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CONTAINING DISTRESS

Working with Compassion in a Prison-Based Democratic Therapeutic Community

Geraldine Akerman and Nathan Joshua

This chapter explores the impact and challenges of adopting a trauma-informed approach in a prison-based democratic therapeutic community (DTC) at HMP Grendon, from the perspectives of those who live and work there. Those in custody may well have experienced adversity which impacted on their life pattern. The context in which each person is located can affect their ability to address their past and process any unresolved trauma. By providing structure and, most of all, safety, the residents in a DTC can consider their previous responses and what has led to their present situation. A more naturalistic setting can allow previous problematic behaviour patterns to be demonstrated and alternatives practised. A DTC provides a culture of enquiry in which decisions can be considered and their consequences tolerated. Therapy within a custodial setting allows for the exploration of the meaning of previous responses and the impact they had on others in a safe environment. One resident will illustrate this through his journey in a DTC. The chapter will also discuss the challenges of a compassion-focused approach within a custodial setting and with residents who, although they volunteer for the intervention, would rather not be incarcerated.

The DTC model works on the premise that the environment and social relationships provide the optimal conditions for change. The DTC aims to provide a pro-social, supportive, and caring environment in which all individual, residents, and staff reach their full potential. This requires ongoing monitoring and attention. To do this while feeling constantly under threat is not an easy task. Haigh and Pearce (2017) describe how compassion and kindness are basic tenets of a DTC. It is important to create a safe environment in which people do not feel the need to be hypervigilant (Akerman, Needs, & Bainbridge, 2018).

The structure of the day provides numerous opportunities for therapeutic interactions from which to learn more about the nature of relationships. The community itself is the primary therapeutic instrument (Rapoport, 1960) and so all aspects
of it are under consideration (see Akerman, 2019 for further details). The DTC environment provides a corrective emotional environment in which such experiences can be processed. The importance of maintaining a trauma-informed approach to supervision, as highlighted by Varghese, Quiros, and Berger (2018), is emphasised. It is vital for staff to be able to continue their work in such stressful conditions that they have regular supervision to help process their own fears. Furthermore, the increased emotional load of containing the fear and anxiety within the community needs to be explored and processed.

The Democratic Therapeutic Community at HMP Grendon

HMP Grendon opened in 1962 as an experimental psychiatric prison and remains unique in that the whole institution is a dedicated DTC. It has been documented extensively (Genders & Player, 1995; Shine & Morris, 1999; Shuker & Sullivan, 2010). Compassion-focused therapy (CFT) is based on the evolutionary and neuroscientific models of emotional regulation (LeDoux, 1998; Gilbert, 2010a, 2010b). Panksepp (1998) described emotions that are the most primitive and shared with other species, such as proximity seeking, panic, play, fear, and rage, which, when evoked, lead to defensive emotions (including anxiety and anger). The threat response evokes the fight, flight, or freeze reaction. CFT suggests that the second system, the drive system, motivates us towards resources. The third system is the drive for safety and contentment, soothing, and affiliation. Cozolino (2008) considers that the key to regulation of the threat system is by activation of the soothing system, which generally happens at early stages of development. This is central to the work of DTCs. Residents whose habitual response has been to react and then regret it later are encouraged to slow down their responses and consider what is happening for them in the very moment emotions are evoked. Gilbert (2010b) posits that mental health difficulties happen when the threat system is poorly regulated. This can develop from a hostile and unsupportive environment when growing up. The threat system can then be overly sensitive and continually activated. Self-criticism is a common response in this situation. Therefore, one aim of the DTC is to help move from shame to guilt, which can then lead to reparation (Taylor, Akerman, & Hocken, 2020).

The CFT approach provides a non-judgemental environment which supports personal development. Residents in the DTC at HMP Grendon have all committed interpersonal violence and coming to terms with feelings of having done this can be hard to navigate. When the victim has died it is particularly painful, especially if the victim was a loved one. It is a journey of faith that the resident is going to be able to tolerate the emotions evoked. A compassionate, containing supportive, environment is vital to enable this work. There is a fine line between accepting responsibility, living with the consequences of one’s own actions, and being aware of the impact this has had on the remaining family and friends. Lucre and Corten (2012) found that CFT had a beneficial impact on those with personality problems. Finding ways to ameliorate feelings of shame and self-criticism, and to calm and soothe the threat system, is vital in this intervention.
The Structure of the DTC at HMP Grendon

When residents first arrive at HMP Grendon they spend 3–6 months on the Enhanced Assessment and Preparation Unit (EAPU) to allow them to acclimatise to the environment. The EAPU is integrated by offence type, so those with sexual and other violent convictions work together. Although they do not speak about the details of their offences, they do state what they are convicted of. A number of groups within the DTC experience increased stigmatisation, for instance those who are convicted of killing children (Jacobs & Shuker, 2019), and those who perpetrate sexual offences (Kotova & Akerman, in press). Residents learn to overcome their prejudices towards others based on their offence, but this can take some time to achieve. There are two community meetings a week and one therapy group. There are other courses to help residents to understand their emotions and the DTC processes.

Residents on therapy wings at HMP Grendon have groups every morning, generally lasting one and a half hours. The whole community meets twice a week to discuss the current business, which could involve seeking jobs, explaining behaviour, or resolving conflict. As it tends to be a large group (approximately 40 residents and 4/5 members of staff) attention is paid to group dynamics. These meetings can be loud and contentious or deep and reflective all in the space of one session. Constant attention is paid to the emotions evoked for all those present, and how it may impact then and later. Those in the room will be aware as the meeting draws to a close of the need to contain the emotions, and the importance of not taking these back to the wing. There is an inherent tension between providing the opportunity for residents to learn to express their emotions and resolve their differences, and the risk of this escalating to “anarchy” (Shine & Morris, 1999). Residents can be struck by their own ability to shout at a member of staff or another resident and then continue with the relationship, which in the past has not been the case and, at worst, has ended in violence. After the community meeting the staff team meet to debrief and consider the dynamics of the community. This provides the opportunity to draw aspects of the individual together that have previously split off, and hold them in mind, just as should have happened in their early lives. The discourse between the multi-disciplinary team contributes to a powerful inclusive environment. The difference of opinion is tolerated and modelled to residents (one of the underlying principles of a DTC, see below for further details) without recourse to acting out. The input from the residents is integral and valued alongside that of staff, as meaningful and relevant experts by experience.

Small groups (comprising eight to ten residents, and two members of staff) meet three times a week to explore the unconscious material of the group members and how it impacts throughout their lives. Much of the work includes reintegration of aspects of self that have been split off. For instance, if the person had committed a violent crime against a loved one, the emotions that led to and resulted from the offence may have been repressed and these can be felt and expressed in these small groups. This is a tentative process, as the individual takes responsibility for their actions while being able to tolerate the immense feelings evoked. Further, the understanding of why the incident happened is also vital to help ensure it does not happen again. In a
DTC, everyday events are explored in depth to understand what is being re-created. For example, a comment made in a community meeting about how those who need drugs may commit all sorts of acts to fund their habit can evoke shame in a community member who has committed acts of violence against a loved one to gain money. One individual swears at the person speaking and storms out of the room. He would be encouraged to explore this in his therapy group and express his feelings about his actions in the past and how these feelings drive him to respond in the present day.

In therapy groups residents have feelings, both positive and negative, towards staff (known as transference) as they would have had in the past towards various people in their lives. The groups present the opportunity to expose and explore these feelings so they hold less heat and fire and can be seen for what they are, rather than continuing to unconsciously drive their behaviour. The staff discuss their responses to individuals (countertransference) in supervision and reflective practice.

Gilbert (2010a) encourages the cultivation of compassionate states of mind, and the DTC offers support in accessing safety and soothing. The therapy naturally encounters the hurdles, fears, and resistance to these ways of relating and feeling and seeks to overcome them. CFT promotes the giving and receiving of compassion and care, and it can be as hard for staff and resident to receive it and overcome self-criticism. The DTC and CFT aim to develop the compassionate self and use this as a secure base from which to engage with, and integrate, previous experiences which have been fragmented when in a threat-based situation (Gilbert & Irons, 2005).

Gilbert (2017) suggested the use of compassion to create a safe space to enable this integration.

Traditionally, DTCs have encouraged the expression of anger and other strong emotions, but more recently Veale et al. (2014) have questioned this, arguing that this is unhelpful because it triggers other threat systems and hinders feelings of safety which are crucial for opening up and encouraging exploration. For residents who have experienced an upbringing with high expressed emotions, such as critical comments, hostility, emotional over-involvement, with a lack of positivity and warmth, this can impact on their mental health or emotional management. Therefore, Veale et al. recommend that DTCs work towards an environment of relatively low expressed emotion and trying to prevent unnecessary activation of the threat system.

For this reason, DTCs, along with other accredited programmes, have moved away from discussing offences in detail, due to the levels of emotions evoked.

Nathan's Story

Introduction

With infant memories of blood on the walls, mother’s screams and broken glass on the floor, my early years were scarred with the violent breakdown of my parents’ marriage. Following our move to the big city, with promises of prosperity, we soon got a new stepdad, who did not drink, clearly loved my mum and, it turned out, worked hard and put food on the table. They
soon married and my brother was born and along with my older sister our new family unit spelt out an idyllic childhood for most.

I was a very emotional child, struggled to settle and was needy from an early age. I have one recollection of my mother smacking me with a wooden spoon so hard that the spoon broke, although she never did anything like that again. I stole sweets and food as a child, then pinched money from my mother’s purse and my stepdad’s pockets. These occurrences met with attention and chores for punishment. I have recollections of him giving me the silent treatment and although I remember some good role models, I ended up in the Criminal Justice System (CJS) after stealing a car on my paper round. Whilst in no doubt that my family loved me, I already felt unable to express my feelings of abandonment and separation and by the time I was 16 my problems outgrew my family unit. At this age I was already heavily using drugs and alcohol to cope with my reality, which culminated into 30 years of addiction, homelessness, several unhealthy relationships, progressively more serious acquisitive criminality, violence and years and years of prison time. My family and authorities offered me all interventions known to the western world. These included children’s homes, moving house, 12 steps, rehab, NLP, counselling, joining sports clubs, school, homeschoool, work programmes, financial support, detachment with or without love, anti-psychotics, opiates replacements, DTTOs, young offenders institutes, Enhanced Thinking Skills ad infinitum.

Research has shown that spanking children is a risk factor for violence (Straus, 2000) and when residents are asked about childhood experiences they tend to use excuse the behaviour, stating “I was naughty”, or “I was always playing up”, sounding as if that is how they have rationalised it in later life.

Eventually prison became a welcome break for the family and a place where I had rules and conformed, would detox, attend the gym, and plan ‘going straight’ with all the passion I had to muster for a better life.

Thing is, prison never facilitated tangible, compassionate change. It just reinforced submission. Prison, by its very nature, suppressed my problems. The courts, with limited options, often take traumatised offenders and send us to further traumatising environments to serve our punishments, never truly addressing the root cause of my behaviour. Rather, facilitating a gradual worsening of my criminality, and the way in which I struggled to form meaningful relationships with anyone significant, led to distinct loneliness and eventual lack of empathy for victims while committing acts of robbery. All that follows is by no means written to seek to justify my behaviour, somehow setting myself up as a victim, but does intend to demonstrate that through the compassionate and safe environment, insight into one’s personhood can be gained and maladjusted coping strategies challenged, replaced with healthier, more nurturing alternatives.
Sign Up and Assessment

I will now describe my stay as a resident of Grendon. Whenever I use the term ‘other prisons’ I mean it to encompass experience of all other interventions. These include hostels, mainstream prisons, offending behaviour programmes, etc. Whilst all of these experiences had benefits and limitations, none offered the environment of compassionate safety I believe I required for me to open up unreservedly for the therapeutic process to heal in the ways I hope to do justice to here. A bold statement I could not have made with any authority until now.

Stevens (2013) describes a common theme in presentation of offenders as “hypermasculinity” where the traits of manhood (aggression, toughness, guarded emotions) are intensified to establish dominance within the closed community group (imagined or real). Compassion Focussed Therapy (CFT) would view this as an evolutionary process to stay safe. There has been no institution where I have witnessed this presentation more evidently than the Enhanced Assessment Unit at Grendon. The contrast between senior Therapy Awareness Course (TAC) mentors who were years into therapy and those newly arrived from long-term prisons was glaringly obvious. Furthermore, the commonly passive, timid polite traits I witnessed in my early days in many of those arriving from prisons having been convicted of sexual crimes and those against children, compared to many long-term violent offenders was stark. Over time, the environment is the catalyst for some to allow defences to drop and others to gain in confidence to share experiences too.

The assessment unit process was at times an overwhelming experience where two worlds collided, in contrast to the mainstream, where the written and unwritten rules are set. A hierarchy for all its hypocrisy is familiar (Joshua, 2019), and, despite its flaws, bearable. This new world is where everyone is equal, people here represent both a crime and its victims, but also as a son, father, brother, musician, artist, electrician, driver or whatever. In the Grendon environment we learn to tolerate and respect one another and seek honesty and patience with a genuine human connection built through these mutual tenets amongst others. My first impressions hooked me in.

The first meeting involved a round robin in which everyone introduced ourselves by our first name, our sentence and our index offence charge. The most poignant example of one beginning the road of taking full responsibility for our criminality, creating victims, though also recognising, sometimes for the first time, we all have a voice. Despite how others feel about our crimes, people can no longer hide from their past, nor do we need to. A wholly compassionate and empowering act, whether I recognised it initially or not! Other prisons, however, are traditionally places crimes are not fully disclosed (unless it is to gain notoriety, imagined or real), even on offending behaviour programmes, when open discussions are part of the model. Meeting honest unguarded responsibility in people was rare, usually
due to real fear of retribution through bullying, intimidation, and of course violence.

**Managing Conflict Differently**

My first conflict arose following a visit. Strong family relations are seen as an indication of desistance post-release, and so Grendon makes the visits centre a huge part of the compassionate work we do here. Sitting outside on a picnic table in the sun, I went up to the counter to buy an ice cream for my niece, my sister and me. This would be unusual in another establishment, but part of the culture here. My attention, having sat down and enjoying a moment with my family, was drawn to a yelp by a young lady being inappropriately touched by the man she was visiting. The look on my niece and sister's face, of concern and fear, left me feeling very angry. Recognising him as a resident who was here for a sexual assault, who I knew from earlier days in Grendon, left me with the urge to protect the lady. This is a very natural evolutionary response. A problem, I later discovered, was a primal need to protect the females in my family from my father and his drunken rages. I had been in Grendon a month and I recognised how traumatised I was, hypersensitive and on guard, ready to snap. I had 3 weeks to wait until I was given the opportunity to challenge the resident, in what is known as a Minute Meeting. When this occurred I lacked the skills to resolve the incident directly with the man. It could have resulted in violence, however, by the time the minute came to the top of the list the powerful feelings had subsided.

In placing a minute, I was going against other prison values of ‘not grassing’. I gave the other resident the opportunity to hear the impact his behaviour had on my sister and niece and was able to reflect how I felt guilty for the victims of my robberies over the years, which included females, and the deep shame I felt about that. The whole community asked questions. The experience allowed me to begin to trust the therapeutic process, for all its alien nuances, thereby learning to sit with powerful, previously destructive emotions. I developed insight into my reasons for such a primitive response beyond the trigger.

**Commitment**

On the morning of my move from the assessment unit to C wing, where I was to continue my therapy, having already visited twice, for a meal and for association, I hand the assessment unit officer, Vernon, my key and remote control. I thanked him for all his help, whilst lying to him that the missing batteries were my own. The induction rep from C wing arrives to escort me down and help me to carry my belongings to my beautiful new room, a carpeted cell with a million-pound view and I breathed a sigh of relief because of the welcome I received...
Meeting my group on C wing was nerve wracking. Talking about my offending history for all to judge, was not easy, but for most, with differing periods of experience of therapy, (due to the rolling nature of Grendon), they expressed compassion, understanding and a sense of genuine honesty, unrecognisable in other prisons.

The following week I brought to the group that I have a problem I want to discuss. I explained that while shaking the hand of an officer I lied about stealing some batteries from a TV remote control. Trivial to most, judging by their initial response, though I knew as a life-long offender this incident lay at the core of my problems. While smiling at the nice man (who of course represented authority, fatherhood, mentors, etc.) I was hypothetically picking his pocket; this was my work. My commitment was met with mixed responses, by most, “are you a screw boy?”; “What are you doing?”; “What is really going on?” were some of the questions asked. I explained to the whole community that prior to my latest relapse and arrest, my grandad lent me a substantial amount of money to help me in a business venture, and I never got the chance to pay him back before he lost his life to cancer. His final memories of his grandson were of me ripping him off and being locked up again. At the roots of my offending, and despite how much I loved my grandad, I was unable to demonstrate that through empathy. A pattern I discuss further below. Following community and staff votes I was backed to remain in therapy. As a part of my commitment I had to fulfil some forfeits selected by the community. A mixture of tasks that included writing a letter to my grandad, which I was required to read to the whole community. I also had to have a sit down with Vernon and write a piece on what stealing does for me. The sit down involved my personal officer, (‘Daisy’), the wing chairman, Vernon and myself. It was a very emotional experience that I will never forget, compassionate, honest and real.

**Understanding PTSD**

My diagnosis of PTSD occurred some months after I was stabbed in the neck, face and head whilst walking away from a fight with a group. I was attacked by one of them, and then stabbed from behind by my newly ex-girlfriend. I collapsed after she cut the main artery to my arm in my neck. Awaking several days later in the High Dependency Unit with a paralyzed arm and a very sudden sense of impending doom, I soon became aware of what had happened. I began to spiral downwards whilst becoming used to the fear that they were coming back to finish me off, which would rule my life for a decade.

My trauma arose several times in quick succession over the first six months. Usual conflicts involved loud, aggressive people, and those who gave me the silent treatment.

One incident in particular involved a new guy who was feral, and threatened me several times, leading to him being placed on a commitment
and me accountable to the community for my response. When he threatened me, I flashed back to the car park floor, scared, numb, holding my neck. After locking myself away I returned to the resident to try to resolve the issue, making the whole scenario worse. Regarding silent treatment, my Stepdad wasn’t violent, but commonly used the silent treatment on me when angry. I found this behaviour as a child very debilitating and hard to manage in others. I find it unpredictable and for many years it left me anxious and hypersensitive. An experience which intensified since being stabbed.

Sitting through hundreds of crisis meetings and living on a wing which becomes a representation of a family unit was at times excruciating. I cried a lot, felt people’s disdain at my apparent neediness, and at times felt singled out, mirroring my childhood home. Of course, I was on my therapeutic journey. I felt safe to open up completely and this was to change my life, in which compassion made it possible to be me unreservedly and honest for once in my life.

As explained above, whatever the trigger, loud aggressive people, heated conflict, sharp objects or silent treatment, I usually ended up back in the car park, laid out on the cold floor wet with blood, holding my neck. Alternatively, I flash back to the ambulance, where I have audible hallucinations of the policeman holding my neck and the amazing paramedic shouting ‘I can’t get a blood pressure’ or ‘stay with me Nathan’. Other prisons offered visits from psychiatrists, potent anti-psychotic medication, counselling, and group work for what it’s worth, when the environment was rarely safe to drop your guard and process the PTSD.

Meeting Geoff however changed my standpoint. In many ways Geoff and I could be no further different as people, though within an hour of talking to him about his PTSD in group and all the things that eased his trauma, felt as though I was no longer alone; the TC principle of universality and community. I completely understood what he described, how he suffered, and how alone the episodes can make us feel. However, our reactions could be distinct. For Geoff, feeling threatened provoked an intense need to lash out in extreme violence. For me however, I either freeze or run away, the classic responses. For many years since diagnosis I have kept everyone at arm’s length as a result. Relationships were based on my needs only and attachments have either been overbearing, unhealthy and borderline obsessive, or not at all. The working relationship with Geoff though was built on the basis of honesty and equality. From this mutually compassionate healthy situation, endorsed by our environment, I have been allowed, over a three-year period, to be open about exploring all the complex issues I have touched on in my writing here, thereby, replacing maladjusted reactions to problems (namely obsession, violence, drug use, and criminality) with a balanced set of coping strategies when my trauma arises. For example, self-searching, sharing my feelings with others and if I do have an episode, which is rare, I implement learned strategies. These grounding exercises, (although I prefer the term “calming” because of my association, with PTSD, of laying
on the floor helpless), I usually take myself to safety. I also use breathing and meditation techniques. With these interventions I tend to come out of it within half an hour, although the last time this occurred was longer ago than I can remember.

**Psychodrama Therapy and Art Therapy**

Augustus and Jefferies (in press) describe how core creative psychotherapies (CCP) were introduced to Grendon in the 1980s in the form of psychodrama and, later, art therapy. There are now three core creative modalities practiced at Grendon, including music therapy, which is undertaken on the wing for men with learning difficulties. The core creative psychotherapies are considered a central component of group work that takes place on each DTC. The CCP groups are once weekly for two hours, and the membership of each group is between six and eight residents. Case and Dalley (1992) state that art therapy involves the use of different media through which the participant can express and work through the issues and concerns that have brought them to therapy. The therapist and participant are in partnership in trying to understand the art process and product of the session. For those taking part it can be easier to relate to the therapist through the art object which can then provide a focus for discussion, analysis, and self-evaluation. As it is more concrete, it stays as a record of the therapeutic process and cannot be denied, eased, or forgotten, and offers a chance for reflection later. The transference that develops within the relation between the therapist and client, and is discussed in all aspects of the DTC, extends to the artwork. The participants engage with art materials, producing artwork and reflecting on the thoughts and feelings that arise in relation to both the work produced and the process itself.

The work undertaken in core creative therapy groups is fed back to the small group and community meetings. Nathan participated in art therapy and describes this below, but first a note on psychodrama psychotherapy.

Psychodrama is an action-based group psychotherapy (for more details see Augustus and Jefferies, in press). It employs action methods to encourage the expression of suppressed emotions and introduces the possibility of change by correcting the earlier responses that have taken place. It uses dramatic format, theatrical terms, and role analysis for participants to explore, in the context of the group, how his/her modes of dealing with significant others is influenced by their internal world and how their dysfunctional *internal working models* (beliefs of self and others) have been brought about by early childhood experiences. The participant is encouraged to find new ways of perceiving and reacting to past and present life experiences and to understand the process of how he/she has come to offend. The technique of role reversal increases victim empathy and provides the opportunity to explore the perspective of others by standing in their shoe and exploring their state of mind. The physical setting of scenes and the use of group members to play significant characters in their lives brings the “there and then” of the past into the “here and now” of the session. This process provokes memories and strong feelings from the past and the present and allows the protagonist to examine the distorted belief systems that have influenced
his/her behaviour and how unexpressed feelings of anger have been displaced onto the innocent victim. Internal working models and dysfunctional attachment strategies are understood and challenged.

I am talkative, always have been, and art therapy (AT) offered a way of communicating my life in pictures, allowing me to explore aspects of my experience in a way I could not articulate as a child. An early picture I showed the group, depicted my family on arrival in London. It illustrated my sixth birthday, a hedgehog shaped chocolate cake (which I had completely forgotten about) and how I had waited the whole day for my father to arrive to watch me blow out the candles. He never arrived, a man I was only to meet three more times before his death at the beginning of this sentence.

Through AT as a medium I processed all my relationships, the shame I felt for my victims and family, my trauma and how these problems affect my relationships today. The message absorbed from my birthday I took to every relationship I ever went into after that. There I discovered the truth; that deep down inside, people abandon you and let you down and eventually reject you. Looking back through my life, much destructive behaviour had its roots in the belief that I had no value and so I shall give everyone a reason to believe this. It's the safe and compassionate environment that eventually led me to that core truth.

Critics may disagree with a compassionate approach. My hard-earned experience, however, depicts a different standpoint. Perhaps short, sharp, shocks work for some. I've been a cog in the CJS since I was a child. The only intervention that has worked has been the compassionate, conflict-facing long-term resolution model I have now completed.

**Resistance to Change**

Whilst the discussion so far has focussed on upholding a safe and compassionate atmosphere to facilitate the processing of trauma, meeting and getting to know 40 men with varying maladjusted traits is difficult.

Violence is rare here, threats more common, though mostly a lot of acting out is done anonymously. Whether the incidents are directed towards the select few or the whole community, occurrences such as blocking locks, notes in the mailbox, deliberate vandalism of artwork, fittings or furniture usually trigger a crisis meeting, which all residents must attend. Sometimes it can be a witch-hunt and people's frustrations spill out in abusive language, either designed to quieten less assertive residents or to shame some. These interactions would be met with challenges of their own. We are not in the business of naming and shaming. The majority of our community have experienced the most horrendous humiliating sexual, physical or emotional abuse and seeking to shame has no place in this environment. Even those who are loud and verbally abusive usually calm down once they recognise the individual struggles with an open honest compassionate approach to our
work here. Whereas other prisons would quickly expel disruptive people, Grendon tolerates a great deal of risky behaviour presented, demonstrating that where people like me would expect rejection, there are other ways to resolve conflict.

Having a wide-ranging timetable of stimulus, beyond therapy groups, empowers ownership for our environment, teaching the importance of timekeeping, upholding commitments and social interactions, whilst focusing on our trauma, rehabilitation and healthy boundaries in relationships, both personal and professional.

Over time the interactions have helped form part of my identity, relieving shame, turning guilt into positive restoration for the harm caused, and ultimately building self-esteem and self-worth, towards a prosocial future as I work towards release.

Whilst the Covid regime was restrictive compared to my time in therapy, it was the compassionate response to my problems that I feel was the catalyst of my transformation. No longer riddled with the stigmatised shame, loneliness, and fear my life in institutions helped to mould; instead, I’m proud of who I am and excited to meet the people I am yet to share my life with.

**Conclusion**

Whilst definite conclusions are difficult to draw from the experiences of a single staff member and a single resident, some encouraging points are raised on the effectiveness of CFT and taking a trauma-informed approach to containing distress.

Firstly, Nathan’s experience is not unique. He observed that when immersed in a more supportive environment, where boundaries and living conditions are compassionate and enable the development of trust to occur over an extended period, the CFT approach can alleviate the destructive defensive barriers that many residents experience when their threat system is overactive. In the first six months there can be a period of adjustment and, over an extended period, as discussed, the ability to self-sooth increased and the threat system decreased significantly. This made my day-to-day experience more manageable, allowing healing.

Secondly, identifying terms such as “dropping your guard” and “feeling safe enough to share” – in addition to not having to endure the overarching threat of persecution, ridicule, and further punishment through violence, bullying, and intimidation of others – appears in stark contrast to other prisons, where experience of culture on the whole was unsafe. This appears to indicate that, among other things, CFT and having a trauma-informed approach alter the culture to a more considerate, mature and healthy one.

Thirdly, during the Covid-19 pandemic, much of the usual groups and staff supervisory meetings have inevitably reduced. Whilst there have been major challenges across the six communities, incidents of crisis have still been very rare. Since Grendon houses some of the most dangerous men serving long sentences, this appears to support the use of the CFT and DTC approaches. Although there has been distress for residents and staff (who have inevitably had their own challenges, balancing
work/life commitments during the pandemic), this has not been evident in their treatment of residents. This demonstrates the multi-disciplinary approach to crisis has been humane and camaraderie has developed.

Fourth, a huge part of the work of a DTC is working through denial and developing invaluable insight through reality confrontation in a compassionate manner. As discussed, much of this work was the catalyst for change, although facing the trauma in the beginning was difficult. During the assessment period only the “here and now” is discussed, and eventually, when each individual feels ready, the move forward happens organically. Within small groups the past offending and experiences are examined. While this is done carefully, in a CFT manner, working through the past experiences helps alleviate the long-held distress. Some struggle with this, and either take time away from the group, which is very intense, or decide they have gone as far as they can on the journey and leave. They can return sometime later to continue the work. Often the defences relate to aspects of offending. One group member could not remember details of his offence, but in psychodrama, when describing the scene, recalled there was a clock in the room which had its face lit up, and he could “see” what happened for the first time. This was in a safe and secure environment, when he felt able to confront what he had done. Recalling events can also link to empathy for victims, through the resident exploring the events from the perspective of others involved. For some this is too much to tolerate and they leave.

Grendon opens its doors to many visitors. One couple who are regulars are Ray and Vi Donovan (see Donovan & Donovan, 2018), whose son Christopher was murdered by a group of young men. They speak of the impact this had on them, and the pain and distress they went through. They describe the journey through restorative justice and the impact this had on all concerned. Those listening cannot help but be moved by their response and relate to how they impacted on their own victims, without the need for individual confrontation. Through all this work it is possible to see people find the person they once were, process the extreme hurt they have carried, and tolerate the pain they have caused others.

In conclusion, whether best practice for other establishments is to take a more trauma-informed approach is outside the remit of this chapter. However, collaborative responses to debate and sharing perspectives between all who live and work in a setting is a great place to start, empowering those who otherwise have not had a voice provides autonomy. This collaborative chapter is a prime example of giving a voice to an expert by experience, thus giving value to their experience. Including and empowering those who have experienced trauma, exclusion, and disempowerment is surely a compassionate place to start, wherever therapy and trauma work is taking place.

Notes

1 Nathan Joshua is the nom de plume of a former Grendon resident.
2 Drug Treatment and Testing Orders (DTTO) are imposed by courts where someone’s offending is linked to drug misuse. The focus of a DTTO is to address drug use to reduce the risk of further offending and harm.
3 Nathan uses the term “offender” whereas the preference is to use person-first language.
4 The TAC course is co-facilitated by residents from therapy wings who have experience of the process and can give a lived experience to new residents.
5 A Round Robin is when each person in the community introduces themselves in turn.
6 In a Minute Meeting residents hold others accountable for their actions, and are also held to account for what they have done and the impact it has had. This could vary in seriousness from snapping at someone to, in this case, a fairly serious incident.
7 A “screw boy” is a resident who spends a lot of time with staff.
8 In the process described, if a person is thought to have broken the rules of the community they would explain themselves to the group and wing, and they would vote whether the rules had been broken, and also whether they would still be willing to work with the resident. If they are allowed to remain, there are generally sanctions to undertake, which can be punitive, therapeutic, and restorative.
9 Not his real name.
10 The term used for the person who is undertaking the psychodrama.

Further Reading

Akerman, G., & Shuker, R. (In press). *Interventions in forensic therapeutic communities*. Taylor & Francis Group. This volume describes various interventions in DTCs, which add to their effectiveness and enhance the progress made by residents. These include core creative therapies, working with gangs and working with mothers of young babies.

Gilbert, P. (2010). *Compassion-focused therapy. Distinctive features*. Routledge. As with all Paul Gilbert’s books, this one is written in an accessible manner and explains the evolution and development of the brain and how to implement more compassion focused approaches for ourselves and those we work with.


References


