Trauma-Informed Forensic Practice

Phil Willmot, Lawrence Jones

Addressing Trauma with Young Adult Males in Custody

Publication details
Kate Geraghty, Chantal Scaillet
Published online on: 11 Mar 2022

How to cite: Kate Geraghty, Chantal Scaillet. 11 Mar 2022, Addressing Trauma with Young Adult Males in Custody from: Trauma-Informed Forensic Practice Routledge
Accessed on: 05 Dec 2023

Full terms and conditions of use: https://www.routledgehandbooks.com/legal-notices/terms
This Document PDF may be used for research, teaching and private study purposes. Any substantial or systematic reproductions, re-distribution, re-selling, loan or sub-licensing, systematic supply or distribution in any form to anyone is expressly forbidden.

The publisher does not give any warranty express or implied or make any representation that the contents will be complete or accurate or up to date. The publisher shall not be liable for an loss, actions, claims, proceedings, demand or costs or damages whatsoever or howsoever caused arising directly or indirectly in connection with or arising out of the use of this material.
16

ADDRESSING TRAUMA WITH YOUNG ADULT MALES IN CUSTODY

Implementing a Stepped Care Trauma-Informed Approach in a Young Offenders Institution

Kate Geraghty and Chantal Scaillet

An Overview of the Complex Needs Service

The Complex Needs Service (CNS) is a day centre, located in a Young Offender Institution (YOI) for young adult men aged 18–21 presenting with complex needs borne out of early, disruptive developmental experiences. Established in 2013, the CNS sits within the overall national provision of Offender Personality Disorder Pathway (OPD)\textsuperscript{1,2} services in the UK (Joseph & Bennefield, 2012). The evidence-base underpinning the psychosocial interventions of the CNS derives from three areas: factors involved in supporting desistance from offending, the impact of relational and developmental trauma\textsuperscript{3} on the development of personality, and the link between complex trauma and offending or increased risk.

Desistance Factors

Desistance is a main objective for the CNS. Agencies promoting desistance from offending in young people (e.g., Youth Justice Board; Youth Offending Teams) recognise that services need to be age-appropriate and trauma-informed, that is, based on a thorough understanding of the young person’s needs in context of their developmental history, psychological and social experiences. As such, treatment mapping in the CNS is sequenced, structured, and premised on the same guiding principles as other phased trauma-informed treatments, such as the Trauma Recovery Model (Skuse & Matthew, 2015) and Golding’s (2015) Pyramid of Needs. More specifically,
Livesley’s (2015) framework for personality disorder treatment proposes integrating common elements supportive of change from a diverse range of interventions. Livesley describes five phases: safety, containment, regulation and control, exploration and change, and integration and synthesis (Figure 16.1).

Drawing from Livesley’s framework, interventions in the CNS take account of individuals’ readiness and capacity to self-soothe and feel safe in the present (safety, attachment, containment, control, and regulation). In particular, and highly relevant to delivering trauma interventions in environments that have the potential to re-traumatise individuals, safety and stabilisation are essential phase 1 tasks, before progressing to processing the trauma. Exploration and change (Formulation) focus on the past and making sense of difficulties. Integration and Synthesis (Onward Pathway planning, ongoing keywords) focuses on the future and the support available in identifying positive goals, as well as areas of vulnerability and obstacles to achieving goals.

**Attachment**

A second objective of the CNS is developing relationships with family and the wider community, as well as developing a more hopeful, internalised self-view. This is done through regular, consistent, face-to-face meetings with the young person. Key staff (keyworkers) will re-parent (Treisman, 2016) and offer a relational experience that
invites the young person to be curious about their difficulties within the context of a safe therapeutic relationship.

Individuals might have learned to adapt and respond to dangerous environments with trauma-related responses such as hyperarousal, hypervigilance, and mistrust (Fonagy et al., 2002; Perry et al., 1995), which may impact on their ability to mentalise (Huang et al., 2020; Fonagy & Bateman, 2008) rendering them more prone to misreading intentions of others and situations. As described in earlier chapters, betrayal trauma severely impairs interpersonal relationships and “epistemic hypervigilance, distrust or outright epistemic freezing is an adaptive consequence of the social learning environment” (Fonagy & Target, 2008; p.694). Furthermore, the need to adapt to ongoing trauma will also further impact on individuals’ mentalising capabilities.

**Formulation**

A third objective of the CNS is to develop self-knowledge and a meaningful personal narrative. This is achieved through co-creating an understanding of the young person’s life from the past to the present (psychological formulation). This personal narrative then forms the backdrop for the integration of a more realistic self-appraisal in relation to difficulties past and present, contributing to the development of a hopeful future orientation. The CNS focuses on strength-based approaches that promote growth and seeks to rebuild trust within context of a curious culture (e.g., Good Lives Model; Ward & Brown 2004), Mentalisation-Based Therapy (MBT: Bateman & Fonagy, 2006) and Schema Therapy (Young & Klosko, 1993). In addition, the CNS is an accredited enabling environment (EE), which plays a key role in supporting the young men’s learning and psychosocial development, as well as providing a safe, containing, therapeutic space to minimise re-traumatisation. In conclusion, interventions delivered within the CNS are aligned to trauma-informed ways of working and are premised on a fundamental shift from thinking “What’s wrong with you?” to “What happened to you?” (Covington & Rodriguez, 2016).

**An Overview of the Complex Trauma Presentations within the CNS**

Having described the main aims and treatment framework of the CNS, this section will report on the diverse range of trauma experiences. In terms of reporting past distressing experiences, the young men in the CNS are no different from their peers across the wider prison estate, where trauma often goes unidentified (Boswell, 1991), with direct or witnessed trauma ranging from one single incident (PTSD, single event) to multiple exposure and type (poly-victimisation, developmental/complex, cultural and racial trauma).

The recording of the types of trauma serves the purpose of identifying complexity in the young person rather than any attempt at diagnosis. This point is important, as the CNS does not routinely administer psychometric testing in order to determine the presence of PTSD or complex trauma. The identification of trauma follows a
less rigid, more inclusive, and contextual approach than the diagnostic approaches found in the psychiatric/medical field and incorporates a range of distressing negative experiences.

As indicated in Table 16.1, 66% of the young men from the CNS have experienced four or more severely distressing negative experiences prior to age 18. As stated earlier, exposure to these initial traumatic experiences results in poorer ability in regulating emotions, significantly impacting on the young person’s sense of safety and ability to manage relationships and stress. This manifests in challenging institutional behaviours such as aggression towards peers or staff.

The term “poly-victimisation” (Finkelhor, Turner, Ormrod, & Hamby, 2009) is described in detail elsewhere in this book. Certainly, within the CNS, the higher the number of different types of adversity experienced, the more pervasive and persistent are psychological problems across the domains of cognitive schemas, affecting dysregulation and relationships. Poly-victimisation is represented in Table 16.1 with very high numbers having witnessed others being assaulted (89%). Cumulative trauma impacts on the young person’s affective responses, which often appear blunted in range. For example, when reporting on their histories, the young men frequently respond with blunted affect, asserting that “it is what it is”, while expressing a belief in a foreshortened future. In addition, the young men appear to minimise the impact of violence on themselves (and others) and to normalise it. Some authors (e.g., Salzinger, Feldman, Stockhammer, & Hood, 2002) propose that this is as a result of the poly-victimised young person’s frequent exposure to violence and trauma and defence against feelings of vulnerability and fear. Linked to this is “offence-related trauma”, which refers to the experience of trauma symptoms such as intrusive, unwanted
thoughts, excessive rumination, guilt, and shame as a result of committing their index offence (Mrug, Madan, & Windle, 2016).

It is well documented that childhood adversity, trauma, and violence blight the lives of young people who are more at risk of joining gangs. In our sample, 39% reported gang exploitation and 24% were groomed into “county lines”. Young people caught up in these are likely to experience intimidation, exploitation, and violence by older gang members (Wigmor, 2018).

### Systemic Issues in Delivering Trauma-Focused Treatment in a YO

Treatment in prison has predominantly focused on offender rehabilitation, and much of this has focused on the area of risk reduction and public protection (McGuire, 2013). It is widely recognised that the needs of young people in prison are different from those within the adult estate. Young people are still developing in psychosocial maturity, which affects how they engage and respond. It is also recognised that young adults can be harder to engage and have poorer outcomes in prison in comparison with older adults (NOMS, 2015). As mentioned previously, young incarcerated men have a high prevalence of complex trauma. However, prisons themselves can cause ongoing traumatisation. They can be volatile environments with concerning living conditions. There are well-known difficulties with violence, rates of assault and self-harm, particularly within the youth custody estate (Ministry of Justice, 2020). There are also issues of overcrowding in prisons, with nearly 50% of prisons being reported as being over capacity (Sturge, 2020). These living conditions do not provide humane, validating environments for people and pose numerous challenges for staff trying to implement trauma-focused interventions.

Some of these challenges are practical issues. This includes the movement of individuals to different departments in the prison. At times, individuals are kept in their cells due to their involvement in an incident, a wing or prison lockdown, or security searches. If individuals are not on the relevant list for the department or area they are due to attend, they may not get permission to go there. They may also be prevented from attending therapy sessions because of low staffing levels or security concerns. These issues may also prevent therapy being provided in a consistent and reliable way, which may undermine the basic requirement of trauma therapy in facilitating client safety. Other issues include sudden endings to therapy, which the therapist has no control over. It is common practice in prison settings that individuals deemed a security risk are moved to another prison. While this may help alleviate some of the prison disruption, it may also lead to an unplanned ending of therapy.

Prisons have been noted to exacerbate previous experiences of trauma (Bradley, 2017). Trauma can occur within prison settings (Jennings, 2004) and mental health services can inadvertently re-traumatise people through a lack of awareness of the impact of trauma (Bloom & Farragher, 2011; Davidson, 1997). Staff may adopt more punitive responses and/or experience vicarious trauma. Jennings (2004) outlines how institutional re-traumatisation can also manifest in staff practices for those with complex trauma histories. For example, those with sexual abuse histories may be re-traumatised by the experience of being strip searched or restrained by staff.
Addressing Trauma in Young Male Offenders

Additionally, some individuals in prison can be in physical danger from other residents, have a perception of danger or feel psychologically unsafe around key dates such as anniversaries. Furthermore, the ability to develop an appropriate attachment to staff (therapeutic relationship) is compromised due to the nature of the volatile environment, staff levels, inconsistency in staffing and the delivery of interventions. There is also a tension between confidentiality (a key requirement for therapy) and risk management. Working in a prison environment requires therapists to be attentive to both issues. It is recognised that there is a need to achieve a balance, albeit a delicate one, between managing risk and maintaining trust between the therapist and young person (Harvey & Smedley, 2017).

The implications of these systemic issues for delivering trauma therapy are significant, but not impossible to overcome. They highlight the need for offering more long-term rather than short-term therapy. Positive experiences have been reported when the conditions of confidentiality are openly discussed and shared at the start of therapy (Harvey & Smedley, 2017). Furthermore, others have reported the value that such tensions can provide as important learning experiences and used as metaphors for change. For example, in spite of these challenges progress and change can still be possible and “imperfect” situations can still be valued (Haley, 2017).

Raising Awareness of Complex Trauma Presentations Among YOI Staff

As alluded to above, not only are service level approaches needed to address trauma but also system level approaches. Staff education and training in trauma-informed care is considered fundamental to treating complex trauma services (Kezelman & Stavropoulos, 2012). This enables an organisational understanding of trauma responses, how to work with those with complex trauma presentations as well as the importance of maintaining personal and professional boundaries. Within mainstream prisons, the majority of staff will predominantly be prison officers, with clinical staff operating from other departments delivering 1:1 assessments/interventions, group work, and consultation to the wider prison. HMPPS is increasingly recognising the importance of staff–resident relationships through the introduction of initiatives such as the Five-Minute Intervention (FMI). It is also recognising the role of trauma through introducing the Trauma Risk Management (TRiM) scheme, a staff support programme designed to help staff deal with the impact of traumatic events. Additionally, HMPPS are also beginning to roll out other trauma-informed approaches, including a trauma awareness group for residents. The introduction of these initiatives is extremely positive, but there is some way to go before mainstream prisons can be considered to comply with the guidelines for developing a trauma-informed culture such as those outlined by Kezelman and Stavropoulos. As such, although the prison could not be considered to be trauma-informed, it is moving towards creating environments that are trauma informed.

As the CNS is non-residential, no CNS staff are available freely on the wing to service users. Additionally, the therapists facilitating trauma-focused treatment are not the young person’s main support worker for the service. This has required
the therapists to educate staff working with the young person about the trauma therapy, what is involved and, importantly, the impact this could have, both positive and negative. Adopting a multi-systemic approach to working with young people is crucial (Squire, Jefford, & Cupit Swenson, 2015). Some understanding of the systems working with the person is needed. This includes systems directly in contact with the person but also wider organisational systems. Discussions were held with other departments including HMPPS Psychology and the prison Mental Health teams about the trauma treatment, what would be involved, and how the young person would be supported through this. Additionally, staff working in the complex needs service directly with the person were given some training on what the therapy would involve. Regular discussions were held with the key workers and within service team meetings to review the person’s progress, appropriateness of trauma therapy, and to raise any concerns.

Open discussions were also held with the residents about the importance of informing some wing staff and having support from staff on the wing outside of the session. This raised some initial anxiety, with concerns about confidentiality and personal information being shared. To support this the residents were asked to identify a limited number of wing staff who would be aware that they were engaging in trauma therapy, but not the content of what was discussed in therapy, so they would be aware if the resident was acting differently on the wing. Informal staff training was offered to these staff on the therapy, covering what it involved and what behaviours staff might see if the resident was struggling. It also involved advising staff on how to support the resident during these times, such as reminding them of positive coping strategies and important people in their life. Consultancy was also offered on how to maintain boundaried discussions of residents’ pasts for those who may be vulnerable to adverse reactions to such discussions, crisis management, and informing staff of other agencies in the prison who could support the resident if needed.

**Reflections on EMDR**

**Service User (AO) Reflections**

I want everyone to understand my trauma; in order to do that firstly I need you to understand who I am.

Like most of kids, I also had a terrible childhood. It’s not because of my family or someone, it’s ‘cause of where I am from. I was born during a civil war in my country where most of the kids don’t even know what a good life is. At the age of seven, I lost everyone I know, even my parents and my brothers and I ended up in a refugee camp with other kids. I spent a couple of years in the camp where everyone knew there was no future for them ’cause we saw people got beaten to death. People did terrible things in order to see another day. We were assaulted every day – mostly they want to show us they are in charge. I prayed to God asking him to take me away from this war because I couldn’t live anymore. In order for us to survive someone was to die. Then, one day out of the blue, the officers came to me and told me “your grandfather is here to see you”. I honestly didn’t know what to say. I was happy and angry because he
came after all these years. Then I saw him through the fence. I felt like it’s miracle day. Inside of me I had so many questions – but my grandfather told me “don’t worry, I’m getting you out soon”. I was emotionally over the moon. I went back to the camp and told everyone “I’m getting out!” Everyone had a smile on their face, but I know that inside of everyone, they felt sad as they didn’t get the same luck. I was so happy I’m gonna leave this life and start afresh – at the same time, I know I’m gonna miss every single one of them, because, for a long time, they are the only family I had. A couple of weeks later, I left the horrible life to move to the UK to start a fresh life with my mum’s family, who is my auntie. She welcomed me with open arms into her family. Then a couple of months later, my grandfather found out my mum and my brothers are in a camp and we managed to get them out. When I heard the news, I couldn’t move and no words came out of my mouth – then my life in the UK was perfect.

When I got… my GCSE, I was over the moon. At the time, I know why I left my old life behind, it happened for a reason. I then started “A” levels in a college where I made friends and enjoyed my life. I went to parties, met new people, and had confidence. And I started drinking soon after that. Alcohol brought my old life memories back. I felt like the scar being ripped open. That’s when I used alcohol as a medicine to help the pain go away. My alcohol use became a problem. That’s when I left the college and started hanging around with the wrong people – that’s when I met my uncle who is an extended family member. I trusted him and he looked after me as, when I say something, he will listen to me, so, as a human being, I trusted him. Then one day he comes to my place where I was staying, with his friends. Soon after that, he came to the house, he opened a bottle of whisky, and I started to drink as always. He got me involved in the conversation that led to a man being assaulted, then again my uncle got me involved in the assault. Then we left the house and went to a park where the assault continued. He and his friends left the victim with me and went to a shop. I spent about 30 minutes with him. The frequent thing he said was “let me go young brother”. I honestly don’t know why I didn’t let him go. Then the assault continued. Then I left. The next thing I know he was dead. When I heard the news, I was scared of who I am, I couldn’t believe I took someone’s life. Even though my assault didn’t kill him, I felt responsible. Then I came to jail where all these traumas keep coming in my mind. I couldn’t deal with it – it’s like a spider web with one thing connecting to another and I was stuck in a hole where I couldn’t get up. I felt like I’m losing my mind.

That’s when I started getting involved in the Prison Complex Needs Service. First, I couldn’t trust anyone ‘cause in my mind, people gonna take advantage of me and use me, so therefore, it’s hard to trust anyone. Then I joined the MBT group with two other inmates. First few sessions, I don’t know whether to trust anyone or not. Then I realised the other two inmates were sharing things that are very personal to them and they are trusting staff with it, so I questioned myself whether I should trust them. So I told myself “let myself in one by one”. It took some time for me to be open about my life. So, I start trusting them. My mind became peaceful. However, the scars are still very painful. I know I need a way to get the pain out of my body and I know for certain I’m not gonna use alcohol. Why? Because it’s gonna help me for some time by hiding it, not solving it. That’s when I started doing EMDR. First I thought,
“it’s weird”, ’cause someone moving their fingers from right to left. Then I know the purpose of the eye movement, which makes me focus on my issues. Then I need to know which trauma to focus on because I have so many and all of them from different situations. That’s when I did the questionnaire, which helped me to understand which trauma I need to work on. That’s when I know I’m living with the guilt of my victim (as I said before, I spent 30 minutes with the victim) – I had the chance to let him go, which I chose not to, and if I had, he would be alive. So I know for certain this trauma is making my day like a hell. Then every week, I did the questionnaire regarding the trauma. That’s when I realised this trauma is very heavy. We then used lights instead of fingers, which was great as it did the same job as the fingers. The more I work on EMDR the better it gets. Unfortunately, because of COVID-19, we stopped the EMDR. But I can say it did help my mind a lot; it did help me with most of the questions I have asked myself for a long time.

Firstly, I would like to say EMDR is great. However, in order to get into EMDR, you need to trust the people who are trying to help you. If you can’t trust them, it will be very difficult to solve your issues. As I say, that was the only thing I find very difficult. I know it’s very hard to trust someone with your personal trauma. Once you trust the people who’s trying to help you, then you know someone’s out there who will do whatever it takes to help you.

Laura Vahabzadeh, Art Therapist for Pathways, was asked to work with AO in order to create a visual representation of his experience of earlier trauma and what his future may look like in relation to this trauma. Figure 16.2 shows the image that Laura and AO created. What is seen at the centre is a beating heart, representing the present that is vulnerable but alive. The images surrounding the heart represent past traumas that are set against the sky which, for AO, represents a view of hope and his future.

**Author 2 (CS) Reflections**

Prior to delivering EMDR in the YOI, both authors sought to contact prison-wide colleagues delivering or thinking of delivering EMDR. At the time we found it was delivered across the estate by a range of commissioned services (OPD) services such as Psychologically-Informed Planned Environments (PIPES) and Therapeutic Communities (TCs), and NHS (mental health in-reach teams) and prison services (HMPPS Psychology) with each service operating under their respective commissioning agendas and operational frameworks. The feedback discussions were largely influenced by how sensitive their establishments were to individuals’ trauma histories and what structures (leadership, governance) were in place to implement TICP safely and ethically.

In terms of my own experience, I work with a young man (AO) following a year with the CNS, so we had already established a strong therapeutic attachment. AO has complex trauma linked to growing up during a civil war and, as a very young child, exposure to extreme violence, witnessing death and being separated from his family. As an adolescent, he was further re-traumatised by the commission of his offence while under the influence of heavy drinking, and was then a victim of an incident of severe violence while in custody. AO was ready to work on his trauma.
as he was experiencing nightmares, intrusive thoughts about his offence, flashbacks, and somatic symptoms. Linked to his complex trauma was a daily struggle to feel safe, a deep mistrust of others, an inability to modulate stress and regulate emotions. AO’s self-view was largely negative, with shame taking centre stage. Reflecting on his presentation at the time, my main concern was to “do not harm”, and whether it was ethically sound to offer trauma intervention work within a custodial environment that has the potential for re-traumatising individuals. I shared this ethical dilemma with AO as I wished to be transparent about what the process would entail in terms of working through traumatic material and what may happen in-between sessions as well as during sessions. He understood the potential side effects and wanted to work on his trauma as he described his current life as “a living hell”. On reflection, this is an important aspect of introducing trauma work within a custodial setting as it provides essential preparation. Another benefit of sharing my concerns was the positive impact on the therapeutic relationship and the building up of trust. Having been part of the MBT group for one year, AO had developed his mentalising capacity and made positive gains in trusting others linked to an increased sense of agency and active collaboration in sessions. As discussed in earlier sections (Figure 16.1), the introduction of any trauma work needs to scaffold on top of other interventions that
promote safety and the development of strong therapeutic alliance with professionals. In other words, EMDR forms part of a toolbox of other interventions rather than a stand-alone treatment.

The initial history taking of the phase 1 took longer than anticipated as AO appeared to be easily distracted by trauma-related ruminating within sessions, leading to unproductive circular thinking. This was a useful observation, as it provided opportunity for some psychoeducation around the role of excessive rumination (about the trauma) in the maintenance of trauma symptoms (Ehlers & Clark, 2000), and how this rumination impacted on his ability to focus on the actual trauma situation. AO chose to process the shame and guilt he experienced as a result of his involvement in the offence.

Author 1 (KG) describes in her reflections the many barriers and obstacles experienced when providing therapy within a prison environment, which I share too. In addition to this, COVID-19 created a major disruption in providing any therapeutic work safely. However, the prison was able to offer in-cell calls from staff, which allowed for some continuation of the work, especially in the safety and stabilisation skills practice.

Phase 2 protocol (preparation) recommenced face-to-face following three months delay and at the time of writing we had installed a safe place and carried out resource installation. In spite of the delays, AO is committed to continuing with the treatment in a consistent manner through the phase at a pace that is realistic and that takes into consideration the many obstacles faced in the prison and current Covid restrictions. AO stated that his main objective was to eventually develop sufficient knowledge, skills, and understanding of how trauma has impacted on his personality development, mental health and behaviour, so that he can look to a future with greater hope and optimism.

**BD Reflections**

Unfortunately, BD was unable to contribute to this book chapter as he was transferred from the prison prior to completing this.

**Author 1 (KG) Reflection**

My experience of introducing EMDR in a YOI has felt slow, frustrating at times, but an incredibly rewarding experience. We were very mindful of how difficult this type of therapy can be and acutely aware of the importance of responsive approaches to addressing complex trauma. BD wished to process a time when he was stabbed in the past due to the lifestyle he led. This event left him hypervigilant to his environment and experiencing repetitive nightmares and flashbacks. BD also reported some earlier developmental trauma in terms of immigrating to the UK and parental divorce.

During the earlier sessions (Phase 1) two therapists initially worked jointly to undertake the history taking. This was part of our local protocol and not a necessary requirement of EMDR therapy. Nonetheless, it felt important given that we were
introducing EMDR in the YOI for the first time. This allowed us to work together to assess BD’s readiness and suitability as well as enabling a space for reflecting with another clinician. BD found it very difficult to allow himself to become vulnerable in the sessions and transference to female figures in his life was noted. BD was engaging very well in schema therapy in the service, so I was aware of his ability to reflect on past difficulties. Focusing on the emotions behind some of these was more difficult for him. Time was spent exploring this, allowing him to feel safe in expressing his vulnerability during EMDR sessions. I found it incredibly helpful for BD to use a structured intervention to explore his experience of trauma in more depth. This appeared to enable him to share his experiences in a way that felt containing, as it was a phased intervention using a semi-structured interview and psychometrics.

One source of frustration was working within the prison systems as part of a non-residential, day service. It was disheartening when I could not continue with planned sessions. This could happen for numerous reasons, for example, operational issues, which delayed the regime and being unable to bring BD to the service. This raised tensions between delivering therapy and the prison regime (which ultimately ensures the safety of staff and residents). Equally, there were challenges working with clients whose default response can be antisocial behaviour. There were times when BD was involved in fighting which meant he was located in the segregation unit and sessions could not continue. The therapy required some flexibility. I also found it hard to continue with EMDR sessions on the wing where he was located due to high levels of disruption there. There was a lot of noise on the wing. During one session another member of staff came into the room! These disturbances need to be avoided, as they are not conducive for facilitating trauma interventions. Sudden interruptions that may occur at any moment do not enable the establishment of emotional safety and may act as trauma triggers for some clients. The hour-long sessions offered did not allow flexibility for any difficulties that may arise on the day in seeing the person at the allocated time. There were times when I noticed myself being more attentive to time keeping and the prison regime rather than the therapy space. On reflection, I would allocate a minimum of 90 minutes to allow for any practical difficulties that may arise and also to enable sufficient time to achieve the aims of the session. Additionally, BD was transferred from the prison prior to processing his trauma. Time was spent managing this. However, it is vital that therapists anticipate any prison moves and respond to this prior to progressing with EMDR.

EMDR can be a very useful trauma intervention within prisons for individuals who are motivated and ready to explore their trauma. However, it should be part of an overall package of interventions offered by a trauma-informed service rather than a stand-alone intervention. It is possible to deliver trauma-specific interventions in prison settings, albeit in an adapted way. If, as a therapist, you can tolerate the inevitable challenges that arise when working in prison environments, and if you can adapt your approach to accommodate these and the needs of the person, then EMDR may be possible to offer. There is something therapeutically rich in being able to offer a trauma-informed intervention in imperfect therapeutic conditions. While it can act as a barrier, it can also act as a source of learning of how to heal trauma, as well as how to continue to change and grow within inevitable challenges.
Implications for Practice

Managing Systemic Issues

Prisons hold a dual role of custody (public protection) and rehabilitation. These roles can often conflict and create tension in trying to achieve progress. As mentioned previously, talking in a safe therapeutic environment promotes integration of fragmented memories but this can be undermined if attention to the somatic experience in which therapy is delivered is overlooked. For example, by not being attuned to the psychological and physiological experiences of undertaking therapy in prisons and the prison environment itself. For the YOI context, not only could individuals experience ongoing traumatisation and continue to experience psychological distress, where offending behaviours may be partly a consequence of past trauma, the offending behaviours could go unaddressed potentially creating future victims if trauma is unaddressed.

The importance of this systemic approach to delivering therapy is widely understood in numerous treatment modalities and other clinical and forensic settings. However, the utility of delivering interventions using a systemic approach is noted to be “the invisible problem” within prison settings (Clements et al., 2007). Creating a culture of physical and emotional safety is a key component for safe delivery of trauma interventions (Golding, 2015; Herman, 1992). Nonetheless, it is our experience that elements of safety can be achieved. This is primarily through the therapeutic relationship. It can also be achieved through attention to practical issues such as conducting therapy in rooms off-wing that minimise noise and distraction levels. Furthermore, it is vital that detailed safety plans and consideration for the individual’s protective factors are formulated prior to progressing to trauma processing. This can be achieved through structured worksheets and staff training to ensure the individual has a support network they need. We found it particularly helpful to identify one member of staff who was regularly on the wing, as well as one or two senior wing staff, and to inform them, briefly, that the individual was engaging in EMDR therapy and what they may expect to see on the wing if the young person was struggling. We spent time with the young person exploring how their trauma may present and what aspects to share with staff before this was disclosed to the staff. One aspect we did not get to deliver due to COVID-19 was formal awareness training for staff. We would recommend this is also achieved. Additionally, we adapted the traditional EMDR protocol (Shapiro, 2018) for working with younger clients to allow more flexibility with introducing different psychoeducational tools and to allow for their suitability for the therapy to be considered. We also created an EMDR resource activation workbook for the creation of the safe place and installing resources.

Managing Self as Therapist

Professional skills need to be developed to take into account these systemic issues. A key skill for therapists is tolerance to these systemic issues. A major part of the work involved building trust and adapting the protocol to the environment. How we
manage our own emotions around delivering interventions in a non-linear way can seem at odds with our own goals as the treatment provider. For instance, wanting to progress therapy sequentially in a rigid manner through the stages of the model. The therapeutic model needs to adapt its approach, and model to the client that compromise is acceptable, and more importantly needed. Tenacity and resilience will be key qualities. Professional skills need to be developed alongside this through training, supervision, and reflective spaces with others working in the field. Positively, it can challenge us to be creative in working with rather than against the processes and systems. It can also contribute to our growth as professionals. More importantly we can offer interventions to those who need it, and which may contribute to public protection in the long term.

It is also important to judge the pace of therapy, balancing the client’s wish to progress to processing trauma and the therapist’s anxiety about moving too quickly. Here, being attuned to the individual’s needs and adopting attachment-informed approaches can support the formulation of this. Addressing trauma in a YOI requires avoiding temptation to adhere to a therapy model in prescriptive ways (where this is unhelpful) and working with the person in an integrative, attuned way while maintaining fidelity to the treatment model.

The Utility of the EMDR Protocol in a YOI

The EMDR protocol has many benefits and the potential to heal trauma in a YOI setting, for those who may need it. EMDR may support people with histories of complex trauma to heal their pasts and contribute to their readiness to then explore their offending and risks. It can support people in making sense of their past in a non-verbal way. This is particularly important for young people in prison whose executive functioning is still developing and may therefore not have developed the skills necessary to engage in talk therapies. Young people in prisons can also present with strong defences that may act as a barrier to talking trauma treatments. EMDR-informed interventions may therefore offer another non-verbal intervention to process trauma. Furthermore, it may be that aspects of the protocol may be beneficial for some. For example, it may be possible to install the safe place and offer resource installation even where a clinical decision is made not to progress to processing a memory. As such, EMDR skills may be offered as a treatment intervention.

Ward and Maruna (2007) have suggested that addressing non-criminogenic needs may be a necessary prerequisite to addressing criminogenic needs. Additionally, there are suggestions that people in prison are eager to receive more interventions that help them more generally, rather than interventions that just focus on offending only (Harvey & Smedley, 2017). There may therefore be benefits in not only engaging in risk reduction work, and internalising this change to prevent future harm, but also supporting people to address their trauma and have meaningful lives. People with trauma histories are more likely to have the cognitive, biological, and emotional capacity to engage in other interventions and learn new skills when their trauma is no longer a present-day threat for them. If we attempt to address the risk without addressing the trauma, we may be inadvertently re-enacting aspects of the
trauma through dismissing, silencing, and ignoring the experience. There is also a growing body of evidence indicating the utility of EMDR in addressing adverse experiences that may contribute to offence pathways as well as targeting factors that drive offending for those who have committed sexual offences (Ricci & Clayton, 2016). As such, EMDR has utility in reducing risk as well as in healing the past.

EMDR should be delivered as part of a holistic package brought by a trauma-informed service where the individual is meaningfully engaged and has developed strong therapeutic relationships with staff. The majority of young people in prison will be experiencing complex trauma reactions related to histories of adverse experiences. These developmental considerations should be taken into account within direct trauma interventions. It is recognised that direct trauma therapies should not be viewed as the primary intervention when working with complex trauma (Rogers & Law, 2017) and as such should be delivered as part of a structured framework of therapies. This view is consistent with our experience. Effective trauma interventions in a YOI require focusing on relationship building, psychoeducation, self-regulation skills, working with rather than against systems in which the young person lives, and system level advocacy on behalf of the young person before any specific trauma processing begins. Once these are being responded to, more specialised trauma treatment, such as EMDR, may be possible.

Notes

1 The OPD pathway programme is a jointly commissioned initiative between NHS England and Her Majesty’s Prison & Probation Service (HMPPS).
2 Across the wider Offender Personality Disorder pathways, the term Personality Disorder has been modified to Personality Difficulties in recognition of stigmatising terminology and growing trauma-informed research.
3 These types of childhood traumas have been named in the scientific literature with different but partially overlapping terms: early relation trauma, developmental trauma, complex trauma, or attachment trauma (Schore, 2009; Isobel et al., 2019).
4 An “enabling environment” is defined by the Royal College of Psychiatrists’ (RCP) Centre for Quality Improvement (CCQI) as a place in which “participants feel safe enough to develop relationships and to share experience and ideas with others”. The CCQI runs an “Enabling Environment Award” scheme, to recognise environments that meet a critical set of standards. The CNS is accredited with this award.
5 However, were we to put a diagnostic slant on the cohort, evidence corroborated by medical notes, psychiatric/psychology reports, risk assessments (OASYs and ASSET) and self-reporting, would indicate a high proportion of those young people as meeting diagnosis for PTSD, complex PTSD, and/or complex trauma.
6 A group of three or more people who have a distinct identity (e.g., a name/badge/emblem) and commit general crime or anti-social behaviour as part of their identity. This group uses (or is reasonably suspected of using) firearms, or the threat of firearms when carrying out these offences
   
   Home Office, 2008; p.23.
7 Criminal exploitation is also known as “county lines” and is when gangs and organised crime networks groom and exploit children to sell drugs. Often these children are made to travel across counties, and they use dedicated mobile phone “lines” to supply drugs.
Addressing Trauma in Young Male Offenders

Further Reading
Harvey, J., & Smedley, K. (2017). Psychological therapy in prisons and other secure settings. For readers interested in understanding more on the range of therapeutic approaches used in prisons and other secure settings.


Shapiro, F. (2018). Eye movement desensitisation and reprocessing (EMDR) therapy: Basic principles, protocols and procedures. A key book for people interested in reading more about the development and principles of EMDR.

References
Davidson, J. (1997). Every boundary broken: Sexual abuse of women patients in psychiatric institutions. NSW Department for Women and the NSW Health Department.


Addressing Trauma in Young Male Offenders


