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The Traumatic Impact of Violent Crime on Offenders

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THE TRAUMATIC IMPACT OF VIOLENT CRIME ON OFFENDERS

Jennifer Pink and Nicola S. Gray

Introduction
The development and emergence of post-traumatic stress disorder (PTSD) are most commonly associated with being a victim of a traumatic event. However, it is increasingly acknowledged through research and practice that, in addition to the victims of violent and sexual crimes, those who commit the offences can also develop PTSD as a result of their own actions (Gray et al., 2003). In committing offences of this nature, perpetrators witness the serious injury, sexual assault, or death involved or caused by their own offences. Offence-related trauma can lead to a full range of PTSD symptoms that can endure over time, impact longer-term mental health, and increase the risk of violence and aggression (Ternes, Cooper, & Griesel, 2020). This chapter discusses the prevalence of offence-related trauma in offending populations and illustrates through a series of case studies the survival response that some offenders may use in response to their trauma and the complexity in identifying and working with such cases. The case studies are all based on real cases, but with all identifying features changed to protect the anonymity of those involved. It concludes with a practical framework for identifying those with offence-related PTSD and working with them.

The Prevalence of Offence-Related Trauma
While the extent to which offence-related trauma is present in offending populations has not been extensively explored, several studies have identified prevalence rates ranging from around 33% to over 50% in samples of adult offenders with convictions of serious interpersonal violence. Within a group of mentally disordered adult offenders with violent and sexual index offences (n = 37), one third met the criteria for PTSD as a consequence of their offending behaviour, while over half reported symptoms of intrusion, avoidance, and hyperarousal (Gray et al., 2003). Similarly, Crisford, Dare, and Evangeli (2008) identified a prevalence rate of 40% for offence-related PTSD in
their mainly male sample of 45 mentally disordered violent and sexual offenders. In studies with samples of only homicide perpetrators, prevalence rates of offence-related PTSD exceeding 50% have emerged (Papanastassiou, Waldron, Boyle, & Chesterman, 2004; Pollock, 1999). Of the 80 offenders in Pollock’s (1999) study, 42 met the criteria for current PTSD, with 82% of these reporting their offence as traumatic. In Papanastassiou et al.’s (2004) study, 58% of the participants had full PTSD since the index offence, and an additional 21% displayed one or more of DSM-IV’s B, C, or D criteria. However, high prevalence rates of this type of trauma have not emerged in all studies in this area. Only 9% (n = 5) of a sample of adult forensic inpatients (n = 53), all with convictions for violence ranging from arson through to homicide, reported that their own offence had led to symptoms of PTSD (Spitzer et al., 2001). Interestingly, these five inpatients with offence-related trauma included all three of the sample who had committed a murder, and the remaining two were violent and sexual offenders. Therefore, while it is challenging to determine any general prevalence rates for offence-related PTSD, it appears that offence-related trauma is most prevalent in those who have offended violently but is also present in lower levels for sexual offenders.

Of further interest is a possible distinction in trauma symptomatology between violent and sexual offenders: higher levels of PTSD symptoms have been identified in violent offenders compared to levels of symptomatology in those with sexual index offences (Gray et al., 2003). This difference in prevalence and symptomology may be largely driven by the nature of the trauma caused by the offence. However, the deliberateness of the offence may also play a role in this differentiation. Violent interpersonal offences can sometimes be committed “in hot blood” when a person is angered or frightened and does not consider the possible consequences of their actions. This is often the case in forensic psychiatric populations, where the offender may be acting violently when experiencing severe mental health issues, causing them to be fearful or paranoid. Contrastingly, sexual offences are often planned, intentional, and desired (Gray et al., 2003). Thus, the traumatic reaction to committing different types of offence may be driven by both what is witnessed and experienced during the offence, and its intentional.

In younger forensic populations, evidence suggests comparable prevalence rates to those found in adult populations. Evans, Ehlers, Mezey, and Clark (2007) conducted research with young male offenders (n = 105) with convictions for serious violent crime. Similarly high levels of offence-related PTSD symptomatology emerged to those found in the adult samples previously discussed, with 46% of the participants reporting intrusive memories related to their offence. Comparable levels of trauma symptoms emerged in another sample of young male offenders (n = 34) with convictions for serious violence or murder (Welfare & Hollin, 2015). While many of these participants reported symptoms related to their own experiences of trauma as well as their index offence, all of the offenders with an index offence of murder (n = 8) reported ruminations relating to the offence, and six reported intrusions, both experiences thought to exacerbate symptoms of PTSD and maintain the disorder (Arendt, Riisager, Larsen, Christiansen, & Moeller, 2021). Of the 26 serious violent offenders who did not have a murder conviction, only 9 reported intrusions
and 6 reported ruminations related to their index offence. Thus, the type of offence committed appears to be important in the mediation of offence-related PTSD.

In addition to differing levels of prevalence and symptoms emerging for those with murder, serious violence, and sexual offence convictions, research indicates that symptoms and instances of offence-related trauma may vary depending on the nature of the relationship between victim and offender. In a large sample of male violent offenders ($n = 150$), Ternes et al. (2020) found that those whose victims were friends or family members experienced greater trauma symptoms than those where there was no relationship with the victim. Consistent with this, Papanastassiou et al. (2004) identified that homicide perpetrators were more likely to develop PTSD when the victim was a family member: of the 12 participants in their sample where there was a victim-offender relationship, eight had developed full PTSD, while the remaining four had developed partial PTSD. Interestingly, the victim relationship was not found to be important in Gray et al.’s (2003) sample: there was no difference in symptoms of intrusion or avoidance between offenders who had a close relationship to their victim and those offenders where the victim was previously unknown. Therefore, while not definitive, the relationship with victims may be a factor to consider when identifying instances of offence-related trauma in forensic populations.

It is important to note that prevalence rates of offence-related trauma may differ across different types of forensic population. Aside from the Ternes et al. (2020) study, many of the studies published have featured relatively small samples and focused on, or included, offender groups with high levels of mental health difficulties and personality disorders (Gray et al., 2003; Papanastassiou et al., 2004; Pollock, 1999; Spitzer et al., 2001). The relatively small sample sizes are understandable given the specialist nature of the populations being studied and the difficulties in conducting this type of research, which can cause emotional dysregulation and distress in the service-users and offenders. This can raise important ethical issues in balancing the risks of completing the research with the benefits of knowledge acquisition. Due to the high levels of mental disorder in the offender samples that have been investigated to date, the emerging prevalence rates of offence-related PTSD may not generalise within mainstream prison populations. Further, the prevalence of offence-related trauma may differ in female offenders as while the majority of the research has been completed with mixed-gender samples, these have mostly consisted of male offenders (Gray et al., 2003; Papanastassiou et al., 2004; Spitzer et al., 2001).

Another demographic factor largely overlooked in the literature to date is whether differences emerge in the prevalence of offence-related trauma or symptomatology between those from different racial/ethnic minority groups. Of the studies discussed here, only Evans et al. (2007) explored ethnicity and its relation to symptoms of offence-related PTSD. In their sample of young male offenders with serious violent criminal convictions, a correlation emerged between being of non-white ethnicity and reporting higher levels of PTSD symptom severity. This is an important area requiring further research and investigatory focus, particularly given a recent review (Asnaani & Hall-Clark, 2017) which suggested elevated rates of PTSD in some non-white groups. While Asnaani and Hall-Clark’s review focused upon rates within the general population, it is possible that particular racial/ethnic minority groups may
experience greater levels of offence-related trauma and its sequelae. This would have important treatment implications for these service-users. Furthermore, the existing data on prevalence of trauma and its sequelae may conceal the true level of those experiencing offence-related trauma, as those with trauma may be more reticent to participate in such research studies and may engage in avoidance behaviours (Spitzer et al., 2001). Therefore, it is essential to extend the research in this area to quantify the incidence of offence-related trauma across different racial/ethnic minority groups, genders, and forensic environments.

**Identifying and Working with Cases of Offence-Related Trauma**

Together, the research on the prevalence and the factors associated with the development of offence-related trauma provides a useful starting point for clinicians when thinking about and identifying those service users who may be experiencing offence-related trauma. Firstly, the nature of the offence should be considered, as evidence suggests that the development of offence-related PTSD is greatest in those who have committed a serious violent offence or murder. This is particularly the case if the violent act was conducted in the context of strong emotion (e.g., fear or anger). However, this does not preclude those with sexual offending or other offending histories from developing the disorder, with the likelihood of the development of symptoms of PTSD arising in violent interpersonal offenders. Secondly, the impulsivity of the offence appears to be important. Those who did not plan their offence or committed it impulsively out of rage or fear may be more likely to develop PTSD symptoms as a consequence of their offence. Thirdly, the relationship between the offender and their victim should be examined, as greater levels of symptoms have emerged in those whose victims were friends or family members. The relevance of these issues is illuminated in a case study set out below, which Gray and colleagues describe in detail in Rogers, Gray, Williams, and Kitchiner (2000).

**Case Study 1: Offence-Related Trauma in the Absence of Any Pre-Existing Traumatic History**

CH (Rogers et al., 2000), a 51-year-old white British woman, was convicted of manslaughter on the grounds of diminished responsibility after stabbing one of her employers in the back with a knife over 40 times. Following her conviction, CH was admitted as a mentally disordered inpatient in a medium secure unit. At the time of the offence, she was suffering from major depression, which gave grounds for the findings of diminished responsibility.

CH had been employed as a chef within a hotel for two years, and over time had built a good working relationship with both her employers, who were a married couple. However, the relationship with her female employer began to deteriorate in the three months leading up to the offence. CH perceived that her employer became increasingly critical of her, both
professionally and personally (although it is possible that this perceived criticism may have been due to CH’s symptoms of major depression). On the day of the offence, CH believed that her employer was critical and insulting about CH’s failed marriage. This resulted in an outburst of rage and anger whereby CH stabbed her employer repeatedly, resulting in the woman’s death.

Following conviction, CH was admitted to a medium secure psychiatric service. In the secure unit, CH continued to suffer from periods of severe depression over four years. Once the depression had been treated successfully, efforts were made to prepare her for community discharge and rehabilitation. As part of the preparatory work for discharge, CH came into increased contact with knives as her rehabilitation programme required her to demonstrate cooking skills. As she was encouraged to engage with knives, CH became increasingly avoidant of them, even refusing to use a knife when eating. Her avoidance of knives impacted her daily functioning, affecting her day-to-day living and future prospects for work upon release from the unit. She felt that she could not be trusted with knives and that the responsibility for the safety of others was beyond herself. She reported being “frightened by them in case they make me kill again” (Rogers et al., 2000), and she started to experience offence-related nightmares and intrusive thoughts and memories. Thus, the requirement to use a knife, a significant offence-related stimulus, as part of her rehabilitation programme triggered the acute onset of symptoms of offence-related PTSD. She began to avoid not only physical knives in her presence, but other stimuli related to knives, such as reading about or watching films about assaults using a knife, as well as talking about the offence itself and saying the victim’s name. Therefore, for CH, a strong association had developed between knives and the intrusive thoughts, feelings of fear, and flashbacks to the offence.

A treatment programme was established looking at exposure to triggers to the symptoms of PTSD related to the offence. Through imaginal and live graded exposure, CH was successfully treated and later successfully discharged into the community without any further offending behaviour.

The details of CH’s offence illustrate all of the earlier factors identified as placing her at greater risk for developing offence-related trauma. She had committed a violent interpersonal offence that resulted in the death of another, the attack was impulsive and unplanned, was committed in the context of extreme emotion, and CH knew the victim through working together. However, her case is also an example of offence-related trauma being triggered years after the offence itself, following a change in circumstances. The onset of offence-related trauma differs between individuals. As such, it is important to be aware that while for some it may emerge almost immediately after committing a crime, for others there may be a substantial time delay before the onset of symptoms. The onset of symptoms...
may correspond to the person coming into contact with stimuli that are potent triggers to traumatic symptomatology (in this case, the use of knives and cooking as part of a rehabilitative process). Prior to this, CH had been protected from these triggers due to her residence within medium secure psychiatric provision (where knives were carefully restricted, for obvious reasons).

The Association Between Pre-Existing Trauma and Offence-Related Trauma

While CH’s risk factors are present in the next case study, this client (DB) had a pre-existing trauma that presented different therapeutic challenges. DB had experienced a preceding violent and sexual trauma that led to him committing a violent offence, which subsequently triggered offence-related PTSD. However, as the case study demonstrates, the initial trauma and the offence-related trauma became intertwined in terms of triggers and symptoms of trauma, requiring an integrated treatment approach. DB’s case highlights the importance of identifying any prior traumatic events when working with offence-related trauma, and of carefully considering this in conjunction with what may initially appear to be triggers that are unrelated to the offence itself.

Case Study 2: Pre-Existing Single Trauma with Offence-Related Trauma

DB was a 22-year-old Afro-Caribbean British male. He arrived at a low secure forensic psychiatric unit after a court diversion process identified that he was suffering from severe PTSD. At the time of the mental health evaluation DB was on remand, having hit a woman around the head in her home with a bottle of vodka.

The year before the offence, DB had shared a cell with another prisoner while he was serving a short prison sentence for burglary. He had no previous offences for violence. One evening DB’s cellmate tied him up as he told him he was planning to escape and had informed DB that it would look better for him if it appeared that he had been overpowered and was not part of the escape plan. However, once DB had been tied up, he was sexually assaulted and raped. His cellmate had then strangled him and left him for dead. DB was found by prison staff the following morning when the cells were unlocked. He was severely injured and unconscious and rushed to the hospital for emergency medical assistance. When he awoke in the hospital DB had extensive physical injuries and severe bruising to his face and neck. DB reported experiencing severe PTSD, beginning a few days after he regained consciousness in hospital. He endured multiple daily flashbacks and intrusive memories of the sexual assault and strangulation and displayed high levels of hypervigilance, fear, and anger. After DB’s physical recovery, he was returned to prison to complete his sentence, but was extremely anxious.
and fearful, and became acutely suicidal. DB was therefore transferred to the healthcare wing of the prison. A few weeks later, at the completion of his sentence, DB was discharged into the community. Soon after release from prison, DB began to heavily abuse alcohol to try to cope with his symptoms of trauma, reportedly drinking up to 30 pints of lager each day.

Two months later, DB met a young woman in a local pub. They connected, and she invited him back to her house for a few more drinks. Unfortunately, as they began to kiss at her home, the young woman touched DB’s neck. DB reported that her touch triggered a sudden feeling of terror associated with vivid memories and flashbacks of being strangled and raped flooding back to him, leading to an impulsive anger outburst. He grabbed the nearest thing in reach, which was a vodka bottle, hitting her around the head. DB stated that he was not aware of what he was doing until after the incident. DB was horrified by his actions and immediately telephoned the police. The young woman survived the attack but suffered a significant head injury. DB was convicted of attempted murder.

When he arrived at the low secure psychiatric unit, DB was experiencing frequent flashbacks and nightmares of the attack upon the young woman and was severely depressed. He could not bear anyone or anything to touch his neck. If anything did so, he became very frightened and was immediately explosively violent, often leading to self-harming behaviour, such as headbutting walls, punching doors, and throwing furniture. DB’s sensitivity to his neck being touched even extended to the sensation of clothing against his neck. The severity of these episodes of extreme emotional dysregulation and anger outbursts delayed any opportunities for rehabilitation and discharge as his trigger point was almost unavoidable daily.

In order to treat his PTSD, its source and meaning needed to be understood. The inability to cope with being touched on the neck was clearly related to the initial trauma but was disconnected from the offence-related trauma. However, DB reported that the sensation of being touched on his neck not only triggered memories and feelings associated with him being a victim of assault, but also now images and flashbacks of his offence of violence. Somehow the two traumatic events had become intertwined. DB also reported strong feelings of guilt and remorse for the offence, especially since his victim had been nothing but kind and attentive to him. These feelings of offence-related guilt became intertwined and associated with strong feelings of embarrassment and shame for the rape he had suffered, with one emotion immediately triggering the other. DB reported that he would repeatedly ruminate about how he could have been “so stupid” to willingly allow his cellmate to tie him up prior to the rape and strangulation, thereby placing himself in such a vulnerable position. Through exploring his personal history, the clinician was able to understand the meaning of the touch to DB, how it related to his unresolved trauma from being raped, strangled, and left for dead, and how it then acted as the precipitating factor to his violent offence.
Importantly, the original trauma as a victim had become interwoven and associated with the offence-related trauma, something which DB stated he was unaware of prior to cognitive behavioural therapy. Through discussions with DB, it was clear that his self-view had completely changed and that he struggled to understand his actions in light of his personal experience of being a victim. He said, “I never thought of myself as violent, then I did this terrible thing” and “my cellmate raped and strangled me even though I had done nothing to deserve this. I then did exactly the same to Alice (the victim’s name). I am just as bad as him”. DB also stated that “I can understand I am vulnerable after what happened to me, but then I went and done it to someone else. I am just as bad as my attacker, if not worse, as she was just a young girl”.

DB’s treatment required careful exploration of the meaning of both the pre-existing trauma and the offence-related trauma, exploring the themes that connected these two traumatic experiences and their shared trigger factors. Exposure therapy and desensitisation to key triggers was completed, initially via imaginal exposure and then building to in vivo exposure. DB was provided with exposure therapy and eye movement desensitisation reprocessing (EMDR) to attempt to treat his symptoms of PTSD. Exposure therapy with DB was challenging due to his tendency to explosive violence and self-harm, often with little insight, prior warning, or control of these violent outbursts in response to strong feelings of fear and anger and symptoms of excessive arousal. Much of the therapy was conducted in the presence of two staff nurses, who were present solely to ensure the safety of the therapist and DB himself. However, the presence of other people within the therapy session caused DB to feel greater shame and reinforced his belief of being a bad person who could not be trusted. Treatment progress accelerated once it was felt that therapy was safe to progress on a one-to-one basis, with the trust placed in DB by the therapist supporting his ability to begin to challenge his own negative beliefs about himself. The therapeutic process was a difficult and lengthy process, taking almost two years of weekly therapy. The final stages of therapy involved DB allowing the therapist to touch, and then hold, his neck while he focussed on remaining calm and regulating his emotions. The establishment of mutual trust between DB and the therapist was essential for the success of this therapeutic process. It was felt that this treatment stage was important for DB’s rehabilitation as, without this, he could not be considered safe to rehabilitate to the community. After completion of cognitive behavioural therapy and EMDR, DB reported few symptoms of trauma to either the pre-existing traumatic event or the offence-related trauma and was no longer explosively violent, indicating broad treatment success. However, the changes to his negative sense of self, including feelings of shame and guilt, and to his beliefs about the wider community and his own safety, did not undergo significant change.
Complex Trauma and Offence-Related Trauma

The experience of DB relates to the literature on PTSD and cognitive perspectives following personal trauma. After a personal trauma, there is thought to be a shift in previously held belief structures and life goals, which contribute to an individual's belief system and personal meanings that give direction to day-to-day living (Park, Mills, & Edmondson, 2012). Before a trauma, a person may feel safe and in control. Yet, following a traumatic experience, these belief systems and feelings of personal safety, or trust in oneself to make good decisions, may be violated. For DB, his traumatic experience of being assaulted and raped led him to feel unsafe and extremely fearful, as well as to feelings of self-blame and shame. These feelings of shame and self-blame are a common consequence of interpersonal assault and trauma (Bhuptani & Messman, 2021). Such a meaning system violation can give rise to negative appraisals of global beliefs and personal goals and may sensitise individuals to developing PTSD symptoms.

Park et al. (2012) found that, in a sample of people who had experienced a DSM-IV criterion trauma (n = 130), cognitive appraisals of goal and belief violation predicted PTSD symptoms. This is nothing new to those of us that work in trauma-informed clinical practice. However, what is important to consider here is the association between the pre-existing trauma and the offence-related trauma, and how the beliefs and meaning violations of the pre-existing traumatic incident became intertwined and associated with the beliefs and meanings of the offence-related trauma. For DB, this meant that the consequences of the pre-existing trauma could not be successfully treated without taking a simultaneous therapeutic approach to the offence-related trauma, and vice versa. It is well known that it is frequently the case that people who have committed serious offences against the person (both violent and sexually violent offences) have complex and severe pre-existing trauma histories, often stemming from interpersonal violence experienced in childhood (Fox, Perez, Cass, Baglivio, & Epps, 2015; Ternes et al., 2020; Levenson, Willis, & Prescott, 2016). This suggests that successful treatment of these pre-existing complex traumas is only possible if clinicians also address offence-related trauma and explore therapeutically how the person has connected and associated these disparate traumatic incidents.

If we consider this in light of DB’s case, his preceding trauma violated his meaning system, giving rise to negative appraisals of global beliefs and goals, which in combination with excessive arousal and anger outbursts led to his serious violent offence. This, in turn, sensitised him to developing PTSD symptoms as a consequence of his own offending behaviour.

More clinically complex than cases of simple PTSD (where there is a single, albeit severe, traumatic event, as with DB) are cases of offence-related PTSD where there is a history of repeated trauma or abuse during childhood and adolescence. At the time of trauma, a range of emotional reactions can arise, including fear, horror, and helplessness (Brewin & Holmes, 2003). Beyond the trauma, other emotions can develop, including anger, guilt, and shame. These are thought to result from cognitive appraisals of the trauma and its causes, and to misplaced beliefs about blame and responsibility and its longer-term implications (Brewin & Holmes, 2003). Such longstanding
negative cognitive appraisals of this nature significantly impact upon later life experiences, as illustrated in research by Andrews, Brewin, Rose, and Kirk (2000). These authors found that experiencing childhood abuse, and symptoms of shame and anger towards the self and others, led to the prediction of PTSD following a violent crime in adulthood. Thus, pre-existing shame or anger arising from experiences of childhood abuse can be re-triggered when being a victim of crime within adulthood, leading to the development of crime-related PTSD. While this research explores these relationships between pre-existing trauma and the development of PTSD in victims of crime, it seems reasonable to consider that a similar process may apply in the development of offence-related PTSD. Shame and anger arising from complex trauma in childhood and adolescence may trigger violent offending, reinforcing pervasive feelings of shame and anger, and sensitising the individual to develop offence-related PTSD. Such an association between traumatic personal histories and elevated levels of offence-related trauma has emerged in one study: offenders who reported the greatest exposure to previous traumas, including those early in life, reported the highest level of offence-related PTSD symptoms (Payne, Watt, Rogers, & McMurran, 2008). However, as Ternes et al. (2020) notes, the exploration of this association has been limited thus far, and findings have been inconsistent (see Papanastassiou et al., 2004; Pollock, 1999).

This link between being a victim of early repeated trauma, offending in adulthood, and sensitisation to offence-related PTSD is illustrated in the case study below. These issues are more challenging to resolve therapeutically, as the different traumas constituting the repeated and complex trauma in early life become intertwined and highly associated both with each other and with the offence-related trauma. As with DB, the case set out below highlights the need for clinicians to explore the associations between prior victim experiences and the nature of a person’s offending behaviour. As outlined below, there can be parallels between personal experiences of unresolved early trauma and subsequent offence-related trauma, which are important to understand within the psychological formulation and therapeutic approach. However, as AL’s case below demonstrates, cases of offence-related trauma where there is pre-existing complex trauma can be challenging to treat.

Case Study 3: Pre-Existing Complex Trauma and Offence-Related Trauma

“AL” was a 20-year-old white British woman. Throughout her life, as far back as she could remember, she witnessed domestic violence in the family home. Her father would regularly come home late from work drunk, shout at and threaten her and her siblings, and physically assault her mother. On occasions, AL witnessed her older sisters being beaten and, as she grew older, her father began to periodically physically assault and hit her. As he hit her, her father would tell AL, “you’re a bad person”, “this is all your fault”, “you deserve this”, and tell her that she was “not good enough” as a daughter and as a person more generally. She described feeling useless and stupid, and struggled to make friends.
AL reported that in secondary school these issues of emotional and verbal abuse within the home by her father were replicated within school. She stated that a group of girls and boys in school would taunt and bully her, telling her that she was fat, ugly, and stupid. This led AL to isolate herself from people within school and she reported internalising the negative comments of her peers and believing that she was deserving of the emotional and physical abuse sustained by her father, and the bullying experienced at school. AL stated that she had never reported any form of abuse to a safe adult (e.g., teacher) as she felt that help would not be provided, believing that she was deserving of such treatment.

When she was 19, AL gave birth to a baby boy. The pregnancy was unplanned and was the result of a brief relationship with a neighbour who was significantly older than she was. At the time, AL was still living at home with her parents, but she decided to move out into a flat for the child’s safety as her father was continuing to be abusive and violent. She tried to bring the child up alone due to the informal nature of her relationship with the child’s father who, she later discovered, was already in a committed relationship with another woman. Once moving to her own accommodation, AL became isolated: she had few, if any, friends and could not rely on her mother to help her with caring for the baby as her father would not let her mother visit the flat. AL’s sleep became very disrupted, and she quickly became extremely stressed and anxious, reporting that she felt that she was “not good enough” to care for the baby and was “a bad mother”. When the baby was around one month old, AL began hearing derogatory voices telling her that she “was a bad person” and that her “baby hated her”. AL’s mental state and level of functioning deteriorated rapidly, and she struggled to cope. She reported that she prioritised feeding and changing the baby, but neglected all other aspects of her own self-care or care of the home. AL stated that her typical day involved getting up in the morning to feed the baby, but that after this she would return to bed and lie in bed all day next to the baby with the curtains drawn. She reported that she would attempt to drown out the voices by turning up the television very loudly, but that this sometimes distressed the child, reinforcing her sense of guilt and self-blame. AL subsequently stated that she felt worthless and not deserving of help or support, with the voices reinforcing her sense of worthlessness. AL became totally isolated, not leaving the home for a period of 10 days prior to the offence.

On the day of the offence, AL reported that the baby was crying, and she was unable to soothe him. She reported that the voices were telling her that she was “a terrible mother”, that she was “not good enough”, and “did not deserve to live”. She picked up a pillow next to her, placed it over the baby’s face, and smothered her baby. Shortly afterwards, AL took a large overdose of paracetamol and telephoned her mother. AL’s mother arrived to find the baby was not breathing and lifeless, and her daughter unconscious. AL subsequently reported that neither the murder nor her attempted suicide was
planned and that she felt that she acted on “auto-pilot” and as if she were watching someone else perform these actions from a distance.

AL was charged with infanticide and was later convicted of manslaughter due to diminished responsibility on the basis of a postpartum psychosis. She was admitted to a medium secure psychiatric facility for assessment and treatment. She was displaying symptoms of offence-related PTSD, along with complex trauma associated with the physical and emotional abuse she had suffered throughout childhood and beyond. AL’s traumatic symptoms from childhood had become associated with the traumatic memories and flashbacks related to the offence, with each symptom becoming interwoven and connected. Triggers to traumatic memories from childhood would then trigger offence-related traumatic memories, and vice versa: each symptom cluster from each trauma (the childhood abuse, and the infanticide) becoming connected and acting as a potent trigger for the other.

During therapeutic sessions, attempts to work with AL on resolving her offence-related trauma would trigger thoughts and intrusive memories of childhood trauma, and vice versa. She described frequent memories of the sounds she heard while she smothered her baby, flashbacks to the face of her child after she lifted the pillow from its face, alongside experiencing nightmares of her childhood traumatic experiences and her diminished and negative sense of self. AL’s arrest and police interviews following the offence, which she interpreted as highly punitive and intimidatory, became strongly associated in her mind with the abuse she had experienced at the hands of her father. Of note, there was no evidence that the police had treated AL negatively and these attributions were thought to be false and associated with a persecutory frame of self-reference. Importantly, however, AL did not attribute blame to either the police (for what she believed was punitive treatment of her) or her father for his past abusive actions towards her. Rather, she turned these attributions of blame inwards and firmly believed that she was a “terrible person” who deserved such treatment. These negative self-beliefs formed the genesis of AL’s suicidal ideation and intent, and for a number of months following the infanticide AL had to be managed via close observations to ensure her continued safety and to manage a number of incidents of attempted suicide. However, due to the many instances of early trauma, which each became enmeshed with the offence-related trauma, treatment attempts were largely unsuccessful.

In EMDR sessions, AL reported being unable to focus on one traumatic event and stated that as soon as she attempted to focus on one aspect of a single trauma, many other associated traumatic memories would pop into consciousness, with all the associated emotions of fear, anxiety, guilt, and shame. This made AL feel overwhelmed emotionally and she was often unable to tolerate therapeutic sessions, becoming highly emotionally dysregulated (mainly displayed via excessive anxiety, feelings of panic, or distress and tearfulness). As such, AL would typically attempt to avoid therapeutic work and used numerous strategies of avoidance, both explicit (such
as refusing to attend therapy sessions) and implicit (such as chanting silently in her head, rather than focussing on traumatic events and their meaning to her). Identifying such avoidant strategies proved difficult therapeutically and AL would often appear outwardly to be engaging, but with no sign of therapeutic progress.

AL also struggled to form therapeutic rapport and was unable to learn to trust the therapist, firmly believing that the therapist thought negatively about her and was “lying” when anything positive was said to her. This placed the therapist in a difficult situation, acting as a double-bind and an inherent dilemma: positive comments were met with strong negative affect by AL, due to her firm belief that the therapist was lying to her about this and was being disingenuous. However, neutral comments were also always interpreted negatively by AL and as “punishment” for being a bad person. Thus, much therapeutic effort was spent on attempting to address issues of interpersonal trust with the therapist, to develop therapeutic rapport, and to resolve breaches in the therapeutic relationship (such as AL’s distress if the therapeutic paid her a compliment, and her belief that this was a lie). These interpersonal difficulties and AL’s continued avoidant behaviour meant that little progress was made therapeutically, despite extensive and intensive engagement in psychological therapy within medium secure psychiatric services over a period of five years.

We believe that AL’s case illustrates the difficulties of working with people who have experienced both complex trauma and offence-related trauma. There is also a dearth of research in this area with which to guide clinicians in the assessment and formulation process, or how they may address the many hurdles that arise when engaging these individuals in psychological therapy as part of a rehabilitative process. We would encourage researchers and scientist-practitioners to begin research into this important area of clinical practice.

A Clinical Framework for Offence-Related Trauma

Bringing together clinical experience and research in the field, we have attempted to put together a framework which we hope will be helpful to assist clinicians in identifying key issues when assessing possible cases of offence-related trauma, and when working therapeutically with those experiencing this form of trauma and its repercussions. Fundamental to both assessment and treatment is the importance of asking the right questions, as the answers given by our service users will fundamentally depend on the questions asked.

Identifying Key Issues in Cases of Offence-Related PTSD

- Was the index offence violent?
- Was the crime reactive or impulsive as opposed to planned?
- Did the offence result in death or serious injury?
• Was there a personal relationship with the victim?
• Is there an experience of pre-existing trauma in the past?
• Were previous traumatic incidents interpersonal in nature?
• If yes, was this a single (or simple) trauma or did it represent multiple and complex trauma?

Considerations When Working Therapeutically with Those Who Have Offence-Related PTSD

• How does offence-related trauma impact on rehabilitation potential and future risk of offending?
• Is there previous unresolved trauma that may as yet be unexplored or unidentified?
• Are there issues of re-enactment of trauma in sexual or aggressive acts? If so, what function does the re-enactment have for the person (e.g., in reestablishing a sense of power or control)?
• In what ways are pre-existing trauma associated with offence-related trauma in personal meaning, or similarities of events or actions of the person?
• Are the offence-related PTSD triggers associated with the triggers to pre-existing trauma and have these issues become intertwined and associated each with the other? This may make so-called simple trauma, complex.
• Do treatment strategies need to integrate consideration of both pre-existing trauma and offence-related trauma simultaneously? If so, how should this be organised and prioritised within the therapeutic framework?
• Does offence-related trauma lead to excessive arousal and affect dysregulation which increases the risk of violence to self or others? If so, this needs to be a key treatment target in terms of rehabilitation and safety planning.
• Are there core issues of guilt and shame arising from offence-related PTSD that keep the person within a negative self-view and that serve as barriers to therapeutic progress and rehabilitation?
• Are there avoidant strategies being utilised by the person that act to ensure actual or emotional disengagement in therapy? These avoidant strategies may be overt and explicit (e.g., refusing to engage in therapy or refusing to talk about the offence-related trauma) or implicit and secretive avoidance strategies (e.g., internal chanting or silent singing to avoid engagement with thoughts and memories of traumatic symptoms, or substance abuse and/or medication-seeking as attempts to numb emotional engagement). It should be remembered that severe restriction of eating can serve as an emotional avoidance strategy, effectively numbing the person’s emotions and serving to distract all thoughts from everything but food and sustenance.
• Do offence-related traumatic symptoms trigger issues of dissociation or a sense of disconnection from themselves and the people around them? Can this keep the person distanced in interpersonal relationships and affective connection with others, preventing rehabilitative potential?
• Have there been elemental changes in the person’s core beliefs or values, or sense of self and the future (e.g., hopelessness and helplessness) that act to prevent therapeutic progress or rehabilitation potential?
Are there fundamental issues of interpersonal trust and suspiciousness that need to be addressed as a preliminary to trauma-focused work? If so, how are these associated with offence-related PTSD or pre-existing trauma, or both?

Further Reading


Harry, B., & Resnick, P. J. (1986). Posttraumatic stress disorder in murderers. Journal of Forensic Sciences, 31(2), 609–613. This paper provides a further three offence-related trauma case studies which may be of interest to clinicians in the field.

References


