A significant number of offenders who have survived childhood trauma go on to misuse drugs or alcohol. Relief from the psychological impact of these experiences is often sought through “self-medication” by legal or illicit means. Drugs are widely available in a number of forensic institutions and continue the cycle of offending as individuals seek substances to cope with re-traumatising experiences. This chapter will consider the routes to misuse and/or addiction, the consequences to social and psychological functioning, and the connections to crime, whether as a perpetrator or victim. It will look at treatment considerations when dealing with offenders who are survivors of trauma and who use substances.

**Trauma, Substance Use, and Offending**

The two most prevalent Axis 1 disorders in the prison population are substance use disorders and post-traumatic stress disorder (PTSD) (Butler et al., 2006; Butler & Kariminia, 2005; Sindicich et al., 2014). Substance use-related symptoms such as aggression, impulsivity, and reduced inhibitions, combined with PTSD symptoms including hypervigilance, anger, and irritability, may increase the likelihood that individuals will go on to perpetrate violence. These symptoms make individuals in prisons and hospitals difficult to manage and lead to poor staff morale. This translates into a group of individuals who are considered to be one of the most challenging groups in the criminal justice system (Chandler, Peters, Field, & Juliano-Bult, 2004).

It has been estimated that around one in ten children is neglected, or psychologically abused annually and that that between 4% and 16% are physically abused (Gilbert et al., 2009). Straus (1992) estimated that approximately ten million adolescents in the US are exposed to violence each year. Furthermore, reports of abuse and neglect are probably subject to underreporting because of embarrassment, shame, denial, or lack of insight (Widom, Ireland, & Glynn, 1995). One of the most widely cited
factors associated with juvenile delinquency is the use of illicit substances (Hawkins, Catalano, & Miller, 1992; Williams, Ayres, Abbott, Hawkins, & Catalano, 1999). The Adverse Childhood Experiences (ACEs) study concluded that the number of retrospectively reported ACEs experienced before the age of 18 was highly associated with addictive behaviours later in life (Felitti, et al., 1998). The prevalence of mental health conditions is also higher amongst substance using juvenile offenders (Montgomery, Vaughn, Thompson, & Howard, 2012). Substance use and mental health issues have been estimated to be roughly two to four times greater among those with histories of childhood trauma (Cusack, Herring, & Steadman, 2013).

Sommer et al. (2017) concluded that substance use prior to violence has been shown to make perpetrators feel more powerful, more aggressive, and less fearful in those who find aggression intrinsically rewarding (appetitive aggression). PTSD symptoms such as hyperarousal, hostility, and anger can be a behavioural precursor to aggression (Sommer et al.). When under the influence, substance use usually calms nerves and decreases inhibition, but this may also serve to increase the chances of becoming a victim of violence and thus increase the likelihood of being exposed to more traumatic experiences (Goldstein, Brownstein, Ryan, & Bellucci, 1989). Gang affiliation is often sought for protection from violence in disaffected youth. Gang affiliation is associated with drug abuse and violence which is reinforced by association with criminal peers and the desire to maintain status in the gang (Brunelle, Brochu, & Cousineau, 2000).

Exposure to violence significantly predicts substance use (Khoury, Tang, Bradley, Cubells, & Ressler, 2010), and exposure to traumatic events or dysfunctional childhood experiences are associated with a higher likelihood of depression, PTSD, substance use disorder, particularly intravenous drug use (Messina & Grella, 2006) and more sexual risk-taking behaviours (Davis, Combs-Lane, & Jackson, 2002). Poor social support and a high degree of family problems are related to higher levels of alcohol and marijuana use amongst teenagers (Rhodes & Jason, 1990). The converse was associated with less substance use among adolescents (Averna & Hesselbrock, 2001). Therefore, a positive supporting family network is a protective factor against adolescent substance misuse (Robertson, Xiaohe, & Stripling, 2010). Substance use can result in behavioural reactions such as impulsivity, reduced inhibitions, and aggression. These, coupled with PTSD symptoms such as hypervigilance, irritability, and anger, may serve to increase an individual’s risk of violence (Barrett, Mills, & Teesson, 2011). Once comorbid substance use and PTSD have been established, they both act to maintain or exacerbate the other and this leads to significant harm (Sindicich et al., 2014).

Mechanisms that underlie the co-occurrence of substance use disorder and trauma are not yet fully understood. Biopsychosocial explanations have been suggested as including self-medication, heritability, social influence, and vulnerability factors such as poverty and a family history of mental illness. There is a substantial body of evidence that documents that PTSD occurs prior to the onset of substance use disorders, the suggestion being that substance use may be used to relieve the symptoms of PTSD. Green et al. (2016) studied the cumulative effective of multiple trauma types. They found a dose–response relationship between cumulative trauma
exposure and the severity of mental disorders, including PTSD. Experiences of rape were associated with very high rates of PTSD in both men and women, whereas accidents and disasters were associated with a much lower rate. Ongoing sexual and/or physical abuse contributed significantly to lifetime PTSD, major depressive disorder, and substance abuse, compared with no trauma, traumatic bereavement, and single episode physical assault, suggesting the potency of repeated exposure to interpersonal violence. Briere, Kaltman, and Green (2008) found a linear relationship between a number of trauma types experienced by their participants before age 18 and trauma-related symptom complexity, suggesting a generalised effect of cumulative trauma.

The boundary between being a victim or a perpetrator is often blurred because of exposure to violence, trauma, and substance use (Sommer et al., 2017) and a reciprocal relationship also exists with being a victim and a perpetrator of violence. Howard, Karatzias, Power, and Mahony (2017) suggest the direction of causality in female offenders as the use of violence leading to PTSD and drug use. Those who are perpetrators of criminal acts are rarely thought of as being traumatised themselves (Butler & Kariminia, 2005), so PTSD often goes unrecognised. This is despite a substantial body of literature which documents the co-occurrence of past victimisation and psychological trauma amongst both male and female inmates (Gibson et al., 1999). Prisons can be toxic environments with a culture of violence. Therefore, individuals within prisons are often under threat of further re-traumatisation (Lovell, Johnson, Jemelka, Harris, & Allen, 2001). Up to 90% of prisoners of both sexes are exposed to traumatic events whilst incarcerated, with many having experienced multiple traumas (Indig et al., 2010). Does the system that includes intrusive searches, seclusions, limited privacy, and sanctions for misdemeanours constitute triggering re-traumatising events that lead to resurgence of PTSD symptoms and therefore substance misuse?

Substance Use and Trauma in Female Offenders

Incarcerated women often have extensive trauma histories. Cook, Smith, Tusher, and Raiford (2005) found that 81% had experienced five or more traumatic events in their lifetime. The rates of trauma amongst female prisoners have been reported at 94% for any trauma and 31% and 26% for childhood sexual and non-sexual abuse, respectively (Howard et al., 2017). Women are more likely to be diagnosed with PTSD and to use drugs more heavily than men prior to entering prison and have a higher rate of drug relapse (Kubiak, 2004). The prevalence of PTSD among female prisoners was found by Palmer, Jinks, and Hatcher (2010) to be 40%, compared with 12% of male prisoner. Drug abuse prevalence rates of 30–60% were reported among female prisoners and there were also indications that female prisoners report greater use of the most harmful and addictive drugs such as heroin, cocaine, ecstasy, and LSD than males (Komarovskaya, Booker-Loper, Warren, & Jackson, 2011).

The differences between female and male prisoners with substance use disorders and comorbid PTSD were predominantly in the types of trauma they experienced.
Female samples reported higher rates of sexual assault, which predominantly occurred in childhood (Salgado, Quinlan, & Zlotnick, 2007; Wolff & Shi, 2012), whereas male prisoners reported higher rates of physical assault which occurred in early adulthood. However, it was noteworthy that the prevalence of sexual assault amongst the sample of male prisoners was 47% (Sindicich et al., 2014). Fehrman (2019) reported that traumatic experience and subsequent PTSD are highly prevalent amongst female prisoners and that her findings support the view that this is related to their use of drugs. She stressed the importance of assessing differing needs for men and women who misuse substances, to ensure gender responsive treatment that is trauma informed.

Substance Use and Trauma in Black and Ethnic Minorities

In general, levels of substance use are lower in minority ethnic groups than among the white population. This is despite people of colour in the UK being disproportionately subject to “stop and search” (Beddoes, Sheikh, Khanna, & Francis, 2010). In the UK, the highest rates of substance use are by individuals from mixed ethnic backgrounds and the lowest levels from those from Asian backgrounds (Indian, Pakistani, or Bangladeshi). However, it is thought that substance use amongst minority ethnic communities is underreported due to the high levels of stigma associated with it in those communities. Furthermore, these communities may be at increased risk of drug use because they often live in disadvantaged and deprived areas where drug markets thrive (Beddoes et al.).

The Centre for Ethnicity and Health (2004) studied problematic drug use among asylum seekers and refugees. They reported that these groups experience considerable loneliness and isolation as they are often separated from their families and are living in a culture that is unfamiliar to them. Isolation and frustration also resulted from difficulties in accessing housing, health, and education. Ross Dawson (2003) reported that when accommodation was found it was often in areas where drug taking and dealing is problematic. Thus, substance misuse was not a problem generated by asylum seekers and refugees, rather it was one they had to face.

McCormack and Walker (2005) argue that the use of substances by asylum seekers and refugees is underreported, not only because not all institutions record refugee status, but also because most refugee and asylum seekers tend to hide any involvement in drugs for fear this may impact their status in the UK.

Personal Narratives

Over the course of a number of years I have spent documenting patients’ narratives surrounding their substance use, there are a number of reoccurring themes associated with addiction. The most prominent one has been the experience of trauma. Patients speak of their use of drugs and alcohol as representing their failure to cope with life in general and their wish to escape from the realities associated with the painful memories that they have internalised with a sense of culpability. The shame they continue to experience is internalised as a sense of being fundamentally flawed.
Jay

Jay was one patient who told me of his traumatic experiences. He did so seemingly without an emotional connection to them. Jay told me he had learned to keep his emotions in check because he was scared if he began to “feel” he might not be able to control the outcome and that was a scary prospect. Jay told me that in his early years he had watched his father smoke cannabis and misuse prescription drugs to help with his own poor mental health. Jay was harshly punished on a regular basis when he misbehaved at school by getting into fights with others in his class. That was, he said, if he bothered to go to school at all. He told me that in retrospect, this behaviour started after he was sexually abused by one of his cousins. He said that he had told his mother about this. She dismissed what he had said as lies and an attempt to excuse his bad behaviour. He told me she was the only one who could stop what was happening, but she chose to ignore it. Jay said that this was the most difficult thing to cope with. He said he could “switch off” the pain of the abuse but could not come to terms with the feeling of not being believed and, worse still, not feeling protected. Jay tried to cope by using alcohol in the park with his friends, but he told me he would get aggressive when he drank, and his friends started to shun him as he directed his anger at them. “Speed” (amphetamine) was a revelation to Jay the first time he took it. It made him feel invigorated, energetic, and superior to others. It gave him back the feeling that he was in control and that he was able to protect himself again. However, Jay’s use of speed made him increasingly hypervigilant and paranoid. He said that although he did not recognise it at the time, his mental health was declining rapidly. He felt persecuted by everyone he encountered. He told me that his own sexual offence was committed because no one could be trusted and he wanted to humiliate someone else so they knew what it was like to feel the way he did.

Jay did not feel safe in prison, but he coped by using aggression as he had done in the community. In prison he found a drug that made him feel the same way as he did when he used speed, but it was better, a more intense feeling. Crack cocaine made him feel powerful against the harassment of others who persecuted him because of the nature of his offence. Jay fought back, but when restrained by prison officers it brought back the same feelings as those he had at the time of his own sexual abuse. He described these feelings to me as like a nightmare when he was awake. Crack was his medication; it numbed the painful emotions associated with the trauma such as guilt, shame, worthlessness, and anger at allowing himself to be a victim. Crack increased his sense of self-worth.

Ricky

Ricky grew up in a chaotic environment. He told me that he and his six siblings had to fend for themselves as their mother took prescribed benzodiazepines to escape from her own mental health problems and was “out of it” for most of the day. He told me that his stepfather was an alcoholic and violence was the norm at home. Other children at school would bully him because of the way he dressed in dirty clothing, and the fights he got into as a consequence of this resulted in multiple exclusions
from school. Ricky struggled with his emotions. Rejection was particularly hard to manage. He could not deal with the emotional pain, but it hurt less if he turned some of it into physical pain. Ricky began cutting his forearms, which made him feel better for a fleeting moment but ended in feelings of shame. The trauma of previous neglect and violence was also relieved when he would sniff glue and butane in the park with some of the other children.

Ricky’s safe base was at his grandmother’s house where he would spend the weekends. When she died suddenly at the age of 55, he said that he felt alone as she was the only person who cared for him. He had been stealing his mother’s benzodiazepine medication for some time. He took an overdose that almost killed him. Ricky told me how his mother was more upset that he had stolen her tablets than she was about the fact that he had almost died.

Ricky was moved into a children’s home after that episode and had fond memories of being taken ice skating by the staff. He told me that he would go and visit his mother, who was now in psychiatric care and take her to McDonalds for lunch. He told me that he thought that they could live together, but the rejection continued, so this time he coped by drinking. He said that he was trying to prove that he could hurt himself more than anyone else could hurt him.

Ricky’s life was chaotic – sofa surfing, drinking, and taking any substance he could get hold of. When he was ejected from a friend’s house and faced the prospect of living on the streets, he set fire to the bins in the rubbish well of the block of flats he had been thrown out of.

Joe

Joe was considered a troubled child with disturbed behaviour that his foster family found difficult to cope with. They would lock him in a cupboard under the stairs in an attempt to address his unruly behaviour. He told me that it was frightening being in the dark, but he had experienced worse. Joe had been taken into care after he witnessed his mother being beaten by his alcoholic stepfather. He told me he was relieved at being taken away from the family home as he had suffered sexual abuse at the hands of his stepfather from the age of six. He told me he could not tell anyone about the abuse for fear of retribution, but he learned to live with the abuse by “taking my mind away to somewhere else” when it was taking place.

Joe’s relationship with substances started when he began sniffing glue with a gang of older local “skinheads”. Joe said that he felt a sense of belonging in their company, but they would “dare” him to drink the alcohol they gave him until he either passed out or was sick. By the age of 17 he said he would use anything he could get hold of to give himself “time away from bad thoughts”. He told me he now knows he was self-medicating for the flashbacks to the abuse he had suffered as a child. Joe was a frequent patient in psychiatric units and said that when he was sectioned, he would constantly seek medication from the psychiatrist. Similarly, when he was on the streets, he said he would seek out his next “anaesthetic” from less legitimate drug suppliers.

Joe’s substance use made him a victim of further trauma and abuse. He described a life where he was constantly trying to fit into a world where he felt isolated and
alienated. He said that when he took cocaine or speed, he felt more confident. His said that his sexual promiscuity was also an attempt to manage his feelings of poor self-worth. Feelings of paranoia were dealt with by taking cocaine to make him more alert, and cannabis was smoked regularly to help him relax. His use of heroin gave him respite from the flashbacks of his sexual abuse, but anything else would do if he was offered it. Joe told me his substance use was his personality and that without it the traumatic memories would defeat him, so he would self-destruct with chemicals.

Joe had numerous convictions when I met him. He said that most were associated in some way with his substance use. He said that now he was “clean”, he realised that the last 20 years of his life had been taken up by either being high on any substance he could get hold of, by trying to get hold of the means to get the drugs, or withdrawing from them. Even when Joe had managed to get hold of drugs or alcohol, he would be thinking about how he would get more when it ran out. He told me that, when sober, his mind would be constantly occupied with violent thoughts. He repeatedly told himself that he was to blame for the abuse he had suffered and that he could have stopped the violence his mother had endured.

### Trauma, Substance Use, and Offending from a Treatment Perspective: What Might Work?

As we have seen, trauma and substance use frequently co-occur. This comorbidity makes both conditions harder to treat (Zlotnick et al., 2003) and patients with this clinical profile have poorer functioning, well-being, and treatment outcomes (Roberts, Roberts, Jones, & Bisson, 2016). Within the risk needs responsivity model (Bonta & Andrews, 2016), trauma may be considered as a responsivity factor that moderates the effectiveness of interventions that target the major risk factors for violence. A history of trauma has been linked to drop out from drug treatment programmes (Resko & Mendoza, 2012). Because patients with comorbid PTSD and substance use disorders are often excluded from clinical trials of psychological interventions, it can be difficult for clinicians to decide what treatment is best. Often this results in PTSD and substance use disorders being treated in a sequential fashion, leaving doubt as to whether this is the most effective approach, or whether an integrated treatment approach would be more effective (Roberts et al., 2016).

Pharmacological treatments can be used to block the effects of opioids, reduce cravings, or induce aversive sensations following consumption of, for example, alcohol. They have demonstrated mixed results (McHugh, Hearon, & Otto, 2010) and their use is usually accompanied by unwanted side effects.

The most common model of correctional addiction programme is Cognitive-Behavioural Treatment (CBT: Lipsey, Landenberger, & Wilson, 2007). CBT encourages patients to rethink their attitudes and modify their behaviours to remain abstinent. CBT relies heavily on self-control (Anthes, 2014). It teaches coping skills to deal with cravings and stress and teaches relapse prevention strategies. CBT incorporates homework tasks for patients to complete between sessions. However, trauma may interfere with participation in cognitive behavioural therapy (Miller & Najavits, 2012).
Eye movement desensitisation and reprocessing (EMDR: Shapiro, 2001) is often used to treat PTSD (Cusack et al., 2016) and has also been adapted to treat addiction (Markus & Hornsveld, 2017). The adaptive information processing model (AIP: Shapiro), theorises that dysfunctionally stored memories are accompanied with high levels of emotional arousal, which can be either positive or negative. In the case of substance use, these memories are thought to be weakened and modified using eye movements. Positive memories become less vivid and subsequently, less positive (Engelhard, van Uijen, & van den Hout, 2010; Horneveld et al., 2011). EMDR does not rely as heavily on patients’ self-control, as such it is thought it is better tolerated and accepted, with fewer retention and relapse problems than other therapies (Markus & Horneveld, 2017). Roberts et al. (2016) reviewed the effectiveness of these combined treatments and concluded that trauma-focused therapy alongside substance use treatment had some effect, whereas stand-alone, non-trauma focused therapies had little or no effect.

Two treatment modalities that target the co-morbidity of substance use and personality disorder (the origins of which are understood to lie within early traumatic experience, see Chapter 4) are Dialectic Behaviour Therapy-Substance Abuse (DBT-S: Linehan, Schmidt, & Dimeff, 1999) and Dual Focus Schema Therapy (DFST: Ball, 1998). DBT-S was developed for patients with a diagnosis of borderline personality disorder and a history of substance abuse. Evidence suggests that this dual focus shows both decreased attrition rates and a reduction on substance use. DFST consists of a more individualised, formulation-based approach, built on a comprehensive assessment and conceptualisation of early maladaptive schemas and consequent maladaptive coping styles. The treatment consists of a cognitive-behavioural approach combined with experiential strategies (imagery and chair work) and has shown some promising findings in dissimilar populations of personality disordered and substance abusing individuals (Ball, 2007; Ball, Cobb-Richardson, Connolly, Bujosa, & O’Neil, 2005). However, in a review of all current dual focused treatments (including DFST) it was concluded that whilst it was more effective that regular mono-focused treatments, more valid and reliable research was needed before robust conclusions could be drawn (Shorey, Stuart, Anderson, & Strong, 2013).

Poor resilience has been associated with involvement in the development of PTSD (Fincham, Altes, Stein, & Seedat, 2009). Resilience has been defined as a dynamic or active factor that involves an interaction between risk and protective processes that reduces the effects of an adverse life event. It involves both internal and external factors that enable the individual to recover from crisis. Resilience has been found to moderate the relationship between risk factors and PTSD. Resilience is highlighted in Seeking Safety (Najavits, 2002), a treatment programme that focuses on both traumatic experiences and substance abuse. Najavits reported that those undergoing the programme showed more positive results on measures of substance abuse and PTSD than participants receiving treatment as usual. Lynch, Heath, Mathews, and Cepeda (2012) and Wolff, Frueh, Shi, and Schumann (2012) also demonstrated the feasibility and the effectiveness of a seeking safety intervention for PTSD and substance use disorders using the Seeking Safety programme with incarcerated women.
Whilst perceived coercion to enter treatment, such as pressure from family, criminal sanctions, loss of employment of financial concerns, can heighten psychological distress and may add additional pressure to seek treatment (Cimino, Mendoza, Nochajski, & Farrell, 2017), individuals who have been detained in hospital or prison are presented with an opportunity that they may not have in the community. Less chaotic living circumstances mean that access to treatment is more likely to address their complex needs (Butler et al., 2006). This in turn may also reduce their risk or relapse into substance misuse and criminal activity, particularly for those with comorbid substance use disorders and trauma. Integrated programmes address some of the reasons for substance abuse and criminal activity; they are more likely to influence future behaviour in order to break the cycle of violence (Greene, Haney, & Hurtado, 2000; Gunter, Chibnall, Antoniak, McCormick, & Black, 2012).

Treatment approaches that integrate treatments for trauma and substance abuse focus either on improving current coping skills or on exposure to past traumatic events. The review by Roberts et al. (2016) suggests that the latter are more effective.

Prison-based interventions targeting comorbid substance use and PTSD have been effective in reducing PTSD symptoms and substance use (Zlotnick, Johnson, & Najavits, 2009; Zlotnick, Najavits, Rohsenow, & Johnson, 2003). Brown, Perera, Masho, Mezuk, and Cohen (2015) advocate for an integrated treatment approach to intimate partner violence which includes intervention that addresses substance misuse and previous traumatic experience.

Murphy and Rosen (2014) suggest that promising data are emerging in support of combining trauma-informed therapeutic techniques with motivational enhancement techniques. Killian, Cimino, Mendoza, Shively, and Kunz (2018) suggest a possible link between positive outcomes from trauma treatment and subsequent readiness to change substance use disorders. However, the relationship between readiness to change behaviour and trauma history remains unclear.

Fehrman (2019) studied a female offender population and concluded that treating offending, substance use, and trauma needs in an integrated way would be hugely beneficial in reducing future violent offending. Wallace, Conner, and Dass-Brailsford (2011) reviewed integrated trauma interventions. They described a range of interventions that show promise in reducing trauma and mental health symptoms. Martin, Eljdupovic, McKenzie, and Colman (2015) highlight the multiple social, health and behavioural needs of prisoners who were at highest risk of violence, which should be considered as treatment targets. Wallace et al. stress the need for interventions for inmates with trauma histories to be integrated, that is to target multiple needs simultaneously, rather than sequentially in order to be effective.

**Conclusions**

There continues to be a need to clarify developmental pathways from traumatic experiences to criminal behaviour and substance use and to identify modifiable risk factors that can be targeted through treatment. There is also a need to disentangle causal relationships from associations. Offenders with substance use disorders and trauma are a vulnerable group with complex treatment needs. Yet despite their
vulnerability and the complexity of their clinical profile, they receive little by way of treatment that would reduce recidivism whilst improving psychological well-being and further victimisation. Despite the lack of research into combining substance use and trauma treatment highlighted by Roberts et al. (2016), an integrated approach to treatment, formulating and targeting the interplay between trauma, substance use, and offending is indicated as being the most effective way forward.

Further Reading

Najavits, L. M. (2002). Seeking safety: A treatment manual for PTSD and substance abuse. Guilford Press. Whilst this manual was published in 2002 it represents the first, and most empirically supported, model to address the complex relationships between trauma and addiction.


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References


