself and others” (Klonsky and Glenn, 2009). NSSI can also serve as a means of protection – both as self-protection, as well as protecting others from oneself. When NSSI serves to protect from others, this can manifest in making one’s body unattractive to others “as a barrier against unwanted advances” (Edmondson et al., 2016; p.113):

I’ve been cutting myself so that if someone does try anything they’ll see my body and think what a freak, she’s disgusting, she’s ugly.

Parfitt, 2005

When functioning for the protection of others, it can involve expressing fury at oneself rather than others (Motz, 2009; p.28). Indeed, some describe how they “would rather take it out on themselves rather than take it out on other people” (Gina).

The Reactive Pathway and Functions/Meanings of NSSI

Repeated exposure to stress and maltreatment in childhood is known to stimulate the autonomic nervous system, and lead to alterations in physiological reactivity and the functioning of stress response systems (Yates, 2009). States of hyper- and hypo-arousal can be experienced with overwhelming rapid shifts and fluctuations, and NSSI can serve as a means of attempting to modulate this autonomic dysregulation. The arousal modulation model of the Window of Tolerance (Ogden, Pain, & Fisher, 2006; Siegel, 1999) offers a framework for understanding these biphasic reactions, and NSSI can be interpreted as a strategy to up- or down-regulate autonomic arousal. Therefore, when in a state of hyperarousal, NSSI may be enacted to soothe and lower arousal, and manage the intrusions of flashbacks and traumatic memories (Van der Kolk, Perry, & Herman, 1991), whereas, from a state of hypoarousal, NSSI may serve to reduce or interrupt feelings of numbness and flattened affect.

The role of the pleasure/reward systems in the enactment of NSSI is also noteworthy, as “the turmoil and destruction are nonetheless addictive, and offer a kind of pleasure” (Motz, 2009; p.25). NSSI is described by some as a means of generating excitement and exhilaration (Edmondson et al., 2016; Klonsky & Glenn, 2009), and the potential addictive quality of NSSI is noted, alongside a need to “escalate”:

You can get addicted to it.

Bennett & Moss, 2013

when you first start doing it you think ‘this works’ and then when it doesn’t work anymore then you take it a step further, so then it becomes one big vicious cycle in the end.

Denise

Another system that appears to be impacted by exposure to trauma is the sensory system, with evidence to suggest alterations to sensory processing in the aftermath of
trauma (Schaan et al., 2019). Interoception (the sensing of internal bodily sensations, states, and experiences) appears to be impacted by trauma, and cultivating interoceptive awareness can be considered an important element of trauma recovery (van der Kolk, 1994). There is growing evidence regarding the role of interoception in understanding self-injury (e.g., Forkmann et al., 2019; Young, Davies, Freegard, & Benton, 2021), and interoception may represent an example of alterations to biological systems that may impact on pathways between trauma and self-injury, and offer new avenues for therapeutic interventions.

Responses to NSSI in Forensic Settings

It is recognised that within institutional settings, especially forensic settings, NSSI and aggression can co-exist (Hawton et al., 2014). This phenomenon, sometimes referred to as dual harm (Slade, 2019) is understood as a linked behaviour, with emotional regulation proposed as a shared function (Shafti, Taylor, Forrester, & Pratt, 2021). Within forensic settings there is therefore often a tension between safely managing risk, both to self and others, and avoiding overly restrictive interventions.

The impact of the use of restrictive interventions with female patients in a high secure setting when they engage in NSSI is explored through patient narrative. Restrictive interventions refer to physical, mechanical, or chemical restraint, seclusion and restricting access to risk items. For a broader discussion on restrictive interventions in forensic settings see Völlm and Nedopil (2016).

The reasons why people engage in NSSI are very individual and varied (e.g., Edmondson et al., 2016), and their response to the interventions used to prevent and stop NSSI can also be complex and unique (see Soininen, Konito, Joffe, & Putkonen, 2016). When staff are faced with a person who is engaging in NSSI they can experience strong and painful feelings (Aiyegbusi & Kelly, 2015), and the challenge is to respond in a calm and containing way, which increases the opportunity for the individual to respond positively, to minimise or stop their self-injurious behaviour, and to have a shared opportunity to explore the meaning and function.

It’s helpful if they don’t panic because you’re already distressed, that’s why you are self-harming.

Emily

not judge you for doing it, just think that ‘well she must have done it for a reason, let’s try and find out what that reason is and see if we can help with it’ because that’s just the best way.

Gina

Unfortunately, for a small minority of patients their severe emotional distress, combined with high risk, makes it hard for them to feel safe enough to respond to verbal de-escalation, and in the light of escalating risk it can be necessary to consider
restrictive interventions in order to manage and contain the situation (Elcock & Lewis, 2016). For patients, staff, and organisations the use of restrictive interventions are recognised as interventions of ‘last resort’ to prevent life-threatening self-injury and minimise harm (Hui, 2016), and this is acknowledged by patients:

I think that it’s not nice for the person that has to have it but I think that it is needed sometimes, because they might not see it at the time but … I think they’ll be like ‘yeah realised how serious it was’ and that it’s what was best for them at the time.

*Gina*

because if they are not stopped or something then they will just keep going until they are actually stopped, and that’s a safety thing for them ‘cos they can do what they need to do and then be stopped.

*Denise*

Although restrictive interventions preserve life, they can produce a complex array of emotional and psychological responses in the patient (Soininen et al., 2016). The clear shift of power and control away from the patient, towards the staff and the system, can mirror previous traumatic experiences. The realisation, that attempts to prevent patients from hurting themselves, can in themselves be (re)traumatising (Frueh et al., 2005), can be a difficult concept to rationalise. Patients also describe a real ambivalence towards interventions such as physical restraint:

for some people it does help because it gives them that bit of comfort like … if they are being held then they know they are not going to go further than what they intend to … but for some people it can be a difficult one, because of their past history.

*Denise*

The linked nature of NSSI and violence sometimes seen in forensic settings means that a NSSI incident can shift into a more interpersonally violent presentation, and the containment response can be seclusion, which also triggered mixed views:

Seclusion helps me because it just gives me that space, with the person outside like if I need to talk … to like calm myself down, away from the ward environment where it’s a bit quiet.

*Emily*

it might make them more distressed because you are putting them in a room with nothing.

*Gina*

One identified theme is of the importance of the relationship the patient has with the staff members involved, their knowledge of the patient’s experiences, and what is
the most effective way of keeping them safe. Another theme identified is the importance of matching the restrictive intervention to the risk, to avoid any blanket use of interventions, so when removing risk items:

I think for some people it is not needed … once they’ve done it [NSSI] they feel better and they don’t need to do it again … but if they are still distressed then they’ll try and find anything to use and they will probably regret it the next day … so I think just taking that away for just a while, until they feel better … is right.

_Gina_

It depends on what method of self-harm you’ve done, like if you have like ligated … obviously shutting the wardrobe off and removing all those items that you can do that again with, but like say if someone has cut themselves, emptying their room of like photos and teddies … doesn’t help because that’s like what they need.

_Emily_

Equally the recognition that mechanical restraint should be viewed as the absolute last resort and just for life threatening NSSI e.g., occlusion, or life altering NSSI e.g., blinding oneself (Elcock & Lewis, 2016) is represented in patient views:

I get why they use that ‘cos obviously it’s to save a person’s life if it’s to the extent of where they’re actually almost going to kill themselves, but if it’s for minor self-harming I don’t agree with it because you can try and talk to that person first.

_Denise_

Overall, the patient’s experience of restrictive interventions being used to manage NSSI is mixed. Unsurprisingly there is a clear preference for compassionate interventions that seek to talk to the patient, understand their feelings, and respond in a calm and non-judgemental way. When restrictive interventions are used there is general acceptance of the need for them to preserve life, but a clear request that interventions are individually tailored, based on a thorough knowledge of the patient’s traumatic experiences, their risk history and preferences for risk management. Additionally, explanations as to why an intervention is being used, and the availability of familiar staff can create a sense of safety (Kontio et al., 2014). It is therefore recognised that the trend towards patient involvement throughout the process is a benchmark for good practice (Soininen et al., 2016). Including patients in an open and transparent way in the clinical discussions around the use of restrictive interventions in response to their presenting risk helps the process be more predictable which can: reduce staff injuries (Hill & Spreat, 1987); lead to the patients experiencing some interventions as less restrictive (Carr, 2012); and help form part of advance decisions about their care (Elcock & Lewis, 2016).
Trauma-Informed Treatment

not everyone’s the same … everyone should be treated as an individual, everyone should have different care plans on how to help each individual in that situation.

Emily

The effectiveness of specific interventions to address NSSI has been described elsewhere within the literature (e.g., Hetrick, Robinson, Spittal, & Carter, 2016; Hawton et al., 2016). Given the significant distress and challenges associated with NSSI (for the individual and the wider system), the multiple pathways from trauma to NSSI, and the multifaceted complex meanings ascribed to these acts, it is therefore essential that treatment responses are also multifaceted, individualised, and formulation-driven. We propose that the treatment of NSSI should be viewed through a trauma lens, and that a whole-system approach is necessary to effectively support people engaging in NSSI, whilst responding to the challenges posed in relation to NSSI within forensic settings. An example of a service which aims to provide a trauma-informed whole systems approach to the management of NSSI is the Trauma and Self-Injury (TASI) Service, within the National High Secure Healthcare Service for Women (NHSHSW).

The TASI Service was founded to respond to the co-occurring high rates of trauma and self-injury within the patient population of the NHSHSW. Since its creation in 2007, the service has continually evolved, with patient-involvement central to all elements of service development. The TASI Service influences, and is influenced by, the wider context in which it is situated. The NHSHSW has as a strong multidisciplinary ethos and the role of the TASI Service is in promoting a trauma-informed response to NSSI. A social ecological perspective helps illustrate the different components of TASI across each layer of the system. Figure 9.1 depicts the range of contributions of the TASI Service, illustrating the influence of each part of the system, which all interact in a reciprocal way.

At the centre of the system is the patient, and the interventions that involve working directly with the patient. These interventions can be viewed in the context of the phased approach to trauma recovery (e.g., Herman, 1992/2015), which involves a safety and stabilisation phase, a processing phase, and a reintegration phase. Following admission to the service, an initial priority is to build an understanding of the patient’s trauma history and trauma symptom profile. Patients are supported to complete a document that we refer to as a Distress Signature to help the development of a shared understanding of their experience of distress, ways of coping, and their preferences for how to be supported when in crisis. Patients are also supported to develop their own Sensory Signature document, which considers their sensory preferences, different ways of using their senses to modulate sensory input and arousal, and to develop sensory diets. A key aim for both the Distress Signature and Sensory Signature is to include patients’ voice and choice to inform care planning, and promote trauma-informed sensory-supportive responses to distress and NSSI.
There are a range of therapeutic interventions within TASI that contribute heavily to the stabilisation phase of recovery, and to the pursuit of building emotional and bodily safety (Herman, 1992). These interventions are also focused on addressing the disconnect between cognition and affect, developing a greater understanding of, and language for, emotions, and learning skills to better regulate arousal/emotions and widen their window of tolerance. Three psychoeducational group interventions contribute to these aims: a Wellbeing Group, a Sensory Awareness Group, and a Trauma Psychoeducation Programme; additionally, Dialectical Behaviour Therapy also plays a key role in the provision of interventions to address NSSI. Whilst typically considered a key part of the processing phase of recovery, Eye Movement Desensitisation and Reprocessing (EMDR) can also be beneficial in the stabilisation phase, with the development of resources, and to specifically target NSSI (Annesley, Alabi, & Longdon, 2019).

The focus of psychoeducation, resource development, skills training and rehearsal within interventions contributes to addressing the difficulties highlighted within the
regulatory and reactive pathways of Yates’s model. The treatment needs associated with the representational pathway are typically addressed within the therapies that are offered as part of the processing and reintegration stages of recovery (see Figure 9.1). These trauma-focused interventions can also build on gains made in stabilisation therapies, to further develop the individual’s understanding of their use of NSSI, target the underlying routes to these coping responses, and find new ways of managing distress and relating to others.

An essential component of trauma-informed care is the support and development of the staff team, which is necessary to enable the maintenance of compassionate care, and is highlighted as a priority in the long-term management of NSSI (National Institute for Health and Care Excellence, 2011). The staff support and development layer therefore focuses on interventions related to this, with a key part of this being the regular provision of trauma-informed supervision and reflective practice/case formulation sessions, as well as post-incident diffusion and debriefs; all of which are deemed essential to support staff with the emotional toll of engaging in this work (Beryl, Davies, & Völlm, 2016). A two-day training course on trauma and self-injury is central in efforts to increase knowledge about trauma and how it can affect people and groups; help staff to recognise the signs of trauma; explore power relations, ways of responding effectively, and resisting re-traumatisation. A key aim is to cultivate a compassionate understanding of NSSI and encourage therapeutic ways of responding to reduce harm, and the training has been found to increase staff confidence in working with trauma and self-injury and in asking for support (Robertson et al., 2013).

Supporting and encouraging trauma-informed principles within the ward milieu is another vital layer to foster an environment which can promote harm reduction. Central to this are the roles of the Ward TASI Champions and Ward TASI Patient Representatives. TASI Champions are members of the nursing team who contribute to the provision of TASI interventions and play a key role in promoting a trauma-informed perspective within the nursing team. The role of the TASI Patient Representative is to share information with, and from, the wider patient group, co-facilitate TASI groups and training, contribute to TASI Reference Group Meetings (where all TASI developments are initiated and reviewed), and to take part in the co-production of a quarterly TASI Times newsletters for the service. There is a strong emphasis on encouraging sensory approaches on the wards, with the aim of increasing sensory awareness and cultivating sensory-supportive environments. This includes promoting a range of sensory tools/equipment, as well as the use of essential oils, with assessments administered to identify a ‘prescription’ of oils to assist individuals with calming, activating, or grounding, as a means of helping navigate their window of tolerance.

The TASI Service also focuses on influencing the wider environment/system, for instance from co-producing projects to enhance the physical environment (such as the introduction of a sensory garden) to informing policies and procedures with the aim of promoting a trauma-informed perspective to service design and delivery. Running through each layer of the system, is the culture of the service, informed by its values and the principles of trauma-informed care: safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice, and
choice; and cultural, historical, and gender issues (SAMHSA, 2014). The success of the TASI Service is in its multi-dimensional approach which keeps the patient at its centre, whilst recognising the need to influence all parts of the system in order to meet the needs of patients who engage in NSSI, and those staff who support them.

Conclusion

Unfortunately, there is no ‘quick fix’ to the challenges faced by forensic services when they try and support individuals who engage in NSSI. The complex, varied, and individualised reasons which lead to a person harming themselves makes it clear that no one treatment response is indicated. Traditional attempts by forensic services to ‘manage and control’ NSSI, often through restrictive interventions, can fail to address root causes, and may even negatively contribute to an individual’s distress (both staff and patients). The TASI Service offers a way of approaching the challenge from a trauma-informed and multi-dimensional perspective, which involves encouraging an individualised understanding of distress and trauma, staff training to enhance skills and compassion, developing ward milieus which hold trauma in mind, and influencing the design of services and development of policy. The TASI Service is continually evolving, not least because of the central role of patient feedback and involvement. However, each incarnation holds the trauma-informed principles at its core, and strives to support each patient whilst they are on their therapeutic journey.

Note

1 Within this chapter, we use the term ‘patient’ to describe the women who reside in our service, as this is the terminology used within this setting.

Further Reading

Herman, J. (2015). Trauma and recovery: The aftermath of violence from domestic abuse to political terror. Basic Books.

Motz, A. (2009). Managing self-harm: Psychological perspectives. Routledge. This book offers a thought-provoking exploration self-harm, considering how it is understood, the wider context and systemic issues, as well as offering a focus on women and self-harm.


References


Trauma and Non-Suicidal Self-Injury


