



ESTSS workshop

The two sides of trauma. Victim and offender experience

Childhood violent trauma and PTSD in forensic settings: focus on assessment and treatment



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Treating PTSD in forensic settings

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Prevalence of Trauma Correctional Settings

- *Some researchers describe a pathway in which exposure to violence and pervasive feelings of not being safe develop into a state of chronic threat requiring the youth/adult to use physical aggression in order to manage*

(Schwab-Stone et al, 1995)

What does the prevalence data tell us?

- The majority of adults and children in psychiatric treatment settings have trauma histories
- A sizable percentage of people with substance abuse disorders have traumatic stress symptoms that interfere with achieving or maintaining sobriety
- A sizable percentage of adults and children in the prison or juvenile justice system have trauma histories
- Growing body of research on the relationship between victimization and later offending

Staff

- Prison staff through training are usually able to identify and refer inmates to the mental health support systems in facilities, however some disorders may not be easily identified, such as:
 - PTSD
 - Anxiety disorders

These disorders are likely to increase the risk of management problems for staff, so it is important to acknowledge and attend to these disorders.

Emotional and Relational Sequelae of Trauma

- The use of drugs to elevate mood
 - Alcohol, cocaine, amphetamines
- The use of drugs to calm agitation
 - Opiates, alcohol, marijuana
- The use of drugs to dull memories
 - Opiates, alcohol
- The use of drugs to stimulate feelings
 - Amphetamines, cocaine, PCP

Trauma and imprisonment

- ⑩ Offenders with a history of physical or sexual abuse may experience extreme difficulties in prison settings.
- ⑩ Problems can be associated to incidents of prior abuse, specifically interacting with authority figures or persons who remind them of the perpetrator of violence.
- ⑩ They may have problems with being physically restrained and locked up.

Three Fundamentals Needed To Improve Behavioural Outcomes for Offenders

SAFETY

RESPECT

DIGNITY

Abuse and trauma histories have implications for an understanding of the need for safety and security within prison environments.

Offenders that have extensive abuse (physical & substance) histories can make them *more vulnerable to inappropriate relationships with staff*

Definition of Trauma

Informed Care

- Treatment that incorporates:
 - An appreciation for the high prevalence of traumatic experiences in people in the CJS.
 - A thorough understanding of the profound neurological, biological, psychological and social effects of trauma and violence on the individual and
 - Care that addresses these effects, is collaborative, supportive and skill-based

(Jennings, 2004)

Trauma Informed Care Systems

Key Principles

- Are based on current literature
- Are informed by research and evidence of effective practice
- Recognize that coercive interventions cause traumatization and re-traumatization and are to be avoided

Trauma Informed vs. Non Trauma Informed Care

- What do trauma informed care (TIC) systems look like?
- How are they different from care systems that are not informed by trauma (NTIC)?

- Trauma Informed

- Recognition of high prevalence of trauma
- Recognition of primary and co-occurring trauma diagnoses
- Life context/exposure is appreciated
- Assess for Traumatic Histories & Symptoms
- Recognition of culture and practices that are re-traumatizing

- Non Trauma Informed

- Lack of education on trauma prevalence & “universal” precautions
- Over-diagnosis of schizophrenia & bipolar do, conduct do & singular SA disorders
- Person seen without family/social history
- Cursory or no Trauma Assessment
- “Tradition of Toughness” valued as best care approach

- Trauma Informed

- Power/Control minimized - constant attention to culture
- Staff
- Caregivers/Supporters – *Collaboration*
- Address training needs of staff to improve knowledge & sensitivity

- Non Trauma Informed

- Keys, Security Uniforms, staff demeanor, tone of voice
- Techs, Guards
- Rule Enforcers – *Compliance*
- “Patient-blaming” as *fallback* position without training

- Trauma Informed

- Understand function of behaviour (rage, repetition-compulsion, self-injury)
- Objective, neutral language
- Includes survivor's perspective
- Psycho-education and alternative skill development
- Transparent systems open to outside parties

- Non Trauma Informed

- Behaviour seen as intentionally provocative & volitional
- Labeling language: manipulative, needy, gamey, “attention-seeking”
- Lack of self-directed care
- Over-reliance on medication without skills focus
- Closed system – advocates discouraged

(Fallot & Harris, 2002; Cook et al., 2002; Ford, 2003; Cusack et al., 2004; Jennings, 1998; Prescott, 2000)

Core Issue: Avoidance of Shame and Humiliation

- Gilligan, in his prison research identified shame/humiliation as core element in violence
- Garbarino addresses the impact of trauma on boys & predilection to antisocial behaviour by “regaining control” through aggression
 - Denial of abuse and emotions
 - Explosion with little provocation – hypersensitivity when not feeling respected

(Gilligan & Lee, 2004; Garbarino, Lost Boys: Why Our Sons Turn Violent and How We Can Save Them, 1999)

Another core issue

- Severe Agitation Or Aggressiveness:
 - Agitation frequently precedes suicide in jail or prison settings
 - Its symptoms include a high level of tension – pacing, muttering, restlessness and extreme anxiety, including:
 - Strong emotions such as guilt, rage, and wish for revenge
 - Suicide may follow agitation as means of relieving tension or pressure

Problem Responses:

J. Garbarino's "lost boys"

- Since issues of shame are pervasive - allow child to "save face"
- "Juvenile vigilantism" as a survival strategy
- Gang affiliation offers a new/better family
- Lack of future orientation, sense of meaninglessness – tendency to take risks
(*Garbarino, 1999; Hodas, 2004*)

Treatment Approaches

- Sequential Treatment
- Parallel Treatment
- Integrated Treatment

Integrated Treatment

- Trauma, addictions, and mental health problems, when they co-occur in a single individual, are addressed by a single system and at least in part by a single, unified intervention

Integrated Treatment (2)

- Assumptions
 - the problems of trauma, substance abuse, and mental health interact complexly and causally within a single individual
 - approaches to recovery must be whole person approaches
 - value is placed on individual, family, and community empowerment

Integrative Explanations

- Primary trauma is a stressor that may trigger substance use and the development of psychiatric symptoms
- Trauma sequelae (flashbacks, nightmares) are stressors that may trigger substance use. These sequelae may also result in a psychiatric diagnosis
- Substance use and certain psychiatric symptoms may have evolved as coping strategies at a time when options were limited

Factors In The CJS Environment That Impact trauma

- A necessarily authoritarian environment—regimentation
- Loss of control over future, fear and uncertainty over legal process
- Isolation from family, friends and community
- The shame of incarceration - "Pillars of Community" become high-risk suicide candidates
- Dehumanizing aspects of incarceration--viewed from inmate's perspective
- Fears--based on TV and movie stereotypes
- Officers are familiar with arrest and incarceration, may be unaware of impact on offender
- Trauma of arrest often inversely proportionate to offense

Factors In The CJS Environment That Impact trauma

- Projects hopelessness/helplessness--No sense of future
- Expresses unusual concern over what will happen to him/her
- Speaks unrealistically about getting out of jail
- Begins packing belongings or giving away possessions
- May try to hurt self: "Attention getting" gestures

(Kopp, 2001)

Trauma assessment

Key principles

- Purpose
 - Used to identify past or current trauma, violence, abuse
 - Assess related sequelae
 - Provides context for current symptoms and guides clinical approaches and recovery progress

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(Cook et al., 2002; Falloot & Harris, 2002; Maine BDS, 2000)

Trauma Assessment

Minimal Components

Type

- Sexual, physical, emotional, neglect, witnessed domestic violence, exposure to disaster, combat exposure, other
- - Single, one-time event, multiple events or chronic long term event?

• *Age*

- When the abuse occurred is important in terms of developmental impact

• *Who*

- Was perpetrator a stranger? Family member?

Trauma Assessment: Key Principles

- Early and thoughtful diagnostic evaluation with focused consideration of trauma in people with complicated, treatment-resistant illness in mental health, substance abuse, domestic violence
- Tailor the assessment to the appropriate developmental level of the individual

- Noting that people who are psychotic and delusional can respond reliably to trauma assessments if questions are asked appropriately *(Rosenberg et al, 2001)*
- Noting that people with trauma histories/disorders may not be able to become sober unless trauma symptoms are addressed as part of stabilization plan *(Najavits, 1997)*

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Kinds of Trauma Assessments

Screening

Clinical assessment

Standardized instruments

Trauma screening

Screening does not mean diagnosing

Screening is essential to a public health approach for detecting mental health issues, including trauma

Screening is “the great equalizer”

Clinical Assessment for Trauma

Psychosocial History

Trauma Exposure

- e.g., Use of UCLA PTSD Index interview

Mental Status Exam

- Generic psychological symptoms
- Anxiety, depression, anger, general externalization

Clinical Assessment for Trauma

Posttraumatic stress triggers during assessment

- Symptoms of PTSD
- Dissociation
- Sexual behaviors
- Signs of hyperarousal and avoidance
- Suicidality, danger to others

The Issue of Avoidance

Underreporting of symptoms

- Trauma effect
- Fear of disclosure
- Guilt
- Denial

Potential for apparent symptom increase after initial assessment

Usefulness of validity scales

Standardized Instruments

- results of standardized instruments should be part of psychoeducation
- assessment data is powerful -- clinically and fiscally

Elements of Trauma-Informed Treatment

- What is the diagnosis?
- Is the diagnosis and/or symptomatology related to the trauma?
- Can trauma-focused interventions be integrated with other treatment strategies which address non-trauma problems?

Elements of Trauma-Informed Treatment

1. Trauma-informed assessment
2. Trauma-informed treatment planning
3. Cognitive-Behavioral approach
4. Psychoeducation
5. Repetition of CBT concepts
6. Matching: dose, duration, type
7. Structure (trauma = chaos)

Sequenced Treatment

Common myths:

Creativity is squashed

Therapeutic relationship matters less

No flexibility

Our experience with sequenced treatment:

Creativity and flexibility are encouraged

Therapeutic relationship is central

Exposure & Non-Exposure-based Therapy

Exposure: eliciting client's distress while recalling trauma material leading to decreased arousal over time

Non-Exposure: building skills for coping and resiliency - may be preparation for exposure

Evidence-based Models:

Exposure

Trauma-focused CBT

Non-exposure

SPARCS
TARGET

Combination

EMDR

Trauma-focused Cognitive Behavioral Therapy

Developed by Deblinger at CARES Institute in New Jersey and Cohen and Mannarino at Allegheny Hospital in Pittsburgh

A “hybrid” treatment model that integrates trauma sensitive interventions with cognitive-behavioral strategies

SPARCS

Structured Psychotherapy for
Adolescents Responding to
Chronic Stress

SPARCS

- ✓ developed at Northshore Hospital, NY (DeRosa, et al)
- ✓ targets the 6 domains of Complex PTSD
- ✓ 22 group sessions
- ✓ Non-exposure based intervention

SPARCS

Goals:

- to help traumatized adolescents make better choices for their lives
- to cultivate healthier relationships
- to activate meaning making
- to rouse mindful action
- to teach tools for coping with current and future stressors
- to promote healing

TARGET

Trauma Adaptive
Recovery, Group
Education, and Therapy

Target

Developed by Julian Ford at U of CT

11-17 year olds with PTSD or Complex PTSD

Provided in juvenile justice or residential
treatment settings

Target

- ✓ 10 group sessions
- ✓ bodily self-regulation
- ✓ affect regulation
- ✓ autobiographical and working memory
(information processing)
- ✓ interpersonal problem solving
- ✓ stress management

Dual Recovery Skills

- Self-awareness
- Self-protection
- Self-soothing
- Emotional modulation
- Relational mutuality
- Consistent problem solving
- Judgment and decision-making
- Accurate labeling of self and others
- Sense of agency and initiative

Guidelines for Practice

- Avoiding re-traumatization
 - Policy and procedure review
 - Clear and public policy for investigating abuse charges
 - Absence of shaming and excessive confrontation
 - No forced disclosure
 - Accurate assessment of blame and responsibility

Recommendations for Integrated Treatment For Trauma and Substance Abuse

- Cross training in mental health *and* substance abuse
- Utilize screening and assessment tools that identify needs in both areas
- Provide more intense treatment options to address the magnitude of difficulties often experienced by this population
- Emphasize management and reduction of both substance use and PTSD symptoms early in the recovery process
- Be aware that reducing substance use may initially *increase* PTSD symptoms
- Provide relapse prevention efforts, targeting both substance and trauma-related cues, early in treatment

Core Components of Trauma-Informed Evidence-Based Treatment

Trauma-informed approaches incorporate some or all of the following elements:

- Building a strong therapeutic relationship
- Psychoeducation about normal responses to trauma
- Family support or conjoint therapy
- Emotional expression and regulation skills
- Anxiety management and relaxation skills
- Cognitive processing or reframing

Core Treatment Components

Additional elements of trauma-informed treatment:

- Construction of a coherent trauma narrative
- Strategies that allow exposure to traumatic memories and feelings in tolerable doses so that they can be mastered and integrated into the consumer/client's experience
- Personal safety training and other important empowerment activities
- Resilience and closure

Core Treatment Components

Cognitive

- Traumatized individuals often show negative patterns of thinking as a result of their traumatic experiences
 - Distrust of others or expectations that they might be harmed by others
 - Overestimation of and preoccupation with danger
 - Low self-esteem and self-blame (feeling responsible for the trauma or what happened as a result)
 - Helplessness and hopelessness about the future
 - Shame and/or stigma
 - Survivor guilt

Core Treatment Components

Cognitive

- *Polarized thinking*—framing things in black/white, good/bad terms, either they achieve perfection or they have failed
- *Control fallacies*—feeling externally controlled and helpless or a victim of fate, or feeling internally controlled and responsible for the pain and happiness of everyone around them
- *Blaming*—holding other people responsible for your pain or blaming yourself for every problem (externalizing or internalizing to the extreme)

Core Treatment Components

- Cognitive processing/reframing/restructuring can help consumers/clients identify these faulty patterns of thinking and practice using healthier cognitive coping strategies

Core Treatment Components

Cognitive Processing

- Learn about thoughts, feelings, and behavior
 - Distinguish between accurate and inaccurate cognitions, or helpful and unhelpful cognitions
 - Understand relationship between feelings, thoughts, and behavior
- Learn how to identify and correct unhelpful thoughts
 - Identify: Identifying the thought related to the emotion
 - Challenge: Evaluating the thought based on the evidence and logic
 - Replace: Choosing alternative, more accurate, adaptive or helpful thoughts. Changing the emotion or the behavior by changing thoughts

Core Treatment Components

Motivational Interviewing

- Motivational Interviewing strategies
 - Taking an empathic, non-judgmental stance and listening reflectively
 - Developing discrepancy between the client's goals and their current behaviors
 - Rolling with the client's resistance and avoiding argumentation
 - Supporting/building self-efficacy

Trauma Informed Treatment Safety and Stabilization

- Requires integrated treatment for MH and SA w/premise trauma is central to development of both disorders (*NTAC*, 2004)
- Address impact of trauma on health and need for health prevention
- In general, focus on skill development rather than exploration of traumatic events,
- Cognitive-behavioral approaches demonstrate effectiveness: *cognitive restructuring, skills-training, psychoeducation*
- (Harvey et al, 2003; Najavits, 2003)

Trauma & Stages of Recovery

Safety & Stabilization Herman, 1992

- Skill Development
 - Trigger identification
- Coping skills as alternatives to self-destructive behavior
- Emotional Regulation
- Self-Care
- Self-Soothing
- Assertiveness Training
- Judgment & self-protection

(Linehan M, 1993; Najavits, 1997)

Trauma & Stages of Recovery

– Safety & Stabilization

- Psycho-education
- Impact of trauma
 - Body with attention to physical care
 - Sense of self (damaged goods)
 - Relationships
- Addressing substance abuse
- Recognition of danger
- Making choices
- Healthy relationships vs. unhealthy relationships
- Setting goals
- Setting up supports

(Linehan, 1993; Najavits, 1997)

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Seeking Safety: An Intervention for PTSD and
Substance Abuse

Seeking safety

Developed by:

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Seeking safety

- Evidence-based, **present-focused** therapy designed to promote **safety and recovery** for individuals with trauma histories.
- Relevant for individuals with PTSD and those with trauma histories who do not meet criteria for PTSD.
- Based on 4 key content areas: **cognitive, behavioral, interpersonal and case management.**
- Able to be delivered in a variety of **settings** (inpatient, outpatient, field-based) and **formats** (group, individual).
- Integrates both **Trauma** and **Substance Abuse**

Seeking Safety

Treatment Topics

- Introduction to Treatment and Case Management
- Safety
- PTSD: Taking Back Your Power
- Detaching from Emotional Pain (Grounding)
- When Substances Control You
- Asking for Help
- Taking Good Care of Yourself
- Compassion
- Red and Green Flags

Seeking Safety

Treatment Topics

- Honesty
- Recovery Thinking
- Integrating the Split Self
- Commitment
- Creating Meaning
- Community Resources
- Setting Boundaries in Relationships
- Discovery

- Getting Others to Support Your Recovery
- Coping with Triggers
- Respecting Your Time
- Healthy Relationships
- Self-Nurturing
- Healing From Anger
- Life Choices Game (review)
- Termination

Adapting Seeking Safety to Different Contexts

12 Sessions (original CTN Study)

- **Introduction to Treatment**
- **Safety**
- **PTSD: Taking Back Your Power**
- **Detaching from Emotional Pain (Grounding)**
- **When Substances Control You**
- **Taking Good Care of Yourself**
- **Compassion**
- **Red and Green Flags**
- **Honesty**
- **Integrating the Split Self**
- **Creating Meaning**
- **Setting Boundaries in Relationships**
- **Healing from Anger**

5 Sessions:

- **Safety**
- **PTSD: Taking Back Your Power**
- **When Substances Control You**
- **Detaching from Emotional Pain (Grounding)**
- **Asking for Help**

Seeking Safety

5-Session Module

Session 1: SAFETY

“Although the world is full of suffering, it is full also of the overcoming of it.”

- Safety as the first stage of healing from PTSD and SA
 - Empower the patient to regain control
 - Help the patient to identify cues (who, what, when) that are safe
 - Teach coping skills that may never have been learned in childhood
 - Assess the impact of SA and develop a plan for harm reduction/abstinence
 - Provide psychoeducation about SA and PTSD

WHAT IS EMDR?

- Eye Movement Desensitization & Reprocessing
- Innovative clinical treatment for trauma
- Also effective in treating anxiety-related disorders
- EMDR is a complex method of psychotherapy incorporating a range of therapeutic approaches in combination with **alternative dual attention stimulation**
- EMDR activates the information processing system of the brain

WHAT IS EMDR?

- During EMDR treatment the client attends to emotionally disturbing material in brief sequential doses while simultaneously focusing on an external stimulus
- Traumatic memories stay “stuck” in the non-verbal, non-conscious subcortical regions and are not accessible to the frontal lobes

WHAT IS EMDR?

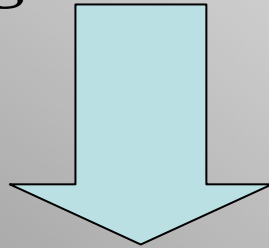
- When the client recalls a traumatic memory or sensation, the therapist encourages them to notice what is coming up whilst tracking the therapist's fingers
- Information is adaptively processed with new associations being made between the disturbing memory and more adaptive memories or information
- Leads to more complete information processing, alleviation of emotional and physiological distress and development of cognitive insights

HOW WAS EMDR DEVELOPED?

Discovered and Developed by Francine Shapiro
1987

She noticed that :

Disturbing Anxious Thoughts



Changed with spontaneous eye movements to:

**LESS DISTURBING THOUGHTS LEADING
TO ADAPTIVE RESOLUTION**

(ie. The negative charge was greatly reduced)

EIGHT PHASES OF TREATMENT

- PHASE 1 : CLIENT HISTORY
- PHASE 2 : PREPARATION
- PHASE 3 : ASSESSMENT
 - Image
 - Negative Cognition
 - Positive Cognition
 - Validity of Cognition (VOC)
 - Emotions
 - Subjective Units of Disturbance (SUDs)
 - Body Sensation

- **Worst Part:** 'Him locking the door, hearing the lock turn'
- **NC:** 'I'm completely helpless'
- **PC:** 'It's in the past, I'm safe now' or
'I can take care of myself' or
'I can make better choices'
- **VOC:** 2
- **Emotions:** 'fear, horror'
- **SUD:** 9
- **Body Sensation:** 'in the throat'

EIGHT PHASES OF TREATMENT

cont...

- PHASE 4: DESENSITIZATION
 - Worst moment : image,
 sound or smell
 - Negative cognition
 - Where felt in body
- PHASE 5: INSTALLATION
- PHASE 6: BODY SCAN
- PHASE 7: CLOSURE
- PHASE 8: RE-EVALUATION

- EMDR is a PAST, PRESENT AND FUTURE model

WHAT HAPPENS DURING EMDR?

