

**Beyond**  
YOUTH CUSTODY

# TRAUMA AND YOUNG OFFENDERS

A REVIEW OF THE RESEARCH  
AND PRACTICE LITERATURE



LOTTERY FUNDED

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# 1. INTRODUCTION

This report presents key findings from a review of the research and practice literature concerning trauma in the backgrounds of young people who offend. It has been produced as part of the Beyond Youth Custody (BYC) programme, funded under the Big Lottery's Youth in Focus (YIF) programme. It is linked to two downloadable BYC practitioner guides on the prevalence and impacts of trauma among young people who offend, and to trauma-informed resettlement practice (Wright and Liddle, 2014a, 2014b).

The YIF programme aims to engender positive change in the lives of vulnerable young people, with a particular focus on three strands: young people leaving custody, young people leaving care and young carers. BYC is one of three England-wide learning and awareness projects that are working to develop best practice in policy and service delivery in each of these three YIF strands. Focusing on the young offenders' strand, BYC exists to advance knowledge and promote better policy and practice for young people making the transition from custody to the community and beyond, in order to improve outcomes.

BYC is being delivered through a partnership between four organisations: Nacro, ARCS (UK) Ltd, the Centre for Social Research at the University of Salford, and the Vauxhall Centre for the Study of Crime at the University of Bedfordshire.

## 1.1 Purpose and scope of the review

This review aims to highlight what is currently known about trauma within the population of young offenders, and to identify the importance of this knowledge for effective resettlement practice. It focuses on:

- Definitions of trauma and the different ways in which trauma has been understood in the research and practice literature
- The prevalence of different types of traumatic childhood and adolescent experiences in the backgrounds of young offenders
- The effects that such trauma can have on young people in the short term, and its longer term impacts on emotional, social, and neurological development
- The links between trauma and young people's behaviour, including the extent of their capacity to comply with youth justice interventions
- The implications that an understanding of trauma and its effects might have for resettlement work undertaken with young custody-leavers

## 1.2 Methods

Members of the BYC research team canvassed a very wide range of academic, professional and grey literature, generated by searches of internet and academic databases. The searches drew largely on combinations of the following terms:

- Trauma, adverse childhood experience, child abuse, child neglect, abandonment, separation, violence
- Impact, effect(s), development
- Young offender, offending, youth justice, criminal justice
- Mental health, problematic behaviour, vulnerable group

Initial searches using terms such as 'mental health' generated vast numbers of sources, but more finely tuned Boolean searches (allowing the combination of keywords with operators such as 'or', 'and' or 'not') using three or more of the above terms helped the team to narrow down lists of relevant material.

Material providing a more specific focus on trauma was found by utilising search combinations from the first group of keywords listed above.

Since the YIF programme works with young people up to the age of 25, the review was not limited to material relating to young people below the age of 18, although much of the published material does focus on this younger age range.

Several hundred key documents – the majority of which were published in the last 20 years – were finally selected for assessment, and it is upon this material that this review is based.

### **1.3 Some comments on the literature**

In comparison with published material on the wider field of mental health, the literature on trauma and trauma-related issues has been slow to develop. In recent years, however, it has grown rapidly with the increasing recognition of trauma and its effects, such as post-traumatic stress disorder (PTSD) arising out of life experiences as diverse as war, child abuse, brain injury and natural disaster, to cite but a few examples.

Due to its diverse origins and effects, trauma defies classification under any one disciplinary umbrella. As a result, so reference to it is frequently found within a range of different theoretical paradigms, often involving different definitions which can occasionally be mutually antagonistic. In no sense, therefore, can ‘the literature’ on trauma be seen as homogeneous.

### **1.4 Structure of the report**

Given the wide-ranging disciplinary sources which inform the phenomenon of trauma and its related issues, there are many different ways in which this material could be synthesised and presented.

For the purposes of this report both relevant generic and trauma-specific sources have been drawn upon to structure the material into four main sections. Section 2 covers definitional issues and gives an overview of some of the background research on trauma and key debates surrounding it. Section 3 provides an overview of the evidence concerning the prevalence of trauma both in the offending and general populations; it also presents material generated by research on a range of mental health issues in both populations.

Section 4 sets out a range of impacts of trauma that have been focused on in the literature. Section 5 discusses some of the key implications of the evidence for trauma and its impacts for the general field of resettlement practice with young people.

## 2. WHAT IS TRAUMA?

### 2.1 Definitional issues

Trauma is a phenomenon that requires both a particular kind of event and a particular kind of reaction to that event – as such, it defies simple definition. The wider disciplinary literature provides many such definitions, most of which focus on the way in which individuals experience negative events. The following examples describe trauma in terms of relevant links between events, individual experience, and its effects upon that individual:

Trauma is an emotional wound, resulting from a shocking event or multiple and repeated life-threatening and/or extremely frightening experiences that may cause lasting negative effects on a person, disrupting the path of healthy physical, emotional, spiritual and intellectual development.

(National Centre for Child Traumatic Stress Network (NCTSN), 2004)

Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being... In short, trauma is the sum of the event, the experience, and the effect.

(Substance Abuse and Mental Health Services Administration (SAMHSA), 2014)

Under these definitions, trauma can be generated by a wide range of events, whether these are interpersonal or impersonal, immediate or one-off, chronic or ongoing. The events below are typically referred to in the literature as having the potential to generate trauma:

- Emotional, physical, and sexual abuse
- Neglect
- Assaults, bullying
- Witnessing family, school, or community violence
- War
- Racist victimisation
- Acts of terrorism
- Disasters
- Serious accidents
- Serious injuries
- Loss of loved ones
- Abandonment
- Separation

If events of this kind are defined as traumatic, it is because they overwhelm an individual's capacity to cope and elicit powerful feelings such as fear, terror, and helplessness, lack of control, hopelessness or despair.

There is a tension in the literature between the formal approaches to definition taken by the psychiatric profession in particular and the less bounded, more inclusive and contextual approach taken by some other health and social care professionals. For example, the definition of a trauma for a diagnosis of PTSD within DSM-5 – the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (2013) which sets out the criteria most widely used in the United States to classify mental disorders – is that

the individual was directly or indirectly exposed to, or witnessed, either death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, and experienced specified symptoms as a result (see further discussion of PTSD at 2.2.4 below). Although this most recent iteration of DSM has widened its earlier definitions of trauma and traumatic stress, and has recognised the unique trauma experiences and responses of children under the age of seven, the relative rigidity of its definition arguably still provides some scope for overlooking those clearly experiencing traumatic disorder but who do not quite meet the diagnostic threshold, and to rob the notion of trauma of its social, political and other contexts.

Some writers have also claimed that usage of the term within the literature has led to a trivialisation of the concept (Brandell, 2012) or to a blurring of the distinction between traumatic events and traumatic response to such events (Allen, 2001). Brandell considers that common dictionary definitions of trauma are usually “more clinically useful”, citing the Webster’s New College Dictionary definition of trauma as an example:

Trauma – an emotional shock that creates substantial and lasting damage to the psychological development of the individual, generally leading to neurosis; something that severely jars the mind or emotions (Brandell, 2012: 42).

However, rather than trauma ‘generally leading to neurosis’, a further definition allows for the possibility that some people will make a natural recovery:

Trauma is an emotional response to a terrible event like an accident, rape or natural disaster. Immediately after the event, shock and denial are typical. Longer term reactions include unpredictable emotions, flashbacks, strained relationships and even physical symptoms like headaches or nausea. While these feelings are normal, some people have difficulty moving on with their lives.

(American Psychological Association, 2015)

Some of these debates have their roots in earlier work on trauma, conducted by key figures in psychology and psychoanalysis in particular. They have also have taken shape alongside major events such as large-scale conflicts (with two world wars and the war in Vietnam having a particularly strong impact on theoretical development), research focusing on the impact of major disasters, and wider developments such as feminism, community trauma theory, and transgenerational theory.

In the following sub-sections, the key developments and debates which have led to contemporary understandings of the issues surrounding the meaning and content of trauma are set out.

## **2.2 Key developments and debates**

### **2.2.1 Early research on trauma**

Interest in issues concerning trauma and its impacts has developed relatively recently, although stress-related conditions more generally have attracted attention within psychology, psychiatry, health and related fields since at least the middle of the 19<sup>th</sup> century.

Some of the earliest references to what would now be called psychological trauma were made during debates about the impact of violent railway accidents. Rail travel expanded rapidly alongside technological advances made in the wake of the Industrial Revolution and by the mid-19<sup>th</sup> century its use was widespread. Rail travel at that time was not, however, characterised by high levels of safety, and rail accidents were both common and serious when they did happen. Rail accidents were sufficiently numerous to have given rise to a literature focusing on what came to be known as ‘railway spine’, which referred to a cluster of symptoms that appeared to be generated by such accidents. These symptoms included sleep disturbances and nightmares, tinnitus, and sometimes chronic pain (Lasiuk and Hegadoren, 2006a). While some physicians

(e.g. Erichsen, 1875) attributed these symptoms to organic causes, others argued that they were psychological in origin, since they could be found in people who had been involved in such accidents but not suffered any identifiable injury (van der Kolk et al., 1996; Lamprecht and Sack, 2002).

In 1889, Hermann Oppenheim (Oppenheim, 1889) employed the term ‘traumatic neurosis’ to refer to the condition (cited in Weisaeth and Eitinger, 1991). This appears to be the first use of the term ‘trauma’ within psychiatry, although it was of course already used widely in other fields such as surgery (Lasiuk and Hegadoren, 2006a). Oppenheim appeared to believe that the symptoms of railway spine were generated by psychological trauma, but that the trauma itself led to organic changes in the brain which in turn allowed for continuing ‘neuroses’.

The notion of ‘hysteria’ had also become a subject of interest around the middle of the 19<sup>th</sup> century, with the publication in 1859 of Paul Briquet’s ‘*Traité de l’Hystérie*’, in particular. That work presented findings from a long-term study of 430 patients with hysteria, a condition which Briquet understood as being a ‘neurosis of the brain’, but which was triggered by environmental events which acted upon the ‘affective part of the brain’ (Briquet, 1859; Mai and Merskey, 1981; Mai, 1983). Symptoms identified by Briquet were quite similar to those which later came to be associated with post-traumatic stress disorder or dissociative disorders whereby, in order to ward off the effects of intolerable pain, the individual may resort to dissociative behaviours that represent distractions, or attempt to reassert control in place of helplessness. Self-destructive behaviours are also common, as is memory loss related to traumatic incidents (Briere, 2006).

Briquet rejected the previous association of hysteria with physical diseases of the female genitalia. He also rejected previous accounts which sought to explain hysteria in terms of ‘frustrated sexual desire’ (Weckowicz and Liebel-Weckowicz, 1990). Interestingly, a significant portion of Briquet’s sample were (female) prostitutes, and he noted that 53% of these women had the condition, whereas one third of the ‘house servants’ in his sample were thought to have hysteria (Lowenstein, 1990).

In terms of causation, Briquet argued that hysteria resulted from impact on the nervous system of traumatic stresses or experiences, such as severe maltreatment in childhood, rape or sexual violence, but also as a result of other events such as witnessed deaths, serious illness, or family instability (Lowenstein, 1990).

Further examination of links between trauma and mental illness was undertaken by the French neurologist Jean Martin Charcot, who also focused on hysteria in the late 1880s. Charcot described the condition as being characterised by sensory loss, amnesia and “hypnotic states” in some patients. The disorder was felt to be suffered almost entirely by women, although Charcot surmised that the condition had psychological rather than physiological causes. In fact, he went so far as to “describe both the problems of suggestibility in these patients, and the fact that hysterical attacks are dissociative problems – the results of having endured unbearable experiences” (van der Kolk et al., 2007: 49-50). He made the more specific linkage of hysterical symptoms with experiences of violence, rape, and sexual abuse (Charcot, 1887), and his student Pierre Janet also went on to study the impact of traumatic experiences of this kind on development and behaviour. Feminist theorists and clinicians would later build on these ideas by examining the influence of gender on power relations and raising awareness of the pervasiveness of violence and sexual victimisation in the lives of women and children (Herman, 1997).

The famous psychiatrist, Sigmund Freud, was strongly influenced by Charcot (whom he visited in 1885), and many of Freud’s papers on hysteria up until approximately 1896 drew similar links between dissociative states and actual traumatic events. In his 1893 paper ‘On the Psychical Mechanism of Hysterical Phenomena: A Lecture’ (Freud, 1893/1962), he noted:

We must point out that we consider it essential for the explanation of hysterical phenomena to assume the presence of a dissociation, a splitting of the content of consciousness. [T]he regular and essential

content of a hysterical attack is the recurrence of a physical state which the patient has experienced earlier (cited in van der Kolk et al., 2007: 54).

In their influential *Studies on Hysteria* (Breuer and Freud, 1895), Breuer and Freud expanded on that central connection, describing how ‘dissociative states’ developed in response to overwhelmingly unbearable or traumatic experiences. Citing Janet, they argued that ‘hypnoid hysteria’ was in fact caused by external traumatic experiences, rather than solely by internal psychological processes:

Hysterics suffer mainly from reminiscences... the traumatic experience is constantly forcing itself upon the patient and this is proof of the strength of that experience: the patient is, as one might say, fixated on his trauma (cited in van der Kolk et al., 2007: 54).<sup>1</sup>

Freud continued to develop this causal account of traumatic dissociation for the next several years. In ‘Heredity and the Aetiology of the Neuroses’ (Freud, 1896), he asserted that:

A precocious experience of sexual relations... resulting from sexual abuse committed by another person... is the specific cause of hysteria... not merely an agent provocateur (Freud, 1896a/1962: 152).

Controversially, however, Freud subsequently rejected what became known as his ‘seduction theory’ in relation to trauma-related symptoms of the sort focused on by Charcot, in favour of ‘conflict theory’, which focused on the perceived unacceptability of sexual or aggressive desires. Under this view, the patient’s ‘hysterical symptoms’ are not so much anchored in veridical recollections of previous sexual victimisation, as in conflicts generated by fantasies and desires that are themselves so unacceptable that the patient struggles to accommodate them.

In other words, the view that such symptoms were triggered by actual events that were highly upsetting to those who experienced them, gave way to a view that these symptoms had their roots in fantasy.

Freud’s ‘The Aetiology of Hysteria’ (1896b/1962) seemed to mark a turning point; it is in this paper that he began to develop the notion of ‘defence hysteria’, and to move away from the view that hysteria had its roots in actual traumatic events. As Freud put it later on in ‘An Autobiographical Study’ (1925/1959):

I believed these stories [of childhood sexual trauma] and consequently supposed that I had discovered the roots of the subsequent neurosis in these experiences of sexual seduction in childhood. If the reader feels inclined to shake his head at my credulity, I cannot altogether blame him... I was at last obliged to recognise that these scenes of seduction had never taken place, and that they were only fantasies which my patients had made up (Freud, 1925/1959: 34).

The latter position assumed a kind of mainstream orthodoxy within psychiatry for some time after, although a few psychoanalysts did continue to argue that actual traumatic events do have particular negative sequelae. Sandor Ferenczi in particular continued to make such arguments, although his work seems to have been regarded as something of an embarrassment within the mainstream of psychiatry at the time (and also to Freud himself, who was in many respects Ferenczi’s mentor).

Ferenczi’s 1933 paper ‘The Confusion of Tongues Between Adults and the Child’ (Ferenczi, 1933/1955) offers a detailed and impressive account of the psychology of child sexual abuse, and of the processes of traumatising, denial, guilt, fragmentation of memory, and subsequent ‘splitting’ of personality. Ferenczi

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<sup>1</sup> Freud and Breuer also drew comparisons between hysterical symptoms and ‘war neuroses’, which referred at that time to a set of symptoms experienced by soldiers who had been subjected to overwhelming stress during battle.

noted in relation to the latter, that each split in the personality behaves as though “it does not know of the existence of the others” (Ferenczi, 1933/1955: 165). His account is striking in its similarity to current understanding of dissociative processes which are now regarded as being a central feature of adaptation to severe trauma.

### 2.2.2 Shell shock and combat stress

Earlier comparisons between trauma linked to overwhelming interpersonal events and trauma linked to large-scale conflict (as in Breuer and Freud’s 1885 descriptions of ‘war neuroses’, for example) attracted further attention in the wake of the First World War, at which point the notion of ‘shell shock’ also entered common usage. Although similar phenomena had been described in relation to other conflicts, the First World War was unprecedented both in terms of its scale and the industrialised way in which it was conducted. The horrors of trench warfare in particular were seen to mark a unique departure from previous conflicts.

The scale and type of casualties were also unlike anything previously seen, and did much to accelerate the study of war-related psychological trauma as graphically described here:

Under conditions of unremitting exposure to the horrors of trench warfare, men began to break down in shocking numbers. Confined and rendered helpless, subjected to constant threat of annihilation, and forced to witness the mutilation and death of their comrades without any hope of reprieve, many soldiers began to act like hysterical women. They screamed and wept uncontrollably. They froze and could not move. They became mute and unresponsive. They lost their memory and the capacity to feel. The number of psychiatric casualties was so great that hospitals had to be hastily requisitioned to house them. According to one estimate, mental breakdowns represented 40 percent of British battle casualties.

(Herman, 1997:20)

Charles Myers, a military psychiatrist who studied large numbers of traumatised soldiers during and after the First World War, initially felt that sets of symptoms seen in some soldiers after periods of prolonged shelling were a result of cerebral concussion and the rupture of blood vessels in the brain. In what was probably the first academic paper to use the term ‘shell shock’, Myers (1915) also noted similarities between war neuroses and hysteria. He subsequently argued, however, that not all cases that he saw could be regarded as having neurological conditions, and he made a distinction between ‘shell concussion’ to refer to cases of the latter sort, and ‘shell shock’ to refer to a psychological condition brought on by extreme war experience (Lamprecht and Sack, 2002).

Abram Kardiner, an American anthropologist and psychoanalyst, also began his career working with traumatised war veterans, and his research provided a detailed and rich account of the impact of traumatic war-related events and subsequent ‘traumatic neuroses’. The key features of the latter as described by Kardiner are highly similar to what are now regarded in the field as being the defining characteristics of post-traumatic stress disorder, which involve hyper-sensitivity (both physiological and emotional), fight or flight reactions to everyday stimuli, dissociation and withdrawal, cyclical re-living of the traumatic events, anxiety and panic attacks, and shifts in conceptions of the self. Kardiner described the latter:

The subject acts as if the original traumatic situation were still in existence and engages in protective devices which failed on the original occasion. This means in effect that his conception of the outer world and his conception of himself have been permanently altered (Kardiner, 1941: 82).

In effect, because the sufferer’s ego “dedicates itself to the specific job of ensuring the security of the organism, and of trying to protect itself against recollection of the trauma” (Kardiner, 1941: 184), and

because the latter is too overwhelming for the individual to deal with in the normal manner, (s)he becomes stuck in a spiral which Kardiner likened to the myth of Sisyphus.<sup>2</sup> In describing the impact of trauma in this way, Kardiner also highlighted a fundamental dilemma of treatment in such cases – how to balance the possible benefits of intervention against the risks involved in disrupting mechanisms which are to some extent adaptive for the individual suffering the effects of trauma.

### 2.2.3 Disaster research

Contemporary trauma theory was further developed by a range of studies focusing on the impact of large-scale disasters. Research and enquiries into disasters well-known to current generations, such as the terrorist attack on the World Trade Center (Koplewicz et al., 2002) and the Hillsborough Football Stadium disaster (Hillsborough Independent Panel, 2012) have benefited from these early analyses and attention to the place of trauma in disaster. Connections between trauma and more recent mass violence events such as the Paris terrorist shootings in November 2015 have also attracted media and research attention, although detailed studies have yet to be published.

One of the early studies was of the 1942 Cocoanut Grove nightclub fire in Boston, when some 493 individuals perished, with many being trampled to death. Erich Lindemann, a Boston psychiatrist, worked with survivors in the aftermath of the disaster, and conducted focused interviews with many of them, as part of his study of acute grief and traumatic loss. Lindemann found common symptoms in that group of disaster victims, including disorganisation, somatic problems, profound guilt feelings, hostile reactions and behavioural changes (Lindemann, 1944). He also noted, however, that interventions could be made which allowed trauma victims to avoid reactions that were maladaptive in the longer term.

Gerald Caplan, a psychiatrist who came to be known as the father of crisis intervention, also worked with Cocoanut Grove survivors, and drew on the experience to describe key components of survivors' efforts to come to terms with overwhelmingly stressful events. The notion of 'insurmountability' is of key importance in his account:

People are in a state of crisis when they face an obstacle to important life goals... an obstacle that is, for a time, insurmountable by the use of customary methods of problem solving. A period of disorganisation ensues, a period of upset, during which many abortive attempts at solution are made.

(Caplan, 1961: 18)

Howard Parad, another pioneering crisis theorist, worked with Caplan to identify five components that affected a trauma victim's ability to cope with overwhelmingly stressful events:

- The stressful event poses a problem which is by definition insoluble in the immediate future.
- The problem overtaxes the psychological resources of the family, since it is beyond their traditional problem solving methods.
- The situation is perceived as a threat or danger to the life goals of the family members.
- The crisis period is characterised by tension which mounts to a peak, then falls.
- Perhaps of the greatest importance, the crisis situation awakens unresolved key problems from both the near and distant past (Parad and Caplan, 1960: 11– 12).

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<sup>2</sup> Sisyphus is a figure of Greek mythology, who is condemned to an eternity of rolling a large rock up the side of a mountain, only to have it roll back down again once he reaches the top. Kardiner describes how some of the sufferers of "pathological traumatic syndrome" had persistent 'Sisyphus dreams' in which the trauma is re-lived in a cyclical and utterly futile manner – futile because the dream simply involves fixation, and no resolution or scope for resolution.

Their first and third points about a perceived danger or threat to life which appears insoluble in the immediate future provide some of the ingredients of what would later become known as PTSD. The final point about the extent to which the current crisis resonates with an individual's previous history of traumatic experiences feeds in to more recent understandings of the effects of cumulative and complex trauma (further discussed in subsection 2.2.5).

While much of the earlier disaster research focused on specific events (and can therefore be regarded as case studies), a number of wider reviews (e.g. Green and Solomon, 1995) and meta-analyses (e.g. Rubonis and Bickman, 1991) have also been produced more recently, which aim to synthesise and assess a broader range of disaster research.

Reviews of that kind now form a key part of the 'trauma literature' and the themes identified in them resonate strongly with contributions from other disciplines referred to throughout this report. The meta-analysis undertaken by Fran Norris and colleagues, for example, (Norris et al., 2002a, 2002b) canvassed more than 250 previous publications focusing on disasters and their impacts. They also undertook very detailed analysis of information concerning 160 samples of disaster victims, in order to identify key links between types of incident, trauma, psychosocial impacts and the characteristics and backgrounds of victims. Findings from that analysis suggest that:

- Disasters that involve some human intent (e.g. mass shootings, bombings) are more likely to be experienced as traumatic and overwhelming than those that do not.
- Mass violence is the most likely type of disaster to result in 'severe' or 'very severe impairment' among victims or witnesses in terms of adverse psychological/emotional impacts including anxiety, stress, and a range of PTSD symptoms (described in more detail in section 2.2.4).
- Individuals who have a previous history of traumatic experience are more likely to be affected adversely by new disasters or other stressors.

## 2.2.4 The evolution of post-traumatic stress disorder (PTSD)

One of the most commonly referred to conditions relating to traumatic experience is PTSD (previously referred to in section 2.1). It was partly as a result of the traumatic stress being reported over time by Vietnam War veterans (Kulka et al., 1990) that the term came into usage in the 1970s, and entered official psychiatric discourse with the addition of PTSD to the third iteration of the DSM (DSM-III, 1980).

The International Classification of Diseases (ICD) is the classification used by the World Health Organisation (WHO) since 1994. It has become the international standard diagnostic classification for most general epidemiological purposes. The ICD-10 Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines also provides international guidelines for the diagnosis of PTSD, which are broadly similar to those used by the DSM. Arguably a modern version of shell shock, the term PTSD served to fill a theoretical gap by specifying that its root cause was outside the individual rather than emanating from an inherent weakness or neurosis.

To be categorised as PTSD within the terms of its first inclusion in the DSM, the traumatic event associated with the condition had to constitute actual or threatened death or injury "outside the range of usual human experience", such as mass violence, the Holocaust, Hiroshima, earthquakes, air crashes and so on. This did not make allowance for the less visible, but potentially no less traumatic impact on the individual of such events as child abuse, loss, and serious illness; in 1980 these would have been categorised as 'adjustment disorders'.

Since that time, the DSM has been revised four times, making gradual changes in parallel to its sections on PTSD. In the 1987 version (DSM-III-R), the definition of PTSD added the stressor of ‘threats to psychological integrity’, which meant that events could be categorised as traumatic if they were highly upsetting even if they did not involve any actual or threatened death or injury. However, this revision has not appeared in subsequent versions, and it was therefore argued that more recent versions will “underestimate the extent of actual trauma in the general population” (Briere and Scott, 2013: 4). Or, to put it more accurately, the narrower definitions will fail to cover a range of people who have not experienced events involving such ‘threats’, but who are experiencing negative impacts or symptoms that are similar or identical to those of others who have experienced such events.

The most recent revision – the DSM-5 (American Psychiatric Association, 2013) – has made a number of evidence-based revisions to PTSD diagnostic criteria. As a result, PTSD, which hitherto had been classified as an Anxiety Disorder is now classified within the new category of Trauma- and Stressor-Related Disorders. The onset of every disorder in this category has been preceded by exposure to a traumatic or otherwise adverse environmental event.

It is worth setting out the DSM-5 criteria for PTSD in full, since this is the version that is currently in operation, and since the criteria themselves have very wide currency and are used by a large number of mental health professionals both within and outside the psychiatric field.

The first set of criteria is specific to children over the age of six years, adolescents and adults. Criteria A-E require a history of exposure to a traumatic event that meets specific stipulations and symptoms from each of four symptom clusters: intrusion, avoidance, negative alterations in cognitions and mood, and alterations in arousal and reactivity. Criterion F concerns duration of symptoms, criterion G assesses functioning, and Criterion H clarifies symptoms as not attributable to a substance or co-occurring medical condition. Again, based on research evidence, DSM-5 now includes the new specifications of a dissociative sub-type of PTSD, and of delayed expression.

The DSM-5 criteria for PTSD are as follows:

### **Criterion A: Stressor**

The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, as follows (one required):

- Direct exposure
- Witnessing in person
- Indirectly, by learning that a close relative or close friend was exposed to trauma. If the event involved actual or threatened death, it must have been violent or accidental
- Repeated or extreme indirect exposure to aversive details of the event(s), usually in the course of professional duties (e.g., first responders, collecting body parts; professionals repeatedly exposed to details of child abuse); this does not include indirect non-professional exposure through electronic media, television, movies, or pictures

### **Criterion B: Intrusion symptoms**

The traumatic event is persistently re-experienced in the following way(s) (one required):

- Recurrent, involuntary and intrusive memories (note: children older than six may express this symptom in repetitive play)
- Traumatic nightmares (note: children may have frightening dreams without content related to the trauma(s))

- Dissociative reactions (e.g., flashbacks) which may occur on a continuum from brief episodes to complete loss of consciousness (note: children may re-enact the event in play)
- Intense or prolonged distress after exposure to traumatic reminders
- Marked physiologic reactivity after exposure to trauma-related stimuli

### **Criterion C: Avoidance**

Persistent effortful avoidance of distressing trauma-related stimuli after the event (one required):

- Trauma-related thoughts or feelings
- Trauma-related external reminders (e.g., people, places, conversations, activities, objects, or situations)

### **Criterion D: Negative alterations in cognitions and mood**

Negative alterations in cognitions and mood that began or worsened after the traumatic event (two required):

- Inability to recall key features of the traumatic event (usually dissociative amnesia not due to head injury, alcohol or drugs)
- Persistent (and often distorted) negative beliefs and expectations about oneself or the world (e.g., “I am bad” or “The world is completely dangerous”)
- Persistent distorted blame of self or others for causing the traumatic event or for resulting consequences
- Persistent negative trauma-related emotions (e.g., fear, horror, anger, guilt or shame)
- Markedly diminished interest in (pre-traumatic) significant activities
- Feeling alienated from others (e.g., detachment or estrangement)
- Constricted affect – persistent inability to experience positive emotions

### **Criterion E: Alterations in arousal and reactivity**

Trauma-related alterations in arousal and reactivity that began or worsened after the traumatic event (two required):

- Irritable or aggressive behaviour
- Self-destructive or reckless behaviour
- Hypervigilance
- Exaggerated startle response
- Problems in concentration
- Sleep disturbance

### **Criterion F: Duration**

Persistence of symptoms (in Criteria B, C, D, and E) for more than one month.

### **Criterion G: Functional significance**

Significant symptom-related distress or functional impairment (e.g. social, occupational).

### **Criterion H: Exclusion**

Disturbance is not due to medication, substance use, or other illness.

### **Specify if: With dissociative symptoms**

If, in addition to meeting criteria for diagnosis, an individual experiences high levels of either of the following in reaction to trauma-related stimuli:

- Depersonalisation: experience of being an outside observer of or detached from oneself (e.g., feeling as if “This is not happening to me” or one were in a dream)
- Derealisation: experience of unreality, distance, or distortion (i.e., “Things are not real”)

### **Specify if: With delayed expression**

Full diagnosis is not met until at least six months after the trauma(s), although onset of symptoms may occur immediately.

For the first time DSM-5 has also specified criteria for the diagnosis of PTSD in children under seven years. Although professionals working with young offenders are not likely to be working directly with children of this age, it is not impossible that their young clients will reside in families with such children, which may include their own. It is also possible that these young people may have experienced PTSD in these terms as an infant, and that possible complex trauma (see subsection 2.2.5) could have ensued. It is therefore important to be aware of the signs and symptoms.

The DSM-5 criteria for PTSD in children under seven years are as follows:

- Exposure to actual or threatened death, serious injury, or sexual violation
- Presence of one or more specified intrusion symptoms in association with the traumatic event(s)
- Symptoms indicating either persistent avoidance of stimuli associated with the traumatic event(s) or negative alterations in cognitions and mood associated with the event(s)
- Marked alterations in arousal and reactivity associated with the traumatic events(s)
- Duration of the disturbance exceeding one month
- Clinically significant distress or impairment in relationships with parents, siblings, peers, or other caregivers or in school behaviour
- Inability to attribute the disturbance to the physiologic effects of a substance or another medical condition

While there have been no specific laboratory studies that establish the diagnosis of PTSD, a range of psychological tests, scales and checklists that follow the format of the PTSD criteria have been developed. Measures following the most recent DSM (DSM-5, 2013) notably include the Clinician-Administered PTSD Scale for DSM-5 (CAPS-5), the PTSD Checklist for DSM-5 (PCL-5), and the Life Events Checklist for DSM-5 (LEC-5) (National Center for PTSD, 2014). The application of such measures is further discussed in section 3.5 in relation to PTSD among young offenders.

### **2.2.5 Complex trauma**

While many aspects of trauma outlined in the foregoing subsections involve a focus on specific events and their impacts, some writers argue that a focus on multiple or chronic forms of adverse experience is perhaps of greater value, not least because in cases where trauma is anchored in sets of events or experiences, the scope for damaging impacts is broader.

The term ‘complex trauma’ describes the early-life experience of multiple and/or chronic and prolonged, developmentally adverse traumatic events (Herman J., 1997; van der Kolk, 2005). Such experiences are usually of an interpersonal nature and, in particular, the term is often used in reference to multiple traumatic

events that begin at a young age and are perpetrated by adults responsible for care of the child (Cook et al., 2005; van der Kolk and Courtois, 2005).

However, Friedman (2014) suggests that scientific evidence in support of this notion is insufficient and inconsistent, hence not being included in DSM-5 as subtype of PTSD. Rather, he considers that the dissociative sub-type of PTSD, referred to in section 2.2.4, will prove to be the diagnostic sub-type that incorporates many or all of the symptoms originally set out by Herman.

The term, however, continues to be widely used in the literature, along with several similar terms which also focus on multiple events or types of event. For example, the notion of ‘polyvictimisation’ is used by a number of researchers (e.g. Finkelhor et al., 2007; Finkelhor et al., 2011) to refer to multiple forms of traumatic experience or victimisation experienced by individuals, sometimes over long periods of time. The notion of ‘cumulative trauma’ is also much used in the literature to refer to similar histories or experiences of multi-faceted traumatic experiences.

Concepts of this kind are useful because, as will be shown in section 3, the evidence suggests that those who suffer from particular childhood and adolescent traumas are also more likely to suffer from other traumatic events than those who do not.

The relevance of such notions is that they also highlight a need for professional awareness, as expressed by van der Kolk in the following comments:

Research has shown that traumatic childhood experiences are not only extremely common but also have a profound impact on many different areas of functioning. For example, children exposed to alcoholic parents or domestic violence rarely have secure childhoods; their symptomatology tends to be pervasive and multifaceted, and is likely to include depression, various medical illnesses, as well as a variety of impulsive and self-destructive behaviours. Approaching each of these problems piecemeal, rather than as expressions of a vast system of internal disorganisation runs the risk of losing sight of the forest in favour of one tree.

(van der Kolk, 2005: 402)

### **2.2.6 Trauma, power and victimisation – radical and critical approaches**

The idea that traumatic experience for some individuals is multi-faceted and chronic is also argued from other perspectives which place much more emphasis on the systemic and power-related features of trauma.

Some of these perspectives involve a distancing from mainstream psychiatric approaches which, it is argued, have tended to dominate debates about trauma and its impacts. Writers such as Danieli (1998) have provided accounts of ‘transgenerational trauma’ for example, where trauma is described as arising through relationships with others who have directly experienced traumatic events such as war, genocide, or other forms of mass violence. A number of studies have focused on the families of Holocaust survivors from that perspective, and have highlighted the extent to which the impacts of trauma (including the development of PTSD) can be transmitted across generations (Auerhahn and Laub, 1998; Felsen, 1998; Solomon, 1998).

Similar accounts have been offered of transgenerational trauma relating to particular social or cultural groups, such as Indigenous people who have suffered colonial oppression or slavery (Duran and Duran, 1998; Gagne, 1998). The notion of ‘insidious trauma’ has also been used to describe the reality of trauma experienced by individuals who live under constant oppressive conditions, such as those who experience daily racism, for example (Brown, 1995). Indeed, Brown has argued for a change to Criterion A in the DSM, since the kind of stressor which can be covered by the notion of insidious trauma may not involve the (direct or indirect) experiencing of an event involving actual or threatened violence, death or injury (as required under the current Criterion A in the DSM, for a diagnosis of PTSD).

The idea that whole communities can be regarded as suffering trauma and its impacts is also developed by writers such as Erikson (1995), who use the notion of ‘community trauma’ to highlight the way in which traumas experienced by entire communities (e.g. in the wake of significant disasters) can have impacts that are wider than the individual:

Sometimes the tissues of community can be damaged in much the same way as the tissues of mind and body, as I shall suggest shortly, but even when that does not happen, traumatic wounds inflicted on individuals can combine to create a mood, an ethos – a group culture, almost – that is different from (and more than) the sum of the private wounds that make it up. Trauma, that is, has a social dimension.

Erikson (1995)

What should already be clear from such accounts is the extent to which they deviate from what is laid down in the DSM concerning the way in which trauma should be understood, and the way in which conditions such as PTSD should be diagnosed and treated.

If there is a consensus among the writers referred to above it is that ‘mainstream’ approaches to trauma tend to de-contextualise the phenomenon and, in particular, to strip it of its essentially social and political dimensions.

Writers associated with the ‘anti-psychiatry’ movement (e.g. David Cooper, 1967) have made such objections even more explicit, and have also been outspoken about what they regard as the shortcomings of mainstream accounts of trauma. Thomas Szasz famously argued against the coercive aspects of traditional psychiatry and denied that the DSM provided any objective and reliable way of identifying mental disorder; in fact, he suggested that mental illness itself was a myth and that the DSM should be seen as part of a wider effort to medicalise what he called “problems in living”.

Other critics of mainstream psychiatry have also noted that, historically, some efforts to medicalise human experience appear decidedly oppressive and atheoretical in retrospect. Gary Greenberg (2013), in his critique of the DSM (which he refers to as ‘The Book of Woe’) describes in some detail a medical condition called drapetomania. ‘Discovered’ by a physician named Samuel Cartwright in 1850, drapetomania was a disorder that “caused Negroes [slaves] to run away”. Cartwright’s account of this new disease came complete with an aetiology, symptomatology and recommended treatments.

Greenberg notes that such an example is perhaps an ‘easy target’ for those who wish to criticise mainstream medicine or psychiatry, but other writers also point out that homosexuality was itself regarded as a mental disorder even in the DSM as recently as 1973 (Kutchins and Kirk, 1997). The fact that homosexuality is now not regarded as a disorder suggests, at the very least, that the range of phenomena which the DSM seeks to name and understand scientifically is both historically variable and highly politicised.

Feminist writers have also been at the forefront of critical responses both to mainstream psychiatry and the DSM. It was writers such as Judith Herman who exerted pressure on the APA to make changes to earlier versions of the DSM and, in particular, to make changes which would allow it to be recognised that women who experience domestic or sexual violence can develop precisely the kinds of trauma-related symptoms related to a diagnosis of PTSD.

Other feminist theorists have continued in their criticisms of the DSM, with some arguing that radical approaches to trauma and its treatment – outside of traditional psychiatric frameworks altogether – need to be developed. Bonnie Burstow has argued that the PTSD diagnosis within the DSM is essentially beyond redemption and that, for example, the account of PTSD is inadequate “... as a diagnosis, as a framework, and as an account. It is contradictory, impractical, presumptuous, pathologizing, arbitrary, evasive, confused, insensitive, and reductionistic” Burstow (2005: 442).

Like Szasz, Burstow argues that the way in which the DSM approaches trauma and its impacts is insensitive “to the complexities of human existence” because it seeks to medicalise “problems in living” (Burstow, 2005: 444). She highlights what she sees as a fundamental tension between the reality of trauma and the motivation to provide a consistent diagnosis for it as a medical condition:

The more sensitive PTSD is to the complex and variegated realities of trauma and so the less distasteful it is to progressive practitioners, the less defensible it is as a medical diagnosis, and thus the less likely it is to continue to be of use for legal and for insurance purposes; that is, the more room allowed for differences in experiences, including experiences such as insidious traumatisation, the greater the variety of experiences that qualify. The greater the variety of experiences that qualify, the more readily people with almost no alleged symptoms in common could be given the diagnosis. And the more readily people with almost no alleged symptoms in common can be given the diagnosis, the less likely the diagnosis will be accepted in lawsuits or by insurance firms. In addition, the more inclusive the definition is and so the more sensitive it is to the different ways in which human beings are ‘wounded’, the greater the number of people who will be so labelled; and the greater the number of people so labelled, the greater the number invalidated and placed in jeopardy of further psychiatric intrusion. I see no way around these conundrums.

Burstow (2005:444)

In short, critical theorists argue that ‘trauma’ needs to be extricated from the medical and psychiatric mainstream which has claimed the notion for science, and place it back firmly on a terrain of power and victimisation.

Such views are also linked to criticism of ‘deficit models’ of trauma and its impacts (Burstow, 2003) within which individuals’ attempts to cope with trauma are described as ‘dysfunctional’. Hyperarousal, for example, is deemed to be dysfunctional because it highlights a mismatch between individual response to the world and the actual level of danger that is present for the traumatised individual. Burstow argues instead that some of the symptoms of PTSD are effective survival mechanisms which, in fact, involve perceptions of the world and its dangers that are more veridical than mainstream accounts seem to suggest (i.e. the experiences of the trauma sufferer may in fact have given them an accurate perception that the world is a dangerous place – in which case their defensive strategies are apt rather than dysfunctional). We will expand upon this issue in section 4.

### **2.3 The link with brain injury**

In discussing key approaches to understanding and defining trauma, it is also important to highlight recent developments in relation to the study of brain injury.

This is important because there are clear overlaps between the impacts of brain injury and those of traumatic experience more generally and there are also overlaps in terms of individual experience of each (and the circumstances in which those experiences take shape).

An acquired brain injury (ABI) is brain damage caused at any point after birth. It may occur for many reasons but most commonly it is a result of trauma, infection or stroke. Traumatic Brain Injury (TBI) is also injury that is caused at some point after birth, but is caused by an external force of some kind, such as being in a road accident, sustaining gunshot injuries to the head, being physically assaulted, striking the head in a fall or in a sports accident, and so on (Williams, 2012).

Age is a key risk factor for TBI, with the very young being most at risk, particularly from falls. Adolescents and younger adults are then the most at risk group for TBI resulting from road accidents and assaults (Williams et al., 2010). Males and females are at equal risk in childhood but in teenage years and throughout most of

adult life males are at much higher risk than females. Other factors associated with increased risk include being from a deprived socio-economic group; geographical location, with urban dwelling youth being more at risk (Yates et al., 2006); and use of alcohol and/or other drugs, particularly in adolescence and young adulthood (Kolakowsky-Hayner, 2001).

Brain injury often occurs in a socio-economic and family context that is also sometimes linked to particular kinds of traumatic experience in childhood and adolescence (such as violence, physical or sexual abuse, or neglect; Williams et al., 2010), and such injury can also have impacts that are similar to (and overlap with) those generated by traumatic experience that does not involve immediate brain injury. We return to some of these issues in section 3.2.

The important advances in the past few years in our understanding of brain systems, their development and what may happen after injury, as noted by Williams et al. (2010), will be considered in section 4.

## 2.4 Summary

Trauma is currently understood as a phenomenon which requires for its existence a particular category of event which has generated a particular category of human reaction. It is a phenomenon which has been formally identified – though in earlier times differently named – since at least the mid-1880s. Hysteria, neurosis, shell shock and combat stress have all held a key place in the evolving conceptualisation and definition by clinicians and researchers. More recently, the notions of trauma as a legacy of colonialism and intergenerational transmission have begun to receive critical attention.

Over the last half-century, in the wake of highly-publicised natural disasters and terrorist attacks, and with increased media attention to phenomena such as child abuse and neglect, domestic violence, bullying and racism and their effects upon individuals, PTSD has come to be a recognised term in both psychiatric and wider clinical and popular discourse. The official criteria for its diagnosis first appeared in the DSM of the American Psychiatric Association (1980) under the category of ‘Anxiety Disorder’. Those criteria have been widened after several iterations of that Manual, and PTSD now appears under the category of Trauma- and Stressor-Related Disorder. Tests directly related to the Manual criteria have also been developed during that period, and can be employed as assessment tools by any recognised professional in the field.

The notion of ‘complex trauma’ (Herman, 1997) refers to multiple traumatic effects that begin in early childhood, continue sometimes via a chain reaction into early adulthood, and potentially across the lifespan, with a particularly poor prognosis for those who enter the criminal justice system. The nomenclature remains contentious and may yet come to be classified under the umbrella of dissociative disorder. Although of a different order, traumatic brain injury has also become recognised as a factor in the life histories of young offenders. In these cases and in all the situations referred to above, it is crucial that professionals are equipped with the knowledge and skills to ask the questions that would lead to the uncovering of information about trauma so that accurate assessment and tailored interventions or support may follow.

Finally, we have noted in this section that debates concerning how trauma should be defined and understood are both continuing and heated, with some arguing that mainstream definitions ignore contextual factors which give rise to trauma and even sustain it, and others arguing against the medicalisation of trauma and the ‘deficit models’ used by the psychiatric profession in particular. We return to some of the latter issues in section 4.

## 3. HOW COMMON IS TRAUMA?

As noted in earlier sections, although definitions of trauma do vary in the literature canvassed by the research team, all of them effectively describe it as constituting individual short- or long-term reactions to particular kinds of adverse events or experiences.

This section will therefore focus on the prevalence of key types of adverse experiences and present findings about the prevalence of particular sets of symptoms and/or trauma-related conditions. Material will be examined from within the general population, and within the mental health and offending populations, with particular focus on prevalence in the young offender group.

### 3.1 Traumatic experience in the general population

Evidence from adult and child/young people surveys about the prevalence of traumatic experiences – such as those listed in section 2.1 – is wide-ranging, especially in relation to child abuse and violence within the family. While much of the evidence is from studies conducted in North America there is also a growing body of UK material and, when taken together, that evidence suggests that traumatic experiences are very common across all population groups.

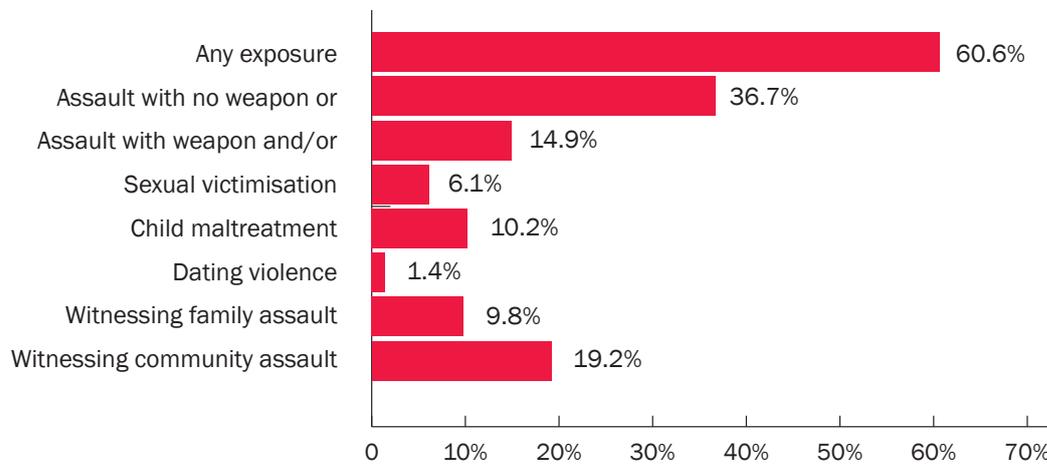
In the United States, surveys of the general population suggest that at least half of all adults have experienced at least one major traumatic stressor (Elliott, 1997; Kessler et al., 1995). However, it is important to remember that while such stressors are common, their ability to produce significant psychological disturbance varies according to a wide variety of other variables (Briere and Scott, 2013).

Studies suggest that childhood sexual and physical abuse are both quite prevalent in North American society, with estimates ranging from 25–35% of women and 10–20% of men having been sexually abused as children, and 10–20% of men and women reporting experiences consistent with definitions of physical abuse (Briere and Elliott, 2003; Finkelhor et al., 1990). The evidence also suggests that many children are psychologically abused and/or neglected, although these forms of maltreatment are harder to quantify in terms of incidence or prevalence (Erickson and Egeland, 2011; Hart et al., 2011).

Much higher prevalence rates have been suggested in studies that also include experiences of indirect victimisation – where individuals have witnessed serious violence, for example. The USA's National Survey of Children's Exposure to Violence (NatSCEV) gathered feedback about their experience of violence and maltreatment via direct interviews with 4,549 children and adolescents aged 17 and younger (Finkelhor et al., 2009a, 2009b). The survey covered a range of types of violence within the family, in school, and in the community, and captured details concerning both direct experiences (i.e. where the respondent was directly victimised) and cases where respondents witnessed violent events (primarily in the family or the community).

Percentages uncovered by NatSCEV relating to key forms of violence are summarised below, in Figure 1.

**Figure 1– National Survey of Children’s Exposure to Violence: exposure to selected categories of violence in the past year<sup>3</sup>, for all children surveyed (% by type of violence)**



More than one-third (38.7%) of the children surveyed reported more than one direct experience of victimisation within the previous year, and nearly two-thirds (64.5%) of those reported more than one. High levels of exposure to violence were revealed: 10.9% reported five or more direct exposures to violence in the past year, and 1.4% reported 10 or more direct victimisations.<sup>4</sup>

In the UK, a study conducted in 2000 by the National Society for the Prevention of Cruelty to Children (NSPCC) focused on the prevalence of a range of forms of child maltreatment and bullying, using a random probability sample of 2,869 young people aged from 18-24 years. In terms of parental physical violence the study found that 7% of the sample were seriously abused by parents or carers, 14% had experienced ‘intermediate abuse’ and 3% reflected ‘cause for concern’ (Cawson et al., 2000).

A further study was conducted by the NSPCC in 2009 (Radford, et al., 2011). It used a computer-assisted self-interviewing (CASI) approach, with a large, three-banded sample: 2,160 parents or guardians of children and young people under 11 years of age, 2,275 young people between the ages of 11 and 17 (with additional information provided by their parents or guardians) and 1,761 young adults between the ages of 18 and 24. The research found significant levels of reported child maltreatment – 4% of young adults aged 18–24 years reported childhood experiences of being beaten up or hit over and over again and 5% reported coerced sexual acts under the age of 16. More generally, the research also found that a substantial minority of children and young people reported having been severely maltreated. Percentages by age band are summarised below:

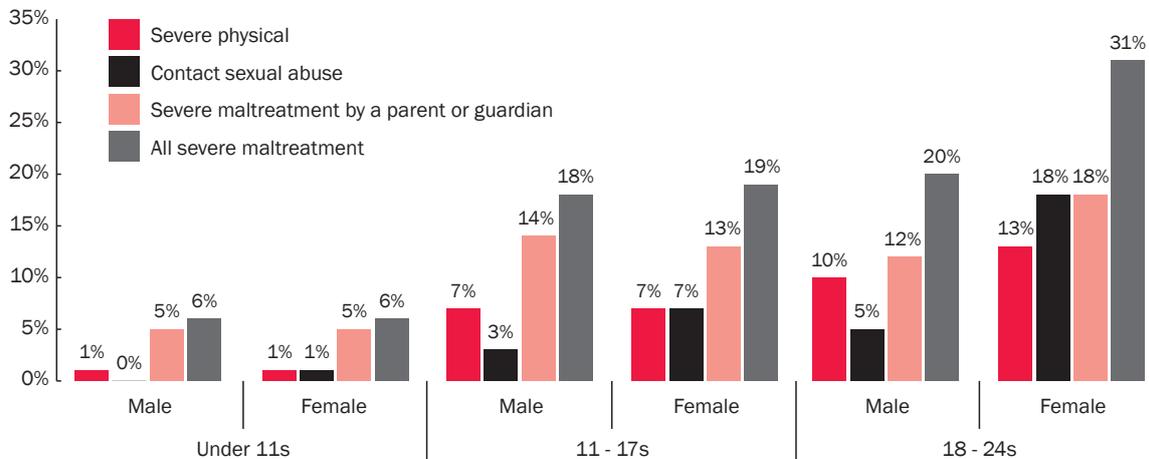
- 6% of children aged under 11 years had experienced severe maltreatment
- 19% of young people aged 11-17 years had experienced severe maltreatment
- 25% of young adults aged 18-24 had experienced severe maltreatment in childhood

The study also examined the co-occurrence of maltreatment and found that children and young people who were maltreated by a parent/guardian were more likely to suffer other forms of abuse from other perpetrators. In particular, those aged 11–17 years who had experienced severe maltreatment by a parent or guardian were three times more likely to witness family violence than those who were not severely maltreated.

Figure 2 provides a detailed breakdown of the prevalence of different types of abuse among the different age ranges and genders under study.

<sup>3</sup> The survey was conducted between January and May, 2008.

<sup>4</sup> Victimisations that could be counted in more than one category, such as physical abuse by a parent or caregiver that could also be considered an assault, were not included in the counting of multiple victimisations.

**Figure 2 – NSPCC child abuse and neglect study: breakdown of prevalence by age and gender\***

\*Figures are based on findings presented in Radford et al., 2011

Against a vast background of literature on adverse childhood and adolescent experience, the references to particular studies in this section have been necessarily selective. However, they resonate clearly with a very wide range of other research both within and outside the UK. Although the estimated prevalence of particular forms of abuse and maltreatment varies widely, when taken together they do suggest that traumatic events of this kind are very common in the general population.

The available research also suggests, however, that events of this kind are even more common and pervasive in the backgrounds of offending groups than in the general population, and some of the relevant data concerning this is outlined in the following sections.

### 3.2 The extent of trauma among the young offender population

In terms of children and young people who come into contact with the criminal justice system, evidence from successive studies clearly suggests that they tend to come from the most disadvantaged families and communities, with high levels of exposure to social and economic deprivation, neglect and abuse. Young offenders – both in custody and community – are a particularly vulnerable group, frequently with a history of neglect, child protection intervention, social care placements, family breakdown and school exclusions (Harrington et al., 2005; Jacobson et al., 2010). Official estimates suggest that a quarter of boys and two in five girls in custody report suffering violence at home (Youth Justice Board 2007) and that 27% of young men and 45% of young women disclose having spent some time in care (HM Inspectorate of Prisons 2011; Caplan, 1961).

A detailed study examining the backgrounds and psychiatric morbidity of young offenders in custody in England and Wales was commissioned by the Department of Health (Lader et al., 2000). Its key findings included the following:

- 29% of the male sentenced group, 35% of the women and 42% of the male remand group had been taken into local authority care as a child.
- Approximately two-fifths of the women and a quarter of the men interviewed reported having suffered from violence at home.
- Approximately one-third of the women reported having suffered sexual abuse compared with just fewer than one in 20 of the men.

- 29% of women, 13% of male remand and 11% of male sentenced respondents reported having received help for mental or emotional problems in the year before coming to prison.<sup>5</sup>
- Around one in 10 male respondents and one in six female young offenders had been offered help for mental, nervous or emotional problems which they had turned down in the year before coming to prison and a similar proportion had turned down some form of help since coming to prison (or in the past year).

Stuart and Baines (2004), in their research for the Joseph Rowntree Foundation, reported that among their sample of 100 girls across five establishments and 2,500 boys across 14 male establishments:

- 40–49% had a history of local authority care
- 40% of girls and 25% of boys suffered violence at home
- 33% of girls and 5% of boys reported sexual abuse
- 50% of girls and 66% of boys reported hazardous drinking
- 85% (across both boys and girls) showed signs of personality disorder
- 66% of girls and 40% of boys reported anxiety/depression

However, the figures may be even higher than these self-report studies suggest. A review of the literature conducted by Day et al. (2008) estimated that anything between 33% and 92% of children in custody have experienced some form of maltreatment. This variation in the figures may be explained by the use of differing definitions of maltreatment in the various studies and the reliance on self-reporting in some of the studies. Research on children who had committed more serious offences suggest that there may be some correlation between serious offending and serious and ongoing abuse, and that the prevalence of abuse is higher in those who commit more serious offences (Boswell, 1996, 1997; Widom, 1998, 2000).

Jacobson and colleagues (2010) undertook a census of nearly 6,000 children imprisoned in the second half of 2008. Their research highlighted that within their sub-sample of 200 children, there were concerns about vulnerability in custody for almost half of them. Only 6% of the sample had no previous convictions. Almost half of the children with previous convictions had their first conviction at the age of 13 or younger. In terms of the prevalence of home and family disadvantages and psycho-social and education problems (among the sub-sample of 200), the following factors were found:

- 76% of children had an absent father (i.e. has lived apart from father for significant period of childhood, not solely through bereavement)
- 54% of children were involved in truancy or other non-attendance of education (currently or previously, due to refusal to attend, lack of provision or other reason)
- 48% had experienced school exclusion (currently or previously, fixed-term and/or permanent)
- 47% had ever run away or absconded
- 39% had ever been on the child protection register and/or had experienced abuse or neglect
- 38% had a parent and/or sibling(s) involved in criminal activity
- 33% had an absent mother (i.e. has lived apart from mother for significant period of childhood, not solely through bereavement)
- 31% were involved in substance use that placed them at particular risk (e.g. injecting, sharing equipment, poly-drug use) and/or has a detrimental effect on education, relationships, daily functioning, etc.

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<sup>5</sup> Questions about help received for mental, nervous or emotional problems in the year before coming to prison this time were only addressed to those who had been in prison for less than two years – it was felt that those who had been in longer would not be able to recall the information accurately.

- 28% had witnessed domestic violence
- 27% had ever been accommodated in local authority care (through voluntary agreement by parents and/or care order)
- 26% had difficulties with literacy and/or numeracy
- 20% had self-harmed
- 17% had a formal diagnosis of emotional or mental health condition
- 13% had experienced bereavement, of a parent and/or sibling(s)
- 11% had attempted suicide

The authors summarised the implications of their findings for criminal justice policy as follows:

The high level of correlation between offending behaviour by children and multiple disadvantage suggests that the prevention of offending depends, at least in part, on effective action to tackle these children's deep-rooted and complex needs. In other words, a justice system that puts more emphasis on addressing welfare and less emphasis on punitive responses is likely to achieve better results in terms of reducing offending and reoffending.

(Jacobson et al., 2010)

A quarter of boys and two in five girls in custody have reported suffering violence at home (Youth Justice Board, 2007) and 27% of young men and 45% of young women have said that they have spent some time in care (HM Inspectorate of Prisons, 2011).

The experience of traumatic abuse and/or significant loss has been identified as a significant factor in the lives of the majority of young violent offenders sentenced to custody.<sup>6</sup> Boswell's 1996 examination of 200 files (one third of the population) for violent young offenders subject to what has now become a Section 90/91 sentence revealed that:<sup>7</sup>

- 72% had experienced abuse; this was broken down into emotional abuse 28.5%, sexual abuse 29%, organised/ritual abuse 1.5%, combinations of abuse 27%
- 57% had experienced significant loss via bereavement or cessation of contact, usually with a parent
- 91% of Section 90/91 offenders had experienced abuse and/or loss (only 18 out of the 200 cases studied had no reported evidence of either phenomena)
- 35% had experienced both abuse and loss, suggesting that the existence of a double childhood trauma may be a potent factor in the lives of violent young offenders

Among the individuals focused on the above study, only 18 (9%) had no reported evidence of either abuse or loss.

While there may be experiences of abuse and loss which took place when the young offenders were too young to be able to recall them, the researchers emphasise that child abuse and loss are not the only potential causes of violent offending, nor does every abused child become an offender. Yet unresolved trauma is likely to manifest itself in some way at a later date. Many children become depressed, disturbed,

<sup>6</sup> Young people from deprived backgrounds are more likely to be cared for by their grandparents which places them at greater risk of losing their primary caregiver during their childhood.

<sup>7</sup> Section 90/91 sentences, under the Powers of Criminal Courts (Sentencing) Act 2000, can only be given at a Crown Court. Section 90 is passed on a murder conviction. Section 91 is used for young people who have committed crimes so serious that if an adult committed them they would go to prison for more than 14 years.

violent or all three, with girls tending to internalise and boys to externalise their responses (Alisic et al., 2014). The researchers conclude that these experiences are sufficiently prevalent to warrant the introduction of systematic assessment for violent young offenders – a message also echoed by Smith and McVie (2003) and Lösel and Bender (2006).

In an attempt to elicit the voices of the young people whose behaviour and backgrounds give cause for concern, the ‘My Story’ project (Grimshaw et al., 2011) encouraged young people who had been convicted of grave crimes as children to recount their life stories, thereby shedding light on the relationships and events that had shaped their lives. In asking participants to describe their life experiences, the project sought to help them form a coherent narrative about their lives, uncovering traumatic histories which included interruption of care, abuse and domestic violence – all of which seriously affected the participants’ childhood attachment relationships. The report highlighted a number of themes derived from the stories, including:

- The inaccessible parent
- Parental jealousy
- Impulsive courting of danger
- The roots of sexual assault
- Bereavement
- Normalisation of continuous and intrusive trauma
- Multigenerational abuse
- Failures of intervention

These first-hand stories both confirm and develop much that the research, cited in this and preceding subsections, has shown about the life experiences of troubled young people. The authors stress the need for positive, nurturing support to help them forge more positive lives and maximise their potential to desist from offending in the future:

It is important to avoid the impression that young people subjected to violent and abusive childhoods are ‘puppets’ who have been simply propelled into despair and violence. Their emotional needs do not mean that they cannot make choices or acknowledge wrongdoing; the urgency of those needs can sometimes be managed by the application of other inner psychological resources that enable the individual to survive. A grim backdrop of emotional need, however, is inescapable, unless it is addressed by positive nurturing.

(Grimshaw et al., 2011: 8)

The findings reported within the studies discussed in this subsection indicate a high prevalence of traumatic events and experiences in young offenders’ life histories, with some evidence to support the suggestion that exposure to multiple types of mistreatment may be linked with offence severity (Smith and Thornberry, 1995). Nevertheless, direct representation from some of the young offenders themselves reminds us that choice and change are not impossible for them, especially if protective or resilience factors are present in their lives or provided by professional intervention. Such intervention can stem the development of traumatic stress, as further discussed in Section 4. The following subsections discuss the symptoms which may ensue from trauma experiences.

### **3.3 Trauma and mental health conditions**

As noted in Section 1, there is a vast literature on the subject of mental health, and trauma is a phenomenon which may constitute both cause and effect of adverse mental health conditions. Specific connections

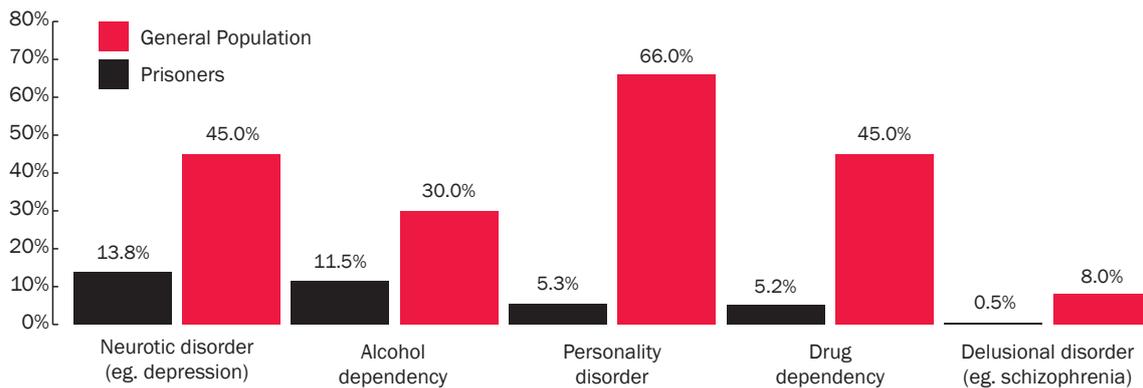
between traumatic experiences in childhood and an increased likelihood of subsequent mental illness are very well documented (e.g., Watts-English et al., 2006), although cause itself is difficult to isolate outside of random control trials, which are rarely conducted in this field.

The ensuing subsections focus largely on trauma in the backgrounds of different types of incarcerated populations where mental health problems have emerged as prevalent, incorporating studies containing comparisons with prevalence in the general population.

### 3.3.1 Trauma and mental health in adult prisoners compared with the general population

Over time, and at all stages of the Criminal Justice process (police custody, courts and probation) research has indicated higher rates of mental illness among those who have contact with the system than among the general population (Gudjonsson et al., 1993; Mair and May, 1997; Shaw et al., 1999). Figure 3 illustrates the prevalence of a range of mental health and related dimensions within adult prison populations as compared with the general population.

Figure 3 – Mental illness among adult prisoners and the general population



Based on data from Singleton et al. (1998) and Singleton et al. (2001)

The above data reveals very much higher mental illness levels among adult prisoners than in the general population; these kinds of statistics are commonly found in the literature on prisoners of both sexes and across the age span. Further examples are provided by the Prison Reform Trust and the Mental Health Foundation below:

- 10% of men and 30% of women have had a previous psychiatric admission before they entered prison. A recent study found that 25% of women and 15% of men in prison reported symptoms indicative of psychosis. The rate among the general public is approximately 4%.
- 26% of women and 16% of men said they had received treatment for a mental health problem in the year before entering custody.
- Personality disorders are particularly prevalent among people in prison. 62% of male and 57% of female sentenced prisoners have a personality disorder.
- 49% of women and 23% of male prisoners in a Ministry of Justice study (Light et al., 2013) were assessed as suffering from anxiety and depression. 16% of the general UK population (12% of men and 19% of women) are estimated to be suffering from different types of anxiety and depression.

- 46% of women prisoners reported having attempted suicide at some point in their lives. This is more than twice the rate of male prisoners (21%) and higher than in the general UK population, amongst whom roughly 6% report having ever attempted suicide.  
Prison Reform Trust (2015)

The Mental Health Foundation (2015) also summarises key statistics from a variety of sources:

- More than 70% of the prison population has two or more mental health disorders; in particular, male prisoners are 14 times more likely to have two or more mental health disorders than men in general, and female prisoners are 35 times more likely than women in general (Social Exclusion Unit, 2004, quoting Psychiatric Morbidity Among Prisoners in England and Wales, 1998). See also Ramsay, 2003.
- The suicide rate in prisons is approximately 15 times higher than in the general population. (In 2002 the rate was 143 per 100,000 compared to nine per 100,000 in the general population. See further: The National Service Framework for Mental Health: Five Years On, Department of Health, 2004; Samaritans Information Resource Pack, 2004).

As Singleton's and the Prison Reform Trust's figures indicate, Personality Disorder is extremely prevalent within adult prison populations and has remained consistently so over time. For example, the survey conducted by Gunn et al., (1991) with a 5% sample of men serving prison sentences across England and Wales found that 652 (37%) had a psychiatric diagnosis.<sup>8</sup> Within this, a total of 177 participants (10%) were diagnosed with a personality disorder, a 21 (1%) diagnosed with schizophrenia and 15 (1%) with organic disorders. The only disorder more prevalent than personality disorder was substance misuse in 407 participants (23%). As in the case of PTSD, personality disorder is usually diagnosed following criteria set by the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association, or by the World Health Organisation's ICD-10 Classification of Mental and Behavioural Disorders (see section 2.2.4). The DSM-IV-TR definition (unchanged in DSM-5) will serve for this section's discussion:

An enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture. (American Psychiatric Association, 2000)

More recently, Fazel and Danesh (2002) conducted a systematic review of 62 studies from 12 countries published between January 1996 and January 2001, investigating the prevalence of personality disorders in prison populations. The total number of participants across the 62 studies comprised 22,790. Of these, 18,530 (81%) were men and 4,260 (19%) women. They reported that Anti-Social Personality Disorder (ASPD) was most prevalent. Other notable forms include Paranoid Personality Disorder and Borderline Personality Disorder, the latter having high co-morbidity with ASPD (Moran, 2002). Of the studies specifically reporting it, 5,113 (47%) of 10,797 men and 631 (21%) of 3,047 women had ASPD.

Of offenders detained in high security hospitals, research has shown that those with a personality disorder are more likely to reoffend after discharge compared with mentally ill offenders (Jamieson and Taylor, 2004). The authors conducted a 12 year follow-up of a cohort of 204 patients discharged from UK high security hospitals in 1984. They found that 38% were reconvicted, 26% for serious offences. Discharged patients with a personality disorder were seven times more likely to commit a serious offence than mentally ill offenders.

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<sup>8</sup> Participants were selected from 16 adult male prisons and nine young offender institutions, representative of prison type, security levels and sentence length nationally. All participants completed semi-structured interviews to assess their present mental state. Prison files were examined to obtain demographic, clinical and behavioural information. The sample comprised 1,769 participants, of which 1,365 (77%) were adult men and 404 (23%) young adult men (17-21 years).

Young people under the age of 18 years cannot be diagnosed with a personality disorder though their behaviour and symptoms may lead to diagnosis in adulthood. As the next section on wider mental health conditions among young people shows, however, its ingredients may lie in earlier life events and/or previously diagnosed disorders.

### 3.3.2 Trauma and mental health in young offenders compared with the general population

In its 2004 study, the Office of National Statistics estimated that one in 10 children and young people aged 5–16 had a clinically diagnosed mental disorder (ONS, 2004). This is broken down as follows:

- 4% had an emotional disorder (anxiety or depression)
- 6% had a conduct disorder
- 2% had a hyperkinetic disorder
- 1% had a less common disorder<sup>9</sup>

The study also found that 2% of children had more than one type of disorder and that boys were more likely to have a mental disorder than girls. Among 5–10 year olds, 10% of boys and 5% of girls had a mental disorder. In the older age group (11–16 year olds), the proportions were 13% for boys and 10% for girls (ONS, 2013). The experience of emotional and behavioural difficulties had particularly serious implications; among young people aged 11–16 who had an emotional disorder, 28% said that they had tried to harm or kill themselves. Among young people aged 11–16 who had a conduct disorder, 21% said that they had tried to harm or kill themselves (ONS, 2013). The report also highlighted that 194 young people aged 15–19 committed suicide in 2011 (ONS, 2013).

Worrying as these figures are, rates of mental health problems are estimated to be at least three times higher for young people in the criminal justice system than for those in the general population. Leon's 2002 review of the mental health needs of young offenders suggests that 13% of girls and 10% of boys aged 11–15 years in the general population have mental health problems, while the prevalence for young people in contact with the criminal justice system ranges from 25% to 81%, with the highest estimates being for young people in custody.<sup>10</sup>

A study commissioned by the Youth Justice Board (Harrington et al., 2005) focusing on young offenders in custody and in the community identified that one-third of young offenders had a mental health need.<sup>11</sup> This was broken down as follows:

- Almost a fifth (19%) of young offenders had problems with depression
- One in 10 young people reported a history of self-harm within the last month
- Approximately one in 10 (11%) young people were suffering from anxiety
- 11% of young people were suffering from PTSD
- 7% of young people reported hyperactivity
- 5% reported psychotic-like symptoms

The researchers found that female offenders had more mental health support needs than males and that young offenders from ethnic minorities had higher rates of post-traumatic stress. The study also found that the most common reason for unmet need was the failure to adequately assess and review the young

<sup>9</sup> Including autism, tics, eating disorders and selective mutism.

<sup>10</sup> The most common disorders for both groups are conduct disorders, emotional disorders and attentional disorders although substance misuse is also a substantial problem (Leon, 2002). The wide range in these estimates is a result of differences in the way that the studies canvassed by this author operationalised 'mental health problems', and the area of the criminal justice system that they focused on.

<sup>11</sup> See also Chitsabesan et al, 2006.

people's needs. In 8% (n=46) of cases, Asset<sup>12</sup> had not been completed and a further 8% of files could not be found to ascertain whether the Asset had been completed or not. Of the 600 Asset forms that were evaluated, only 15% of young people with mental health problems were identified<sup>13</sup> – a much lower rate than the 31% that the research team identified through use of their needs assessment tool. The authors concluded that Asset was not sufficiently sensitive in identifying mental health needs in young offenders. They consequently recommended that an initial structured assessment of risk and mental health needs form the basis for planning interventions for every young person.

Young people in prison (whether these are juvenile offenders aged under 18, or young adults aged 18-20) have an even greater prevalence of poor mental health than either other young offenders or adults in prison: 95% are estimated to have at least one mental health problem and 80% have more than one (Lader et al., 2000; Durcan, 2008). A study of psychiatric morbidity among prisoners in England and Wales (Lader et al., 2000), commissioned by the Department of Health, found huge divergence in the rates of mental health difficulty for young people in custody compared to those in the general population:

- 51% of young men on remand reported depression, as did 36% of sentenced young male offenders and 51% of sentenced young women. In contrast, 6% of young men and 11% of young women from the household sample reported depression.
- 42% of sentenced young male offenders and 68% of sentenced young women reported experiencing a neurotic disorder;<sup>14</sup> whilst rates among the general household population were 7% for young men and 19% for young women.
- Nearly one in 10 of the female sentenced young offenders reported having been admitted to a mental hospital.
- 20% of the young offenders interviewed for the study were selected to participate in a second stage clinical interview. Among this group, 84% of male remand and 88% of male sentenced young offenders were identified as having a personality disorder, while 10% of male sentenced and 8% of male remand offenders had experienced functional psychosis in the previous year.
- High proportions of respondents reported suicidal ideation: 38% of male remand young offenders had thought of suicide in their lifetime; 30% in the previous year and 10% in the week prior to interview. Rates of suicide attempts were also high – 20% of male remand young offenders said they had attempted suicide at some time in their life, 17% in the year before interview and 3% in the previous week. Women reported higher rates of suicidal thoughts and suicide attempts than the males: a third of the female sentenced respondents had tried to kill themselves in their lifetime – twice the proportion of male sentenced young offenders.
- Rates for self-harm without the intention of suicide (parasuicide) ranged from 7% for male remand young offenders to 11% for female sentenced young offenders.

Evidence of high rates of both diagnosed mental illness and behaviours that are often indicative of emotional distress is wide-ranging. Joint work by the YJB and Prison Service (Stuart M. and Baines C, 2004) on young people in custody suggests that 85% show signs of personality disorder, two-thirds of girls and one in five boys report anxiety/depression, and half of girls and two thirds of boys reported hazardous drinking.

Given these high rates of vulnerability and the stressful experience of incarceration, it is not surprising that prisoners exhibit high rates of self-harm and suicidal ideation and/or attempts. In particular, young adult males are significantly more likely to commit suicide while in prison than when they are in the community (Fazel et al., 2005). In 2004 the Audit Commission highlighted that up to 300 young people in secure

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<sup>12</sup> Asset is a structured assessment tool used by Youth Offending Teams (YOTs) in England and Wales on all young offenders who come into contact with the criminal justice system.

<sup>13</sup> In Asset, those identified with mental health problems score a three or four on the mental health section.

<sup>14</sup> The most common neurotic symptoms among male sample groups were sleep problems and worry (not including worry about physical health), followed by irritability and depression. Among women, fatigue was the most common symptom.

establishments were requiring transfers to specialised mental health facilities, concluding that, ‘The provision of mental healthcare for young people in prisons is particularly poor’ (Audit Commission, 2004).

Further comments on links between trauma and mental illness are made in later sections, but it is important to stress that the body of research cited in this section has demonstrated with considerable consistency that, in comparison with general populations, adverse mental health conditions are highly prevalent in both adult and young offender populations, where traumatic life events are similarly prevalent. Since many young offenders become adult prisoners in their later years, this progression probably serves to explain the prevalence in that adult population, and is a trajectory upon which greater knowledge and awareness could intervene in the future.

### 3.4 Trauma and neurodevelopmental disorder with particular reference to brain injury

In addition to the highly disadvantaged and traumatising backgrounds described in previous sections, mental health difficulties, communication difficulties and neurodevelopmental disorders are all far more common among young people in custody than among those in the general population (Hughes et al., 2012). This includes the incidence of brain trauma, which is specifically associated with involvement in violent offences and a younger age of incarceration. The following table summarises findings from a number of research studies to compare the prevalence of a variety of neurodevelopmental disorders between young people in general and those in custody:

**Table 1 – Neurodevelopmental disorder rates: young people in general and those in custody**

Neurodevelopmental disorder	Reported prevalence among young people in the general population	Reported prevalence among young people in custody
Learning disabilities <sup>A</sup>	2-4% <sup>B</sup>	23-32% <sup>C</sup>
Dyslexia	10% <sup>D</sup>	43-57% <sup>E</sup>
Communication disorders	5-7% <sup>F</sup>	60-90% <sup>G</sup>
Attention deficit hyperactive disorder	1.7-9% <sup>H</sup>	12% <sup>I</sup>
Autistic spectrum disorder	0.6-1.2% <sup>J</sup>	15% <sup>K</sup>
Traumatic brain injury	24-31.6% <sup>L</sup>	65.1-72.1% <sup>M</sup>
Epilepsy	0.45-1% <sup>N</sup>	0.7-0.8% <sup>O</sup>
Foetal alcohol syndrome	0.1-5% <sup>P</sup>	10.9-11.7% <sup>Q</sup>

(Reproduced from Hughes et al., 2012:23)

A There are specific concerns with definition in this category, as outlined in the Hughes et al. (2012) report.

B McKay and Neal, 2009; Australian Institute of Health and Welfare, 2003; Gerber, 1984.

C Kroll et al., 2002; Rayner et al., 2005.

D [www.bdadyslexia.org.uk/about-us.html](http://www.bdadyslexia.org.uk/about-us.html) (British Dyslexia Association, 2015).

E Rack, 2005; Reid and Kirk, 2002; Snowling et al., 2000.

F Bryan, 2004; Tomblin et al., 2000; Larsen and McKinley, 1995.

G Bryan et al., 2007; Bryan, 2004; Snowling et al., 2000; Gregory and Bryan, 2011.

H SIGN, 2001; NICE, 2008; Merrell and Tymms, 2001.

I Fazel et al., 2008.

J Chakrabarti and Fombonn, 2001; Gillberg, 1995; Baird et al, 2006.

K Anckarsater et al, 2007.

L McKinley et al, 2008; McGuire et al, 1998.

M Williams et al, 2010; Davies et al, 2012.

N Bell and Sander, 2001; MacDonald et al, 2000; Gunn and Fenton, 1969; Fazel et al, 2002.

O Fazel et al, 2009; Fazel et al, 2002; Rantakallio et al, 1992; Kendall et al, 1992.

P May et al, 2009; May and Gossage, 2001; Young, 1997; Abel and Sokol, 1991.

Q Popova et al, 2011; Murphy and Chittenden, 2005; Rojas and Gretton, 2007.

As shown in the table above, communication disorders and brain trauma are particularly common among young people in custody – the latter arising for almost two-thirds of them, approximately 16% of whom have suffered moderate or severe brain injury (Williams H. 2013).

Further studies confirm that traumatic brain injury (TBI) is the most prevalent form of brain injury (Fleminger and Ponsford, 2005). Among the general population, approximately 8.5% are estimated to have suffered mild to severe TBI (Silver et al., 2001). In males, a range of 5-24% of prevalence for TBI of all severities has been given across studies (McGuire et al., 1998). While less than 10% of the general population has experienced a head injury, studies from across the world have typically shown that this is between 50-80% in offender populations.

This is particularly important to recognise because head injury has been associated with a younger average age of incarceration for offenders, and it has been found that the greater the number of times an individual has been knocked out, the greater their likelihood of committing violence. Since traumatic brain injury is clearly the most prevalent neurodevelopmental disorder both in the general young person and young offender populations, with the latter being particularly high, it is important to highlight it as particular condition that may increase the risk of offending. Yet many of those within the criminal justice system have received little or no treatment and their injury is generally not taken into account in the way they are dealt with.

With such consistent findings over the disproportionately high prevalence of neurodevelopmental disorders amongst young people in the custodial estate, Hughes et al. (2012) raise a number of key issues for the youth justice system in England and Wales. Considerations include how the behaviour and cognitive functions associated with neurodisability increase the risk of offending and how, in the absence of systematically applied assessment of neurodisability and associated needs, criminal justice interventions and sentences can further criminalise young people, rather than encourage desistance from further offending. Moreover, they question whether the current criminal justice system approach is fair in committing young people with neurodisability to custody, when those young people may not be able to understand the consequences of their actions or have the cognitive capacity to instruct solicitors.

### **3.5 Post-traumatic stress disorder (PTSD) among young offenders**

In examining the prevalence of PTSD in the general population and its relationship with specific traumatic events, the most useful findings emanate from studies which have employed formal diagnostic tests. As explained in section 2.2.4, a range of psychological tests, scales and checklists that follow the format of successive Diagnostic and Statistical Manual PTSD criteria, have been developed. They have tended to be utilised with ex-military populations and those who have been exposed to natural disasters, rather than in the wider community. An exception to this, however, is a study by Frissa et al. (2013) utilising the Primary Care PTSD screen (PC-PTSD) (Prins et al., 2003) a structured face-to-face interview, which was designed to capture the four PTSD symptom clusters of re-experiencing, numbing, avoidance and hyperarousal.

Frissa et al. (2013), interviewed a representative community sample of 1,698 adults aged 16 and above, from two south London boroughs, in order to estimate the prevalence of these four symptoms and examine their association with traumatic events. Current symptoms of PTSD existed for 5.5% of the sample. Women were more likely to screen positive (6.4%) than men (3.6%), and symptoms of PTSD were high in the unemployed (12.5%), in those not working because of health reasons (18.2%) and in the lowest household income group (14.8%). Current symptoms of PTSD were found to be associated with both childhood and lifetime trauma, to the extent that as cumulative traumatic events increased, so did the likelihood of reporting symptoms of current PTSD. Almost four in five (78.2%) of the study population had experienced trauma in their lifetime and more than one-third (39.7%) reported childhood trauma. Although the highest prevalence of current symptoms of PTSD was found in those who migrated for asylum or political reasons (13.6%), the prevalence of exposure to most traumatic life events was higher in the non-migrant group. The

conclusion was that high prevalence of exposure to trauma may thus exist in the general community, with cumulative effects upon current symptoms of PTSD.

Sarkar et al. (2005) examined rates of trauma and PTSD among offending and non-offending psychiatric patients who had a primary diagnosis of paranoid schizophrenia.<sup>15</sup> They used the Personality Diagnostic Questionnaire, a self-report questionnaire derived from the personality disorders section of the original DSM-III (American Psychiatric Association, 1980). Of the entire group, 93% reported previous trauma, with the offending group reporting higher rates of physical and sexual abuse. While not statistically significant, the offending patients had also experienced more multiple traumas than the general psychiatric sample. PTSD was common among the whole group, with 27% identified as currently experiencing it and 40% having a diagnosis across their lifetime. Offending patients had higher rates of both current (33% v. 21%) and lifetime (52% v. 29%) PTSD. Yet despite such high rates, very few patients had received a formal diagnosis of PTSD or were receiving trauma-focused psychological therapy.

As with general populations, formal PTSD testing has rarely been the norm for research with young offender populations, despite growing evidence of trauma in their lives. The two exceptions set out below serve to illustrate the need for this testing to become much more routine.

The Lader et al. study of psychiatric morbidity among young offenders in England and Wales (2000), discussed in sub-section 2.3, also examined the incidence of PTSD among young offenders, using the ICD-10 measure of PTSD (WHO, 1992). About one-fifth of the young men and two-fifths of the sentenced young women reported experiencing a traumatic event that was likely to cause pervasive distress. Indeed, between one-third and a half of those experiencing such an event also reported persistent symptoms (such as flashbacks) and half of them also met the other criteria necessary to be considered indicative of post-traumatic stress.<sup>16</sup> Four per cent of both male sentenced and remand offenders, and 7% of female sentenced young offenders were categorised as having PTSD – proportions that the researchers point out are very similar to those found among prisoners as a whole (Singleton et al., 1998).

A further example of the employment of a diagnostic measure of PTSD, and its application, is the PTSD-1 test – a psychosocial and cognitive assessment containing 17 items with a summary section, three introductory questions, and a rating key for respondents to indicate the frequency with which any PTSD symptoms occurred. This is a test in line with DSM-III-R (American Psychiatric Association, 1987) which had been shown to have very high internal consistency (Watson et al., 1991). When employed in research in a Young Offender Institution (YOI) enhanced unit for young men who had committed violent offences, it found that one-third of them had current or lifetime PTSD, which had not been previously diagnosed (Boswell, 2006), with others coming quite close to the threshold (it is important to bear in mind the criticisms of researchers who believe the criteria to be too rigid, especially where it applies to young people whose linguistic and reflective abilities may not yet be fully developed (Pynoos et al., 2009)). The majority of these young men had reported traumatic experiences of abuse and/or loss. Yet, despite a mandatory health requirement in a contemporary Prison Order for a multidisciplinary team (HM Prison Service, 2000) skilled and experienced in adolescent mental health, this facility did not appear to be present.

The studies discussed above would suggest that PTSD linked with earlier traumatic events is present in the general population perhaps at least as much as it is in the young offender population, if somewhat more so in the offending psychiatric population. It is possible that its highest presence in a migrant group within the general population could be linked with asylum and political-related issues rather than with more commonly-reported trauma experiences. It is clear that more research employing diagnostic tools needs to be conducted in order to supplement the existing limited material.

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<sup>15</sup> Twenty-seven disordered offender patients were compared with 28 non-offender (general) psychiatric inpatients.

<sup>16</sup> Those criteria include avoidance of circumstances associated with the event and the onset of symptoms occurring within six months of the event.

### 3.6 Trauma within the overlap between young offenders and looked after children

While looked after children account for less than 1% of the total child population, they are hugely over-represented in the youth justice system (Blades et al., 2011). A survey of 15-18 year olds in YOIs found that more than a quarter of the boys, and half the girls, were or had been looked after at some point previously (Blades et al., 2011). This may be even an under-estimate as the Youth Justice Board/Prison Service (Stuart and Baines, 2004)<sup>17</sup> estimate that 40–49% of young people in custody have a history of local authority care, while Nacro also suggests that 50% have experienced time in care or substantial social services involvement (2003).

Many young people at risk of offending or who have criminal convictions are vulnerable because of past abuse, neglect or unstable living arrangements. Looked after children are also likely to have received poor quality parenting and there is a significant possibility of maltreatment prior to entering the looked after system. These factors may impact on their coping skills, including the ability to act appropriately, to express themselves adequately and to conform to social norms. In some instances, troublesome behaviour may arise more from these difficulties than from criminal intent.

Nacro (2012:4)

Unsurprisingly, the prevalence of mental disorders among children (aged between five and 17-years-old) being looked after by local authorities and their associations highlight similarly high rates to those for young offenders (Meltzer et al., 2002),<sup>18</sup> with 45% of children being assessed as having more than one type of disorder:

- 45% were assessed as having a mental disorder
- 37% had clinically significant conduct disorders
- 12% were assessed as having emotional disorders – anxiety and depression
- 7% were rated as hyperactive
- 4% of the sample were assessed as having less common disorders (pervasive developmental disorders, tics and eating disorders)

Among the 5–10 year olds, those looked after by local authorities were about five times more likely to have a mental disorder; 42% compared with 8%. For each type of disorder, the rates for looked after children compared with private household children were:

- Emotional disorders: 11% compared with 3%
- Conduct disorders: 36% compared with 5%
- Hyperkinetic disorders: 11% compared with 2%

The research also found that 11–15 year olds looked after by local authorities were four to five times more likely to have a mental disorder (49% compared with 11%), which was then further broken down to provide more detailed prevalence rates for categories of disorder, as follows:

- Emotional disorders: 12% compared with 6%
- Conduct disorders: 40% compared with 6%
- Hyperkinetic disorders: 7% compared with 1%

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<sup>17</sup> With reference to 100 girls in five establishments and 2,500 boys in 14 male establishments. November 2003 presentation described in: Joseph Rowntree: Safeguards for Vulnerable Children [www.jrf.org.uk/sites/files/jrf/1859352278.pdf](http://www.jrf.org.uk/sites/files/jrf/1859352278.pdf)

<sup>18</sup> See also: Christine Cocker et al. (2003).

Children with a mental disorder were more than five times more likely than those with no disorder to have been in trouble with the police (26% compared with 5%). Carers of children with a conduct disorder were the most likely to have reported this experience (29%) and this group were also the most likely to have been in trouble three or more times (14%).

As part of its Out of Trouble programme, The Prison Reform Trust's study based on a census survey of more than 6,000 children in custody set out to find who these children were and how and why they came to be there (Jacobson et al., 2010). It showed that most young people in custody are being doubly punished: first, by having very difficult childhoods characterised by loss and disadvantage; then, by being locked up, often for not very serious crimes. At least three quarters of children had absent fathers, and one-third had absent mothers; more than a quarter had witnessed domestic violence and a similar proportion had experienced local authority care; a fifth were known to have harmed themselves and 11% to have attempted suicide. More than one in 10 had suffered the untimely death of a parent or sibling.

A more recent prison inspectorate survey cites that one-third of boys and 61% of girls in custody have spent time in care (Kennedy, 2013). Arguments concerning 'double punishment' also resonate with accounts of imprisonment such as those offered by Willow (2015) in her book 'Children Behind Bars', which exposes a catalogue of degrading and abusive treatment which some children and young people experience in custody.

Clearly, then, the problems experienced as commonplace by young offenders are further exacerbated for looked after children in custody. The HMIP thematic review estimated that approximately 400 looked after children are in custody at any one time, finding a lack of clarity about who was responsible for looking after the children and a lack of coordination between the agencies involved. The young people themselves were described as, 'Often pessimistic about their resettlement prospects' and HMIP stated that outcomes were indeed poor for those who were followed up. The report concludes that: 'It remains unacceptable that children who are so at risk that they need to be taken into the state's care also remain low among our national priorities.' (HM Chief Inspector of Prisons for England and Wales, 2012).

### **3.7 Trauma and women offenders**

Women offenders form a small minority of both the adult and young offender populations. They are often overlooked as a separate group in criminal justice studies, and so their experiences tend to be subsumed and 'lumped together' with those of their male counterparts. When considering the issue of traumatic experience and its effects, it is particularly important to elicit their discrete experiences. In Boswell's study of 200 Section 90/91 offenders, for example, the 12 young women involved had all been subject to abuse and victimisation, but this had hardly been recognised or addressed by criminal justice professionals (Boswell, 1996).

The Criminal Justice Joint Inspectorate thematic report into alternatives to custody for women (CJJI, 2011) examined the case files of 107 women offenders, finding that 54% were considered to have mental health problems, 51% took illegal drugs, 59% had problems with alcohol, 34% were vulnerable to self-harm and 24% vulnerable to suicide. Additionally, 73% had been victims of domestic abuse, 18% had been perpetrators of domestic abuse and 60% had financial problems. These findings confirmed the factors identified in the earlier Corston report on women with particular vulnerabilities in the criminal justice system (Home Office, 2007).

The Lader et al. study (2000) described in foregoing sections also considered the psychiatric needs of young female offenders in custody. This found that women were far more likely than men to report having suffered as a result of violence at home and sexual abuse. About two-fifths of the women and approximately a quarter of the men interviewed reported having suffered from violence at home, while about one in three of the women reported having suffered sexual abuse compared with just under one in 20 of the men. Other key findings include that:

- 9% of women reported that at one time they had been admitted to a mental hospital (including 2% who had a stay of more than six months)
- 27% said they had received help or treatment for mental/emotional problems before entering prison
- 22% had received help or treatment for mental/emotional problems since entering prison (the biggest proportion across all samples)
- One-third had tried to kill themselves in their lifetime (twice the proportion of male sentenced young offenders)
- 11% reported self-harm without the intention of suicide (parasuicide)
- 32% showed evidence of four or five disorders

The most marked differences between the young women and the young male offenders arose in relation to receipt of treatment for mental health problems. In the 12 months prior to entering prison, 13% of male remand young offenders and 11% of male sentenced young offenders had received help or treatment for a mental or emotional problem. At 27%, the proportion among female young offenders was double this. A similar ratio was also found in terms of the proportion of young offenders who had received help in prison – 11% for male remand and 14% for male sentenced young offenders, compared with 22% among female young offenders.

Similar figures were reported by Rowan-Szal and colleagues in their study of trauma and mental health assessments for female offenders in prison (Rowan-Szal et al., 2012). The study found that female offenders report higher levels of trauma and mental health complications than males, although limited resources prevented consistent screening, diagnosis and assessment.

In relation to brain injury, Williams (2012) suggests that the prevalence of TBI may be even higher for female than male prisoners; his analysis suggested that 42% of women offenders who had committed violent offences had experienced an average of two TBIs. Three factors were significantly associated with current violent convictions: the number of years since direct experience of domestic violence incidents, the number of previous suicide attempts, and previous TBIs with loss of consciousness.

Research conducted in the US suggests that young women and girls involved with the justice system have high rates of traumatic childhood experience but that there are few programmes to address links between trauma and offending (Smith et al., 2012). Similar findings have been generated in studies focusing on adult women prisoners (e.g. Valentine 2000a, 2000b).

The following studies are also US-based, but raise some key considerations that are equally applicable in the UK. For clarity, they are set out under a statement of their key findings:

#### **Women are more likely to have experienced interpersonal sexual trauma than men**

Komarovskaya et al. (2011) analysed gender differences in traumatic experience and associated PTSD symptoms reported by prisoners in a sample of 266 (male and female inmates). In their sample, just under 95% of the inmates had experienced at least one traumatic event, with male prisoners reporting higher rates of witnessing harm to others in childhood (22%) and adolescence (43%) and female prisoners reporting higher rates of interpersonal sexual trauma in childhood (31%), adolescence (35%), and adulthood (28%). Women showed higher rates of PTSD (40%) when compared to men (13%) (as measured by the total PTSD score of the Impact of Event Scale – Revised). For females, interpersonal sexual trauma was a significant predictor of PTSD symptoms, and for male prisoners interpersonal nonsexual trauma was a significant predictor.

**There is a strong association between female homelessness and previous trauma**

Cook et al. (2005) conducted a study to describe the nature, scope, and socioeconomic correlation of traumatic life events in a random sample of 403 women entering a state correctional facility. Of the sample, 99% reported having experienced at least one traumatic life event and 81% experienced five or more. Those who reported several experiences differed by race, age and marital status, but the most significant findings related to homelessness. Those women who had been homeless for a minimum of seven days were between 2.19 and 5.62 times more likely to have experienced 14 of the 21 traumatic events being focused on by the researchers; most of these events were defined by interpersonal violence.

**Decision-making for female offenders is significantly impaired by emotional responses – particularly for those exposed to trauma**

Solomon et al. (2012) examined decision-making behaviours among 213 adolescent female offenders. While the young women had high perceived decision-making competence, this was significantly undermined by their experiences of anger, substance misuse, and depression – particularly among those with more exposure to trauma. Substance misuse in particular linked the young women's psychosocial characteristics to antisocial decision-making.

**Women offenders may have higher risk of trauma and poorer coping skills than women in the general population**

Grella et al. (2013) examined relationships between trauma exposure, familial risk and protective factors, substance abuse and PTSD among incarcerated and non-incarcerated women. A sample of 100 women prisoners were matched with 100 women in the general population (using a case control method). The women prisoners were between 1.7 and 3.7 times more likely to be at risk of trauma exposure compared to women in the control group. In relation to PTSD specifically, exposure to sexual or physical trauma significantly increased the odds of PTSD, as did substance misuse in response to traumatic distress. The researchers argue that incarcerated women are at high risk for PTSD given their high rates of trauma exposure and apparent lack of appropriate coping mechanisms, and they suggest that their findings clearly support the use of trauma-specific interventions for this population.

**Prison fails to address trauma and may further harm women**

Fournier et al. (2011) examined the rehabilitation needs of women in prison in order to assess whether prison-based programmes and policies were addressing these needs. A total of 17 incarcerated women from a medium-security prison were surveyed, revealing significant histories of trauma as well as significant psychosocial deficits typically associated with trauma. The findings suggested not only that there was significant unaddressed need among women prisoners, but that existing institutional policies actually had the potential to further harm survivors of trauma.

**3.8 Summary**

The extent of trauma and its manifestations in both the general population and among offenders have been outlined, with a great deal of evidence to suggest that it is particularly prevalent among offenders. Particular types of trauma have been identified in the lives of young offenders, centring around experiences of child abuse, loss, victimisation, mental health conditions and brain injury. The 'double punishment', of being a looked after child and then being incarcerated within the criminal justice system has been underlined. Gender-specific factors have been explored, and references made to research findings which indicate that although females make up a very small proportion of the offending population, they are more likely than males to have suffered a range of traumatic events including sexual abuse and family violence. The nature and extent of PTSD and the importance of formal testing among young offenders has been highlighted. As a consequence, it can be seen that:

Maltreatment is present in the life histories of a greater proportion of children in custody than in the general population... [this] should be regarded as a critical and primary pre-disposing risk factor in relation to offending behaviour.

(Harrington et al., 2005)

The evidence that both the physical and mental health of children and young people in contact with the youth justice system is markedly worse than children in the general population is overwhelming, with at least 43% of the former estimated to have emotional or mental health needs (HM Inspectorate of Prisons, 2011; Healthcare Commission 2009). NICE recognises that child and adolescent offenders – particularly those in secure institutions – are particularly at risk of mental difficulties. They suggest that the known numbers of successful suicides in YOIs strongly indicates high levels of depression that are not currently adequately assessed or managed. NICE advises that ‘hidden maltreatment’ should be considered in children and adolescents with unexplained mood disorders where there is no family history of depression and an absence of other overt social adversities. Indeed, the evidence appears overwhelming that the introduction of a consistent system of professional assessment for the presence of trauma in these young people’s lives is long overdue.

## 4. WHAT ARE THE IMPACTS OF TRAUMA?

With this array of poor backgrounds, restricted opportunities, stressful life experiences and, in extreme cases, withdrawal of liberty, it is not surprising that the more persistent or serious young offenders are likely to be a disaffected and angry group. In some cases their behaviour and mood could be construed as *a reasonable response to the situations in which they find themselves and even a type of coping mechanism*.

(Leon, 2002; emphasis added)

An event can be considered to be 'traumatic' if it is extremely upsetting and at least temporarily overwhelms the individual's internal resources (Briere and Scott, 2013). But it is well known that individuals having experienced the same or similar traumatic events do not always respond in the same way.

In the first part of this section we outline key factors as described in the literature, which appear to be related to the kinds of impacts which traumatic experience can generate. Following sections then provide details concerning those impacts themselves.

### 4.1 Key factors affecting impact

Trauma can have immediate negative impacts upon an individual but it can also have damaging effects over a much longer term. Yet not all traumatic events generate lasting damage – the impact of traumatic events is usually dependent on a range of factors, including:

- The type of event that gave rise to the trauma – interpersonal traumas (e.g. involving violence or child abuse) are more likely to have negative impacts and to increase the risk of subsequent further traumatic experiences and revictimisation, than non-interpersonal traumas (e.g. road accidents, disasters).
- Previous experience of trauma – where adverse experiences are multiple or chronic, the scope for negative impacts on individual health and development is increased (and this can be exacerbated where a pooling up of trauma is also accompanied by a lack of protective factors).
- Mental and emotional strengths and weaknesses (resilience).
- What kind of support the individual has – at home or elsewhere.

Other factors such as lifestyle, socio-economic circumstances and environment also play a role in determining the complex patterns of traumatic experience and their impact.

Concerning the first key set of factors listed above, the evidence suggests that victims tend to perceive trauma that is caused by people as more intentional, intrusive and malignant – often giving rise to feelings of betrayal – and such experiences are associated with more negative outcomes (Briere and Scott, 2013; Freyd, Klest, and Allard, 2005). Interpersonal traumas that are caused by care-givers can have particularly adverse impacts, especially where such incidents are chronic and begin at a very young age (The National Child Traumatic Stress Network (NCTSN) 2011; Cook et al., 2005; van der Kolk and Courtois, 2005).

Care-giving that is neglectful or unpredictable can also be traumatising, leaving a child less able to deal with longer-term effects and without an adequately secure base to turn to in the face of insecurity or perceived threat (Purnell C., 2010).

The relationship between different traumas and the difficulties they cause for a young person is complex (Briere and Scott, 2013). Childhood abuse may produce numerous symptoms and problematic behaviours

in adolescence and adulthood (including substance abuse, indiscriminate sexual behaviour and reduced awareness of danger). This, in turn, increases the likelihood of further victimisation, as later traumas can lead to further behaviours and responses to these that generate additional risk factors and even more complex mental health problems (Briere and Jordan, 2009).

Many abuse victims have experienced a number of incidents and types of maltreatment during childhood (Finkelhor et al., 2007) and are at greater risk of revictimisation in adolescence and adulthood (Cloitre et al., 1996). For example, abuse victims are more likely to have also experienced psychological neglect (Manly et al., 2001), children exposed to physical abuse are more likely to experience psychological abuse (Briere J. and Runtz, M.R., 1990); Higgins and McCabe, 2003), intrafamilial abuse is associated with extrafamilial abuse (Hanson et al., 2006) and being sexually abused as a child substantially increases the likelihood of being sexually assaulted in adulthood (Classen et al., 2005; Elliott et al., 2004). Furthermore, it appears that there are cumulative effects of different forms of childhood trauma, above and beyond their individual impacts (Briere et al., 2008; Follette et al., 1996). So, where individuals have multiple traumatic experiences in their backgrounds, the impact of these can be cumulative and mutually reinforcing.

## 4.2 Impacts on development

As noted earlier, the impacts of trauma on behaviour, and connections between trauma and subsequent mental health issues, have been documented over many decades. But developmental impacts, and impacts on brain development in particular, have become a focus of research only in recent decades.

Where trauma is particularly acute or generated by multiple events (as in the case of child abuse, for example), there can be adverse physical and emotional impacts which, in turn, can have a profound effect on individual development during childhood and adolescence, and into adulthood. These effects can conspire to blunt affective development and socialisation, levels of self-esteem or confidence, and also the individual's ability to form relationships with others. Experiencing multiple incidences of interpersonal victimisation is particularly harmful, as cumulative experiences may lead to dysfunctional avoidance behaviour (Freyd et al., 2005).

Aside from its immediate negative impact, early child maltreatment interrupts normal child development, especially the processes through which emotions are managed (Briere J., 2002). In order to fully understand the impact of trauma upon children and young people, it is important to consider their developmental process and how this is damaged by their experiences:

### **Adolescents' key developmental tasks include being able to (NCTSN 2011):**

- Learn to think abstractly
- Anticipate and consider the consequences of behaviour
- Accurately judge danger and safety
- Modify and control behaviour to meet long-term goals

### **Trauma can impact upon adolescents by making them (NCTSN 2011):**

- Exhibit reckless, self-destructive behaviour
- Experience inappropriate aggression
- Over- or underestimate danger
- Struggle to imagine/plan for the future

So, trauma can complicate child development, resulting in young people who are on constant alert for danger, and who are quick to react to threats via fight, flight, freeze (Teicher, M. H. 2002; NCTSN, 2011). The way in which trauma can blunt a young person's capacity to manage emotions can also have implications for the formation and maintenance of human relationships, as will be seen in the following section.

### 4.3 Attachment

Attachment theory is fundamental to understanding childhood emotional development (Grimshaw et al., 2011). This approach seeks to explain how relationships with parents and other carers influence each individual's capacity to develop healthy relationships (Bowlby, 1969, 1973, 1980, 1988; de Zulueta, 2006, 2009). Attachment forms through the close relationship between an infant and their primary care-giver, which builds and sustains the child's feelings of security. An infant with secure attachment feels safe and confident to explore their surroundings and the wider world, while a child who has been abused, neglected or rejected, experiences feelings of insecurity and disorganised attachment patterns which can result in anxiety, avoidance, anger and sometimes aggression (Troy and Sroufe, 1987).

The National Child Traumatic Stress Network (NCTSN) has specified several important functions of the attachment process, including the regulation of emotions, developing a view of oneself as worthy and competent, perceiving the world as 'safe' and buffering the impact of any trauma. By anticipating their caregivers' responses to them, children learn to regulate their behaviour (Schore, 1994) and this interaction allows them to construct 'internal working models' (Bowlby, 1980) which combine the affective and cognitive characteristics of their primary relationships. As these early experiences are occurring at a time of rapid brain development, social interaction and neural development are inextricably intertwined. Early patterns of attachment thus impact upon the quality of information processing throughout an individual's life (Crittenden 1992). Children with secure attachment learn to trust both their feelings and their understanding of the world (van der Kolk, 2005).

Repeated experiences of parents reducing uncomfortable emotions (e.g., fear, anxiety, sadness), enabling child to feel soothed and safe when upset, become encoded in implicit memory as expectations and then as mental models or schemata of attachment, which serve to help the child feel an internal sense of a secure base in the world.

Siegel, D. (NCTSN 2011)

Generally, the more exposure to danger there has been through neglect or abuse, the more distortion there will be in the attachment response. But disturbance in a child's early attachment to their significant caregivers does not only occur when there is trauma (Cassidy J. and Shaver P.R. 2008) – such an impact can arise from 'subtraumatic events' which involve growing up in an invalidating (but perhaps not extremely violent) family environment (Linehan, 1993).

Van der Kolk (2005) describes how a primary function for parents is to help children learn to manage their emotions. Repeated interventions to calm emotional upset provide the basis for developing a sense of trust and safety (Fahlberg, 1991; Cozolino, 2006). Secure attachment can thus mitigate against the impact of trauma upon a child as parents/caregivers can help their distressed children restore a sense of safety and control. Many young people who have difficulty regulating emotions and impulses have been exposed to complex trauma (Bath, 2008), which can impair the development of thinking, relationships, self-worth, memory, health, and a sense of meaning and purpose in life (van der Kolk et al., 2005). From a neurodevelopmental perspective, the stress activation systems of traumatised children have become overly sensitized – detecting threat and triggering fight or flight responses when they are not needed (Bath, 2008). Bruce Perry observes that, 'Children exposed to significant risk will "reset" their baseline state of arousal, such that – where no external threats or demands are present – they will be in a physiological state of persisting alarm.' (Perry and Szalavitz, 2007:32).

This constant activation of ‘deep brain’ emotional arousal leads to an impaired ‘higher brain’ capacity to provide emotional regulation. Thus, many troubled young people are prone to emotional outbursts, frustration that escalates to fury and rage, and disappointment that descends into depression and despair. These young people also display high levels of impulsivity, emotional contagion and risk taking (Bath, 2008), partly because, in crisis, the brain is focusing almost entirely on perceived threat and the need for revenge or safety.

Unpredictable and inconsistent parenting means that infants are not able to organise their attachment behaviour in any coherent pattern (Liotti, 2004:2) and may, as a result, suffer from deeply divided attachment feelings – this can include a split perception in which an idealised relationship cohabits with the strong sense of a dysfunctional one (Grimshaw et al., 2011). This can fundamentally impair an individual’s ability to self-regulate their emotional response, resulting in a surge of panic, not only as a response to threat but also because of perceived loss of comfort and protection. Any subsequent terrifying stimulus may result in retraumatisation or defensive violence, and there is a further risk that individuals may identify with their aggressor and go on to violate others (Grimshaw et al., 2011).

Unavailable and rejecting caregivers result in infants with internal representations of themselves as unworthy and unlovable. It is worth considering what van der Kolk has to say on this issue:

When caregivers are emotionally absent, inconsistent, frustrating, violent, intrusive, or neglectful, children are liable to become intolerably distressed and unlikely to develop a sense that the external environment is able to provide relief. Thus, children with insecure attachment patterns have trouble relying on others to help them, while unable to regulate their emotional states by themselves. As a result, they experience excessive anxiety, anger and longings to be taken care of. These feelings may become so extreme as to precipitate dissociative states or self-defeating aggression. Spaced out and hyper-aroused children learn to ignore either what they feel (their emotions), or what they perceive (their cognitions).

If children are exposed to unmanageable stress, and if the caregiver does not take over the function of modulating the child’s arousal, as occurs when children exposed to family dysfunction or violence, the child will be unable to organize and categorize its experiences in a coherent fashion. Unlike adults, children do not have the option to report, move away or otherwise protect themselves - they depend on their care givers for their very survival. When trauma emanates from within the family children experience a crisis of loyalty and organize their behaviour to survive within their families. Being prevented from articulating what they observe and experience, traumatized children will organize their behaviour around keeping the secret, deal with their helplessness with compliance or defiance, and accommodate any way they can to entrapment in abusive or neglectful situations [Summit 1983] When professionals are unaware of children’s need to adjust to traumatizing environments and expect that children should behave in accordance with adult standards of self-determination and autonomous, rational choices, these maladaptive behaviours tend to inspire revulsion and rejection. Ignorance of this fact is likely to lead to labelling and stigmatising children for behaviours that are meant to ensure survival.

(van der Kolk, B. 2005)

Trauma can throw off the healthy developmental trajectory by overwhelming a person’s ability to cope (Briere). Developmental trauma can result in children developing unfocused responses to subsequent stress (van der Kolk, 2005; Cicchetti and Toth, 1995) leading to dramatic increases in the use of medical, correctional, social and mental health services (Drossman et al., 1990).

An attachment-based interpretation of childhood violence suggests that children’s development suffers markedly in the absence of an early nurturing of social relationships. If this damaging type of insecurity

persists, the child’s model of the external world is affected, opening up the potential for violence as a response to later frustrations. It is, therefore, easy to understand how the loss of a primary care-giver – through separation, being placed in care, or bereavement – is experienced as acutely painful and traumatic.

While attachment difficulties have been positively associated with exposure to danger through neglectful or abusive caregiving, not all attachment difficulties arise because of parental or caregiver behaviour. Environmental factors also play a part, as the following presentation by NCTSN (2011) highlights:

Parent contributions to insecure attachment	Environmental contributions to insecure attachment
Ineffective or insensitive care Physical and/or emotional unavailability of parent Abuse and neglect Parental psychopathology Teen parenting Substance abuse Intergenerational attachment difficulties Prolonged absence	Poverty (Egeland, B., Carlson, E.) Violence (victim and/or witness) Lack of support (absent father or extended kin, lack of services, isolation) Multiple out of home placements High stress (marital conflict, family disorganisation and chaos, violent community) Lack of stimulation

It is important to note that trauma does not inevitably lead to anxious attachment; children may experience hardship but will respond with relatively secure attachment strategies because their caregivers are adequately protective (Purnell, 2010). However, neglectful, unpredictable or dangerous behaviour by caregivers is inherently traumatising and leaves a child less able to deal with its longer-term traumatising effect and without an adequately secure base for when danger threatens.

#### 4.4 Dissociation and memory

Psychiatrists use the term ‘dissociation’ to explain how memories are kept away from consciousness. In order to ward off the effects of extreme anxiety, the individual resorts to dissociative behaviours that represent distractions, or attempts to reassert control instead of feeling helpless. Self-destructive behaviours are therefore common among victims of abuse. Examples of dissociation include losing memories of traumatic incidents. Recall of trauma can also be both difficult and uncomfortable. There are psychological reasons for resisting the incursion of painful memories about people to whom we are closely attached.

It is worth noting that many studies focusing on the prevalence of traumatic experiences in a particular population are based on feedback from individual respondents who are asked to reflect back on their experiences, sometimes over very long periods of time. Yet it is known that trauma and poor infant attachment negatively impact upon accessing memories and narrative coherence (Grimshaw et al., 2011; Holmes, 2000; Hesse, 1999). Given the sensitivity of disclosing traumatic experiences, combined with the fact that some of the impacts of trauma include dissociation and avoidance, it is likely that many respondents will under-report such experiences.

The narrative style linked with disorganised attachment tends to be characterised by levels of incoherence (e.g. lapses and discrepancies between thinking and feeling while reporting memories of past attachment relationships) and leads to a classification called ‘unresolved’. Unresolved interviews are characterised by episodic memories or ‘attachment-related traumas or losses that are not well integrated’ (Liotti, 2004:3). Attachment researchers have demonstrated that these children may over-generalise at points in their narrative, have peculiar lapses in narrative, with unusual syntax, sequencing and use of pronouns. They may

recount horrible events in a depersonalised manner, without any affect (van der Hart et al., 2006:40). Transcripts that are classified ‘unresolved as to traumas’, and infant disorganised attachment behaviour, bear close resemblance to clinical phenomena usually regarded as indicative of dissociation (Hesse and Main, 2000:4).

Herman and Schatzow (1987) found that 28% of their clinical sample of women in group therapy for childhood sexual abuse reported ‘severe memory deficits’ in relation to their own abuse, for example. Similarly, Briere and Conte (1993) found that 59% of 450 women and men in treatment for sexual abuse suffered in childhood had ‘forgotten’ about the abuse prior to the age of 18.

#### **4.5 Impacts on brain development**

The incidence of trauma among offenders warrants consideration because the evidence clearly suggests that adverse childhood and adolescent experience can also affect brain development itself.

Recent research focusing on the connections between trauma and subsequent mental health issues have benefited from technological advances which have allowed impacts on brain development to be assessed and measured in much more detail than had previously been possible.

In the 1980s, post-mortem examination of brain sections allowed researchers to draw comparisons between groups that had suffered severe child abuse or neglect, for example, and groups from the normal population. Those studies highlighted key differences between the two groups in relation to the size and functioning of certain parts of the brain (Teicher, 2002).

Research of this kind highlighted strong correlations between brain features for these groups, but further research also focused on causal processes which might generate these kinds of impacts. Some regions of the brain have a higher density of receptors, which are sensitive to stress hormones such as cortisol. Prolonged exposure to stress hormones and their neurotoxicity over time (particularly in relation to chronic abuse, for example) can alter the morphology and functioning of the brain itself, in a way which affects and shapes an individual’s adaptive responses (Perry, 2001).

Recent research has also suggested that the impacts of trauma on brain development may be gendered as well. Research undertaken by the Stanford Neurosciences Institute, for example, involved studying particular brain structures of both boys and girls. They were divided into two groups, with some having experienced trauma (including complex trauma) and others having had no such experience. The study found no difference in brain structure between boys and girls in the control group (i.e., those not having experienced previous trauma), but found key differences between boys and girls in the trauma group. A region of the brain called the anterior cingulate sulcus (which plays a key role in monitoring and integrating emotions) was found to be larger in volume for boys who experienced trauma and smaller in girls who had such experience. It has always been known that girls who experience trauma are more likely to develop PTSD than boys who experience trauma, but the study has provided some clues concerning what the neurological correlates of that might be, and the researchers suggest that the development of sex-specific treatments seems warranted (Stanford Medicine News Center, 2016).

#### **4.6 The impact of trauma upon behaviour**

[T]here are complex interactions beginning in early childhood that affect our ability to envision choices and that may later limit our ability to make the best decisions.

(Perry and Szalavitz, 2007)

We know that adversity affects children's brain development and that experiencing violence in one's formative years heightens sensitivity to perceived threat and anger in others. But, in addition to increasing the risk of offending, the impairment of neuro-cognitive development may make it difficult for these young people to understand and comply with criminal justice interventions and also to comprehend the consequences of breaching them. The challenges faced by these young people in trying to comply with the criminal justice system is apparent when one reflects that they are likely to (Williams, 2013):

- Be disinhibited, make poor social judgements and behave inappropriately (Anderson et al., 2006)
- Lack the communication skills necessary to allow them to negotiate out of conflict
- Have limited planning skills and respond inflexibly to challenging situations (Milders et al., 2003)
- Experience difficulties with attention, working memory and cognition (Anderson et al., 2006)
- Misperceive situations (be unable to read others' emotions (Tonks et al., 2008) or to perceive threat when there is none)
- Have difficulty in considering alternative behaviours or controlling their impulses – especially in conflict situations (Pontiflex et al., 2009)

An individual's experience of traumatic events is related to their ability to cope. Three broad classes of coping mechanisms that people use to overcome stressful situations have been identified as:

1. Consciously seeking social support
2. Conscious cognitive strategies employed intentionally to master stress
3. Involuntary mental defence mechanisms that distort perceptions of reality in order to reduce distress, anxiety and depression<sup>19</sup>

How children and young people respond to traumatic experiences varies depending on (NCTSN, 2011):

- Their age and developmental stage
- Their temperament
- Their perception of the danger
- Their historical experiences of trauma (and their cumulative effects)
- The adversities they face following the trauma
- The availability of adults who can offer help, reassurance, and protection

In addition to increasing the risk of offending, the incidence of brain injury results in neuro-cognitive impairment that makes it difficult for these individuals to understand, comply with and comprehend the consequences of criminal justice interventions. Such impairments can include (Williams, 2013):

- Making poor social judgements (and behaving inappropriately)
- A lack of communication skills to negotiate out of conflict
- Poor planning and inflexibility (Milders et al., 2003)
- Difficulties with disinhibition, attention, working memory and executive control (Anderson et al., 2006)
- Poor emotional understanding of others (Tonks et al., 2008)

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<sup>19</sup> The Defensive Function Scale of DSM-IV describes how such defences can have several manifestations: to abolish impulse (e.g. by reaction formation), or conscience (e.g. by acting out), or the need for other people (e.g. by schizoid fantasy) or reality (e.g. by psychotic denial). They can abolish our conscious recognition of the subject (e.g. by projection) or the awareness of a transgressor (e.g. by turning against the self) or abolish the idea (e.g. by repression), or the affect associated with an idea (e.g. isolation of affect/intellectualisation).

- Misperception of situations (not reading others' emotions, perceiving threat when there is none)
- Difficulties in considering alternative behaviours or controlling impulses, especially in conflict situations (Pontifex 2009)
- Sensitivity to threat and anger in others (Williams, 2013)

Such young people are likely to experience attachment difficulties, feel extremely isolated and have feelings of mistrust towards strangers (for example, resettlement practitioners). Having developed situation-specific coping skills that may be described as 'maladaptive' in community situations, they will be prone to derailing interventions, even those specifically designed to help them (Bailey, 2013). Those sentenced to custody may experience particular difficulties in coping with new situations for up to six months (known as 'adjustment disorder') – this can arise both upon entering and leaving custody. This means, unfortunately, that many current criminal justice interventions will be highly distressing to young offenders who are particularly poorly equipped to deal with such emotional distress.

With limited psychological resources at their disposal, young people who have experienced a range of childhood abuse and neglect will tend to use distraction, self-soothing or the 'artificial' induction of a positive state in an attempt to reduce their negative emotions. Suicidal ideation, self-harm, substance abuse, binge/purge eating, impulsive aggression, compulsive sexual behaviour, dissociation and dysfunctional behaviour may serve the purpose of reducing emotional distress in individuals who have experienced multiple forms of interpersonal trauma (Briere and Rickards, 2007; Herpertz et al., 1997; Zlotnick et al., 1997). The experience of PTSD can result in numbness or frozen emotion and so, for such offenders who have committed violent crime, it is important that they are enabled to come to terms with their violence and become aware of the steps required to prevent its reoccurrence (Boswell, 2013).

Having suffered adversity, young people may exhibit a range of characteristics, such as:

Adversity	Potential associated characteristics
Trauma (and PTSD)	Suspiciousness Intolerance Stubbornness Hypervigilance Inflexibility Lacking emotion Numbness or frozen emotion Having experienced violence in one's formative years heightens sensitivity to threat and anger in others
Neurodisability	Hyperactivity, impulsivity, poor emotional control Cognitive and language impairment Alienation
Brain injury	Poor decision-making capabilities Limited ability to think ahead Lack of feelings Difficulty in understanding others' perspectives

#### 4.6.1 Trauma and ‘problematic behaviours’

Traumatic experience is very strongly linked in the literature to higher risks of a range of problematic behaviours including aggression and violence (Widom, 1989), antisocial/criminal behaviour (Greenwald, 2002), sex offending (Ward and Siegert, 2002), gambling (Scherrer et al., 2007) and substance misuse (Kilpatrick et al., 2003; Ouimette and Brown, 2003; Steward, 1996).

The links between offending behaviour and ‘psychosocial adversity’ are well documented (Harrington et al., 2005).

Williams et al. (2010) also found that those with self-reported TBI had an average of two more convictions than those without, while Kenney and Lennings (2007) found that history of head injury was significantly associated with severe violent offending. As is common in such studies, TBI was found to be associated with wide-ranging cognitive and behavioural problems. Perron and Howard (2008) also report that moderate and severe TBI is associated with greater impairment of cognition and behaviour, psychiatric diagnosis, earlier onset of criminal behaviour and/or substance use, more lifetime substance use problems and past-year criminal acts. While Hux et al. (1998) found that the majority of TBIs appeared to be mild and had no lasting effects, long-term effects on academic performance, behaviour, emotional control, activity level, and/or interactions with friends and family members were reported by over one-third of the parents of delinquent youth. It should also be noted that TBI can cause acquired speech and language difficulties (Ponsford et al., 1995).

All of these forms of abuse were strongly associated with poorer mental health outcomes (including self-harm and suicidal thoughts) and higher levels of problematic behaviour. For example, young people aged 11–17 years who had been severely maltreated by a parent or guardian were six times as likely to have current suicidal ideation and five times as likely to have self-harming thoughts than those who had not been severely maltreated. Those aged between 18 and 24 years who were severely maltreated by a parent or guardian adult were four times more likely to have current self-harming thoughts than those who had not been severely maltreated.

#### 4.7 Impacts of combined and cumulative traumas

The relationship among different traumas – and the symptoms and difficulties they cause in a given individual’s life history – can be complex. Childhood abuse, for example, may produce various symptoms and maladaptive behaviours in adolescence and adulthood (for example, substance abuse, indiscriminate sexual behaviour, and reduced danger awareness via dissociation or denial) that, in turn, increase the likelihood of later interpersonal victimisation... These later traumas may then lead to further behaviours and responses that are additional risk factors for further trauma, and subsequent, potentially even more complex mental health outcomes.

Briere and Scott (2013:16-17)

Some young people who have difficulty regulating emotions and impulses have been exposed to complex trauma (Briere and Scott, 2013). Complex trauma can hinder the development of thinking, relationship skills, sense of self-worth, memory, and a sense of meaning and purpose in life. Therefore, ‘At the core of traumatic stress is the breakdown in the capacity to regulate internal states such as fear, anger, and sexual impulses.’ (van der Kolk 2005: 403).

So, while isolated traumatic incidents tend to produce discrete conditioned behavioural and biological responses to reminders of the trauma (such as identified in a PTSD diagnosis), chronic maltreatment or inevitable repeated traumatisation, in contrast, have pervasive effects on the development of mind and

brain. Chronic trauma interferes with neurobiological development and the capacity to integrate sensory, emotional and cognitive information into cohesive whole (van der Kolk, 2005).

It is, therefore, extremely important for professionals to take, sensitively, a full life history direct from the young person they are working with, to ensure that complex trauma is recognised and worked with appropriately. The dangers of not doing so are highlighted in research into young offenders sentenced to long periods of custody for offences of serious violence and murder, 35% of whom were found to have experienced the double trauma of abuse and loss in their earlier lives (Boswell, 1996).

As Briere and Scott (2013) point out, by listing separately described traumas, one might erroneously assume that such traumas are independent of one another. But, in some cases, experiencing one trauma may actually increase the likelihood of experiencing another. Although not true of ‘noninterpersonal’ traumas (such as natural disasters), victims of interpersonal traumas are statistically at greater risk of additional interpersonal traumas. Such revictimisation occurs in a number of ways – those who have experienced childhood abuse are considerably more like to be victimised again as adults (Classen et al., 2002; Tjaden and Thoennes, 2000) and other lifestyle, environmental, behavioural, personality, and/or social issues can increase the likelihood of the individual being repeatedly victimised. So, child abuse and neglect not only produce significant, sometimes enduring, psychological dysfunction, but are also associated with a greater likelihood of being sexually or physically assaulted later in life (Classen et al., 2005).

Childhood and adult traumas can produce psychological difficulties, so the symptoms and difficulties experienced by adult survivors may represent (1) the effects of childhood trauma that have lasted into adulthood, (2) the effects of more recent trauma, (3) the additive effects of childhood and adult trauma (for example, flashbacks to both childhood and adult victimisation experiences), and/or (4) the exacerbating interaction of childhood trauma and adult assault, such as especially severe, regressed, dissociated, or self-destructive responses to the adult trauma. This complicated mixture of multiple traumas and multiple symptomatic responses means that it is extremely difficult – even for clinicians specialising in this field – to connect certain symptoms to certain traumas, and other symptoms to other traumas or, in fact, to discriminate trauma-related symptoms from less trauma-specific symptoms. Briere and Scott’s 2013 book describes assessment and treatment approaches to clarify these various trauma-symptom connections or examine alternative ways of approaching multi-trauma-multi-symptom presentations.

Behaviour such as suicidality, substance abuse, dissociation and dysfunctional behaviour may, among other things, specifically serve the purpose of reducing emotional distress in individuals who have experienced multiple forms of interpersonal trauma. It may not be the level of PTSD alone that triggers and reinforces such behaviours but, more importantly, the effects of having reduced capacity to control ones emotional responses (Briere et al., 2010).

#### **4.8 Impacts related to brain injury**

Brain injury typically affects an individual’s capacity to make decisions, think ahead, and understand feelings and the perspectives of others (Williams, 2013). In addition, neurodisability (including brain injury) has also been associated with a range of outcomes that include:

- Hyperactivity and impulsivity
- Alienation
- Cognitive and language impairment
- Poor emotional control

These outcomes increase the risk of offending among the individuals and are also linked with other risk factors such as truancy, peer delinquency and illicit drug use. Even only mild brain injury among children and young people can set them on the pathway from experiencing attention difficulties to exhibiting poor behaviour, to school exclusion and then to offending. Such risk is further increased by factors such as:

- Detachment from education
- Challenges in parenting
- Failure of services to recognise and meet specialist needs

It is well established that particular neurological systems are of key importance to the way in which individuals make decisions and anticipate the longer term consequences of their behaviour, and also to the way in which individuals control their impulses (Teicher, 2002). It is also well known that these systems normally grow and develop during childhood and adolescence, and that this development can be adversely affected by brain injury. It is, therefore, not surprising that there is a particularly strong link between brain injury and offending behaviour. Williams describes this connection:

As children develop, their brains become evolved to manage more complexity, and skills, such as these, come 'on line'. Children and young people therefore have a degree of neurologically-based immaturity relative to adults. Unfortunately, this is a time-period also where risk of TBI is very high – the impact of which limits maturity still further. Not surprising, then, TBI in early life seems to be a major issue within offender groups. It is associated with earlier onset, more serious, and more frequent offending. Of course, it is important to note that it is not possible to know for certain how brain injury increases likelihood of offending, and there may be underlying risk factors for TBI and offending behaviour, including deprivation, lack of life opportunities, low concern for self-care, and even being a person who 'takes risks'.

The research, however, seems to show that TBI is a very strong 'marker' for these other factors. It is fair to say that the cognitive and behavioural problems noted here are commonly observed within the young and adult offender cohorts. Early recognition and intervention when there is a TBI in childhood and adolescence, as well as in adults, could help to reduce crime.

(Williams, 2012: 29)

Findings from a number of studies support that general connection between TBI and offending, and the presence of reported TBI within offending groups. A study of young offenders (aged 16-18 years) in custody in the UK found that of 186 participants, 65% reported that a traumatic brain injury (TBI) rendered them 'dazed and confused' (Williams et al., 2010). Forty-six per cent suffered an additional loss of consciousness and for 17% that had lasted for more than 10 minutes. Just under one-third of the sample (32%) reported having suffered more than one TBI. Suffering a TBI during childhood or early adolescence markedly increased the risk of criminal offending among mentally disordered males in the cohort. Furthermore, the onset age of offending was significantly earlier among those having TBIs before the age of 12 than for those who had a TBI between the ages of 12 and 15. TBI was also strongly associated with co-morbid mental health disorders and alcoholism.

Similar rates have been found by Davies et al. (2012), who reported that 72% of young offenders in custody in the UK report having experienced at least one TBI of any severity. Forty-one per cent reported having lost consciousness and 46% reported suffering more than one injury.

These links between brain injury and offending behaviour are also anchored in the more general impacts of such injury – including loss of memory or concentration, a diminished ability to monitor emotional states

(both one's own, and those of others), and difficulties in assessing and navigating social situations (Turkstra et al., 2003; Williams, 2012). For those who have suffered brain injury it is more likely that immature and antisocial behaviour, as well as difficulties controlling impulses and exercising restraint in the use of aggression (Anderson et al., 2009), will continue further beyond adolescence.

Some of these impacts are also of clear relevance to the ability of young offenders who have suffered TBIs, to engage in interventions designed to reduce offending, to comply with conditions imposed on them by some sentences and monitoring arrangements, and to follow advice about how to better manage difficult situations. It is because of difficulties of this kind that researchers such as Williams recommend that a broad focus be adopted, and that service provision both for those already in the system and for those at risk of TBI might require 'close cooperation between criminal justice, health, social and educational systems' (Williams, 2012: 29).

#### **4.9 Summary**

Trauma can have a very wide range of impacts, with these impacts also being mediated by a number of key factors including the type of event that gave rise to the trauma, previous experience of traumatic events, individual resilience, the degree of support that an individual has, and the socio-economic context in which the individual lives. Because of wide variations in terms of these factors and their presence in individual cases, similar events can have widely varying impacts on different individuals.

In terms of development, trauma can have adverse effects on socialisation and also on the individual's scope for forming relationships or attachments. These adverse effects are multiplied or compounded where traumatic events have been chronic or ongoing, and where they are interpersonal in nature.

Trauma is also associated with difficulties concerning memory and dissociation, where traumatised individuals distance themselves psychologically from experience that is perceived to be overwhelming and too difficult to process or resolve.

In terms of behaviour, trauma is strongly associated with a range of 'problematic behaviours' including aggression and violence, antisocial/criminal behaviour, sex offending, gambling, and substance misuse. Traumatic experience is found disproportionately in the backgrounds of individuals who engage in such behaviour, and such experience also increases the likelihood that individuals will suffer from particular mental health difficulties including depression and PTSD, and more generally, from anxiety and stress, and perceptions of low self-worth.

There is evidence to suggest that previous traumatic experience is also related to a greater likelihood of subsequent re-victimisation.

Although the impact of trauma on brain development is relatively new area of research, it is clear from the evidence that traumatic experience does affect brain systems that play a key role in regulating emotion, and that trauma can alter brain systems in such a way that there is an increased likelihood of aggression, anxiety, and suicide and self-destructive behaviour. The most recent research suggests that trauma-related stress (and the biochemical correlates of stress) plays a key role in such changes.

Traumatic brain injury itself can also have impacts that are quite similar to those of trauma more generally, and there is a strong overlap between the risks of having such injury, and the risks of suffering from other kinds of traumatic experience (such as child abuse, neglect, or interpersonal violence).

## 5. TRAUMA-INFORMED PRACTICE

People with childhood histories of trauma, abuse and neglect make up almost our entire criminal justice population.

(Teplin et al., 2002)

### 5.1 Why is trauma an important consideration for resettlement practice?

As earlier sections of this report have explored, young offenders' histories can involve a wide range of adverse childhood and adolescent experience, including assaults and bullying, domestic violence, abandonment, separation and bereavement, as well as witnessing family, school or community violence. Offenders are also more likely to have suffered brain injury during childhood and adolescence than is typical for non-offending groups. The available evidence makes it clear that offenders are more likely than non-offenders to have suffered adverse emotional, social, neurological and developmental effects from these traumatic experiences, and that some of these impacts also appear to be linked to offending behaviour. For those reasons alone it would be important for practitioners to have some awareness of issues concerning trauma. The available evidence also suggests that the effects of previous trauma can narrow the scope for generating positive resettlement outcomes with young people and young adults – it is therefore crucial that understanding of, and appropriate responses to, trauma form part of any resettlement activity.

The effects of previous trauma can, for example, erode a young person's capacity to judge social situations, form attachments, cope with stress, consider long-term consequences, negotiate their way out of difficult situations and respond to authority.

We know that adversity affects children's brain development and that experiencing violence in one's formative years heightens sensitivity to perceived threat and anger in others. But in addition to increasing the risk of offending, the impairment of neuro-cognitive development may make it more difficult for these young people to understand and comply with criminal justice interventions and also to comprehend the consequences of breaching them.

When taken together, the evidence presented in this report strongly suggests not only that people involved in offending are more likely to have had a disproportionate amount of traumatic experience, but that the impact of those experiences is also likely to reduce the scope for traditional 'change programmes' to generate positive outcomes. There are several reasons for this. There are, of course, many people who simply do not have an interest in changing, but even this lack of motivation to change may be linked to previous exposure to trauma. As Greenwald (2009) puts it:

Exposure to trauma or loss is extremely common among those with problem behaviours and can lead to a range of treatment impediments. Trauma-exposed individuals may have impaired empathy and not care about the pain they cause others. Posttraumatic stress symptoms may cause your clients to feel reluctant to trust you, dubious about the value of treatment (nothing good's going to happen anyway, so why bother?), fearful of facing emotions, and highly reactive to apparently minor provocations or other stressors. In short, posttraumatic stress symptoms may not only contribute to the client's behaviour problems but also prevent you from being able to help your client to resolve the problems.

(Greenwald, 2009: ix)

The challenge faced by these young people in trying to comply with the criminal justice system is apparent when one reflects that they are likely to have difficulty in controlling impulses and making plans, and in assessing social situations and longer term consequences of their actions (see section 4.6).

So, young people with histories of trauma face a number of impediments to engaging with and sustaining involvement in interventions – even those explicitly designed with their best interests at heart. Therefore, acknowledgement of trauma and its effects is highly important to the way in which providers work with young offenders, the approaches taken to engagement and the effectiveness of efforts to generate positive resettlement outcomes.

At the current time however, knowledge about the complexities of exposure to trauma, its impact upon offending and the implications for effective resettlement practice is very limited. Research into the potential for psychological interventions with traumatised young offenders is not sufficiently advanced to allow absolute certainty about how best to meet their needs. Substantial investment in mental health support for young offenders is needed, both in terms of screening/assessment and, equally importantly, the actual provision of treatment. As Grimshaw explains, 'Unless there is an adequate mental health services framework for this group of young people the extent and characteristics of their traumas will not be brought to the surface.' (Grimshaw et al., 2011)

Yet, given the available evidence concerning the prevalence of traumatic experience in the backgrounds of young offenders and the impact of that experience on development and behaviour, there are already some clear implications for resettlement practice. As we saw in section 4.2, traumatised young people often feel extremely isolated and have a deep mistrust of strangers. Interaction with the criminal justice system will be perceived as highly threatening and extremely distressing to these young people who are particularly poorly equipped to deal with such stress. Custodial sentences may be extremely damaging to them.

## 5.2 Trauma and desistance

Given the details outlined in previous sections concerning the impacts of trauma, it should be clear that background trauma in the lives of young offenders will be of key importance to processes of desistance, and to the capacity of young people to engage with interventions designed to promote desistance.

In a presentation of their Trauma Recovery Model (TRM), Skuse and Matthew (2015) argue that the impacts of trauma on individual development tend to blunt the 'cognitive readiness' of young offenders in several key respects and that this, in turn, reduces their scope for deriving benefits from many programmes – such as anger management and victim empathy programmes, and some cognitive behaviour therapy (CBT) – designed to promote desistance.

Interventions of this kind tend to be designed to address behaviour rather than what Skuse and Matthew call the 'underlying developmental and psychological drivers' (2015:15) of such behaviour. Hence, the impacts of trauma may be linked to higher rates of non-engagement or disengagement of young people in such programmes.

What is required instead are approaches that are layered or sequential, with early stages of work focusing more directly on basic routines and physical safety, since these are prerequisites for later articulation about (and processing of) previous traumatic experience. In short, effective desistance requires a level of self-awareness and self-efficacy which can be blunted by the effects of previous trauma – as Skuse and Matthew put it:

Non-offending lifestyles within the community and the opportunities to adopt them are more likely to be available and attainable to young people who have processed some of their own experiences and who have an ongoing supportive relationship with an adult or agency who can guide them.

(Skuse and Matthew, 2015)

Similar comments about the need for ‘sequencing’ support for desistance in order to recognise and address background trauma has also been offered by Wilkinson (2009), who describes how participants in her research needed to address emotional issues relating to feelings of personal control and self-awareness, before they could move on to develop what would normally be regarded as key ‘stakes in conformity’. More generally, she describes the way in which the experience of previous trauma can have a key effect on the readiness of individual offenders to develop new non-offending narratives.

Anderson (2016) also forges useful links between desistance research and the literature on trauma, and argues that bearing witness to offenders’ previous victimisation and trauma can be a crucial form of support for the desistance process itself.

Links of this kind are highly promising for the field, although research focusing directly on them has begun to appear only very recently.<sup>20</sup>

### 5.3 What is trauma-informed resettlement?

There is now an extensive (and growing) literature on trauma-informed practice which focuses on a range of areas including violence/aggression, offending and antisocial behaviour, and substance misuse and other addictive behaviour. Trauma-informed practice is defined in a number of ways but most definitions focus on awareness-raising and training, the provision of safe environments, reducing the scope for re-traumatisation, and the coordination of provision designed to increase resilience and support.

Cooper et al. (2007) offer the following definition:

Trauma-informed practices refer to an array of interventions designed with an understanding of the role of violence and/or trauma in the lives of children, youth, and their families. Trauma-informed strategies ultimately seek to do no further harm; create and sustain zones of safety for children, youth, and families who may have experienced trauma; and promote understanding, coping, resilience, strengths-based programming, growth, and healing. Strategies include an array of services and supports that screen and assess appropriately, provide trauma-specific services when needed, coordinate services when necessary, and that create environments that facilitate healing.

Another, much referred to definition describes trauma-informed approaches as incorporating three key elements: an understanding of the prevalence of trauma, recognition of the effects of trauma both on clients and on those who work with them, and the design of services which are informed by this knowledge. In other words:

A program, organisation, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for healing; recognizes the signs and symptoms of trauma in staff, clients, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, practices, and settings.

Substance Abuse and Mental Health Services Administration (SAMHSA)

Key features of trauma-informed approaches relate to four key areas of focus which are explored in the following sections of the report:

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<sup>20</sup> Given some of the key findings presented in this report however, it is perhaps surprising that documents such as the recent HMI Probation inspection focusing on ‘Desistance and young people’ (HMIP, 2016) do not even mention trauma or its links with offending by young people. Within the broader desistance literature as well, there have been few references to the impact of trauma until very recently.

- Staff awareness, training and support
- Assessment
- Approaches to working with young offenders
- Consideration of the therapeutic window

### 5.3.1 Staff awareness, training and support

The development of trauma-informed practice involves equipping key staff with knowledge about trauma and its effects and supporting them in their work with potentially traumatised young people, both by ensuring that there are mechanisms in place for individual monitoring and debriefing and by promoting integrated teamwork.

Psychologically aware approaches recognise that young people with challenging behaviour have particular support needs, often arising directly from their experiences of earlier trauma and abuse. Training enables practitioners to develop clear and suitably consistent responses to young people who may be chaotic and distressed and who have learned not to trust. With more insight into how traumatised young people behave, staff can work more effectively with them, helping them to gain an understanding of their own behaviour, take responsibility for themselves and develop negotiated, positive relationships. This approach leads to much better risk management. It enables staff to work with the challenging behaviour of young people – rather than restricting their access to support until behaviour changes – so that vulnerable and chaotic young people are not excluded from services. This approach is sometimes called ‘elastic tolerance’ (Woodcock and Gill, 2014), allowing behaviour that might normally result in exclusion from a service to be tackled creatively and with flexibility, thereby addressing the behaviour without rejecting the individual.

Such trauma-informed resettlement is delivered by practitioners who understand that traumatised young people are likely to be in an almost permanent state of emotional arousal – prone to emotional outbursts, frustration, fury, depression and despair. These young people also display high levels of impulsivity and risk taking, and in groups may display ‘emotional contagion’. Therefore, one key goal for any resettlement intervention is to constantly de-escalate emotional tension, rather than seek to punish or ‘teach a lesson’; a person flooded by emotion is unable to understand such ‘lessons’ (Bath, 2008).

Staff working intensively with young offenders should also be assisted in building their own psychological resilience – mapping out their own vulnerabilities and strengths and protecting themselves against vicarious trauma.<sup>21</sup> It is important to acknowledge that particular young people may generate some negative feelings in staff, including frustration, despair, anger and hatred. Staff need to be able to disclose and explore their emotions in a supportive environment in order to manage their feelings effectively. But, while staff may struggle to empathise with all of the young people they support, it is perhaps even more risky for staff to over-identify with young people. In these cases, staff can leave themselves vulnerable if they have fantasies about being able to ‘rescue’ young people as this may lead them to underestimate the risks that they may pose.

It is already recognised that YOT staff and those working within the secure estate require support and supervision, but that the necessary levels of support are non-existent or inadequate, even following major incidents (Harrington et al., 2005). It is imperative then that substantial investment is devoted to training, supervision and support for staff working intensively with traumatised young offenders.

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<sup>21</sup> Telephone conversation with Dr Andy Cornes, Everton Free School, October 2014.

In summary:

- Professionals need to be equipped with a firm knowledge base about trauma and how to recognise it; staff and partners may need training in attachment/trauma principles
- Staff will need support to manage their own emotions and deal with stress
- Work will need to be structured in a way that facilitates staff working as part of a united team

### 5.3.2 Screening and assessment

As previously stated, because trauma undermines a child's developmental progression, most young offenders have specific support needs, particularly in relation to their emotional health and functioning. As Boswell also points out (2013),<sup>22</sup> it should not be suggested that trauma is the sole cause of offending or that every abused child becomes an offender. However, trauma is so prevalent among this group of young people that systematic screening and thorough assessment is warranted.

Because trauma and mental health problems are likely to influence the success of resettlement work, it is vital that young offenders' mental health needs are systematically screened for, and responded to with timely provision of appropriate specialist support (Harrington et al., 2005). Previous processes and methods of assessing mental health needs among young offenders have been ineffective. The Harrington et al. (2005) study revealed substantial levels of missing or non-completed assessments for young offenders under YOT supervision.<sup>23</sup> Furthermore, having assessed 600 Asset forms, they found that only 15% of young offenders were identified as having mental health problems, whereas their national study (which used a fully validated mental health screening tool) identified 31% of young offenders as having a mental health need. They concluded: 'Asset, therefore, is not sufficiently sensitive in identifying mental health needs in young offenders.'

While integrated mental health assessment is now being rolled out across YOIs, it is imperative that this is supplemented by sufficient community-based mental health resources and fully trained staff (Harrington et al., 2005).

- Expectations for progress need to be informed by an understanding of trauma and its impact.
- Participants need regular and reliable feedback about their progress.
- Positive shifts in resilience, impulsivity, hope, self-confidence are important and suggest positive longer term outcomes (e.g. reduced re-offending, employability and trauma resolution).

In the community, structured risk and mental health assessment should form the basis for planning interventions. Specific assessment for PTSD, abuse and significant loss among violent offenders would be beneficial (Boswell et al., 2003), although the timing of such work needs careful consideration. Close liaison with other agencies working with the young offender may be necessary to provide fuller insight into their backgrounds. Moreover, as Nader (2011) points out, because developmental issues influence the nature of children's reactions to trauma, it is crucial that diagnostic criteria and assessment measures are specifically designed for different developmental age groups in order to facilitate the selection of appropriate treatment.

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22 See also: Smith and McVie (2003); Lösel and Bender (2006).

23 In 46 (8%) of cases, Asset had not been completed when it should have been. In an equal number of cases (n=46), the files of the young people could not be found to ascertain whether the Asset had been completed or not. In Asset, those identified with mental health problems score a three or four on the mental health section. Of the 600 Asset forms evaluated, only 15% of young offenders were identified as having mental health problems. This is much lower than the 31% identified as having a mental health need in this national study, using the S.NASA – the fully validated mental health screening tool.

However, when considering appropriate arrangements for assessment it is worth keeping in mind that:

- Young custody-leavers frequently complain about what they regard as over-assessment (and many of the young people that the BYC research team has spoken with over the years have pointed this out directly to us).
- Young people are often resistant to assessments which are perceived to label them as victims or as having emotional/mental health problems.
- There is a more general problem concerning assessments that they are perceived not to be followed up by any meaningful service provision; many young people have commented to our research team that they are subjected to numerous tests and then “nothing happens”.

The general point to make here – which applies to trauma-informed practice as well as to resettlement practice more generally – is that assessment of need ideally should be linked to decisions about accessing appropriate services, rather than being part of a more general approach to fit young people into services that are available.

### 5.3.3 Interventions with young offenders

Placing children’s welfare at the heart of efforts to tackle their offending does not mean overlooking or minimising the difficulties and harm that these children’s behaviour causes. Ensuring that children understand and take responsibility for their wrongdoing, and make amends wherever possible, can and should be an integral part of a welfare-based approach to offending. This is an approach, therefore, that recognises just how troublesome is the behaviour of most children who are sentenced to custody, whilst also recognising that these children are themselves very troubled.

(Jacobson et al., 2010)

Understanding the impact of trauma upon young offenders leads to more effective interventions, and helping young people to build their personal resilience and social support systems should form an important part of all resettlement work. There are a range of interventions that can significantly improve the emotional wellbeing and desistance outcomes for young people. Educational and social services can help to prevent the onset of serious violence (Krug et al., 2002; Silvestri et al., 2009; Rose, 2010), support for parents and children affected by domestic violence can reduce harms (WHO/Liverpool JMU, 2009), and children convicted of grave offences can benefit from the services provided by Local Authority Secure Units (Cavadino and Allen, 2000:14).

There is great scope for being able to help young offenders manage their emotions and behaviours. By addressing the emotional and psychological needs of young people, services can enable them to better manage their emotions and behaviours as a first step towards making other long-lasting positive changes in their lives. Trauma-informed approaches that seek to build young people’s strengths and attachment can help to minimise the impact of their complicated lives and traumatic experiences, reducing the likelihood that they will engage in high-risk and anti-social behaviour. In other words, ‘The more strengths these children have developed, the less likely they are to engage in high-risk behaviours. This resilience has major implications for both prevention and treatment’ (Griffin et al., 2009).

As Leon (2002) identifies, meeting the mental health support needs of young offenders is critical for desistance-focused work. Early detection of young people’s trauma and/or mental health difficulties may reduce both their potential to develop a more chronic disorder in adulthood and the likelihood that they persist with offending into adulthood. Of course, providing access to treatment is not as simple as it sounds.

Most people, including young people in the criminal justice system – and even those with severe psychiatric disorders – have a negative attitude towards the issue of mental health and a strong reluctance to engage with any psychological treatment. Failure to attend appointments or engage with the treatment process is common and, perversely, mental health services typically refuse to work with potential clients who either misuse substances or miss appointments, no matter how intertwined with mental health difficulties those behaviours are.

This is a complex field of work and no simple blueprint for intervention can be established. While every individual will have their own specific support needs and preferred styles of engagement and communication, there are also personal characteristics that warrant consideration. Young people from ethnic minorities are over-represented in custody and are likely to have specific needs that warrant further study. Gender should always be considered with respect to antisocial behaviour and offending because of the different rates of antisocial behaviour attributable to young men and young women. There is also the issue of the relationship between mental health problems and physical health problems which further complicates the development of effective interventions for these groups.<sup>24</sup>

Resettlement interventions need to be informed by an understanding of the roots of young offenders' challenging behaviour and awareness of the appropriate responses. This includes a more sophisticated interpretation of their disinclination to engage – not simply labelling them as an individual 'unmotivated to change', but rather being in need of support to build and foster their optimism, confidence and commitment. It is, therefore, important to openly acknowledge both the degree of adversity faced by young offenders and the specific challenges they face in adapting to new situations (particularly adjusting to custody, or returning to the community).

NICE (2005) offer practitioners the following guidance on addressing the mental health needs of children and young people (and in particular where those needs are linked to trauma-related depression):

- Healthcare professionals in primary care, schools and other relevant community settings should be trained to detect symptoms of depression, and to assess children and young people who may be at risk of depression. Training should include the evaluation of recent and past psychosocial risk factors, such as age, gender, family discord, bullying, physical, sexual or emotional abuse, comorbid disorders, including drug and alcohol use, and a history of parental depression; the natural history of single loss events; the importance of multiple risk factors; ethnic and cultural factors; and factors known to be associated with a high risk of depression and other health problems, such as homelessness, refugee status and living in institutional settings.
- Healthcare professionals in primary care, schools and other relevant community settings should be trained in communications skills such as 'active listening' and 'conversational technique', so that they can deal confidently with acute sadness and distress ('situational dysphoria') that may be encountered in children and young people following recent undesirable events.
- A child or young person who has been exposed to a recent undesirable event, such as bereavement, parental divorce or separation or a severely disappointing experience and is identified to be at high risk of depression (the presence of two or more other risk factors for depression), or where one or more family members (parents or children) have multiple-risk histories for depression, then should be offered the opportunity to talk over their recent negative experiences with a professional in tier 1 and assessed for depression. Early referral should be considered if there is evidence of depression and/or self-harm.

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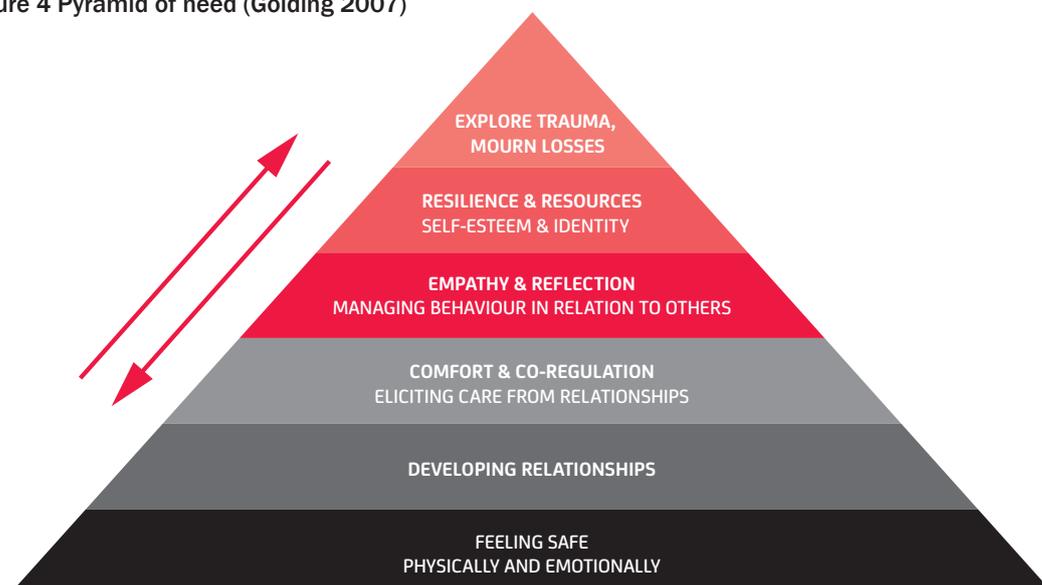
<sup>24</sup> For further reading on these complex resettlement issues, see 'Recognising diversity in resettlement: a practitioner's guide' (BYC, 2015), 'Ethnicity, faith and culture in resettlement: a practitioner's guide' (BYC, 2015) and 'Developing a gender-sensitive approach to resettlement: policy briefing' (BYC, 2015)

- Whenever healthcare professionals come into contact with children and young people who live in families undergoing emotional upheaval, the mental health needs of the children/young people should be considered. Recommended action may include referral to relevant support groups (for example, relating to young carers, substance misuse, bereavement) or other targeted self-help options (e.g. leaflets). Due to the common occurrence of depression in the offspring of depressed parents, special consideration should be given to assessing and supporting children with family members being treated for depression.
- Family risk factors for depression in children and adolescents include parent-child conflict, parental discord, divorce and separation, parental death, parental mental illness and parental substance misuse... The risk is thought not to lie in the variable per se but in its effects on attitudes, behaviour and relationships within the family.
- Depression may not be recognised as such by those working with the child or young person (teachers and school support staff, youth workers, sports coaches, social workers and so on, who may be employed by statutory agencies in primary healthcare, social care, education, or in the voluntary sector. Their primary concern may be a behavioural manifestation associated with the depression, like substance misuse, delinquency, bullying or child abuse. Shame and fear of blame may make it hard to assess this in such settings. Interventions may not have input from CAMHS [Child and Adolescent Mental Health Services] professionals.
- When assessing a child or young person with depression, healthcare professionals should routinely consider, and record in the patient's notes, potential comorbidities, and the social, educational and family context for the patient and family members, including the quality of interpersonal relationships, both between the patient and other family members and with their friends and peers.

However, in addition to this, an awareness of trauma and its effects is also required in order to usefully inform our understanding of young offenders' challenging behaviour, and inform decisions about appropriate responses. For example, violent or aggressive behaviour can sometimes be adaptive for traumatised young people, rather than an indication of a lack of discipline or an absence of motivation to change. Punitive or reactive responses can serve to entrench problematic behaviour in such cases rather than address it, whereas support to build and foster optimism, confidence and commitment can be more effective.

Although initially developed for looked after and adopted children, one model that is also helpful in considering and prioritising approaches and interventions for working with young offenders is Golding's (2007) pyramid of need. This is presented below:

**Figure 4 Pyramid of need (Golding 2007)**



As this diagram highlights, the first priority is to create an environment where young people can feel physically and emotionally safe – any group work activities should be carefully planned to ensure that the risk of conflict between young people is minimised and can be controlled. The next consideration is about developing positive relationships so that young people are able to receive comfort and care from practitioners in a carefully bounded manner. This provides space for young people to reflect on their interactions, enabling them to develop empathy and better manage their relationships and behaviour with others. The young person is then able to develop their self-esteem, identity and resilience and, from such a position, can begin to address the trauma(s) that they have suffered and make positive progress.

The development of trust between young people and staff is important in order to help them overcome ‘maladaptive’ responses that may undermine the effectiveness of any interventions. Young people’s full engagement and ownership are key as they need to feel part of their own change process. Young offenders may need specific support to overcome emotional constraints and to learn to manage their emerging feelings appropriately. Young people with PTSD who have committed violence are likely to need help to come to terms with their actions and the consequences. Even where it is not possible to alter an individual’s cognitive ability, practitioners can seek to change behaviour (Williams 2013), enabling young people to better manage their changing emotional states.

While the key aim of the criminal justice system is to reduce or prevent offending, trauma-informed resettlement practice requires us also to consider the young person’s safety – both from others who may seek to victimise them, but also from the frustration, despair and anger that they may feel at themselves. Such practice also involves another consideration: the personal safety and emotional wellbeing of staff working closely with them. These three priorities are considered in more detail below:

<b>Helping young people</b>	The development of a trusting working relationship is necessary before undertaking in-depth assessment, in order to identify the young person’s trigger points for (self-) destructive behaviour and plan appropriate interventions. An emphasis on helping young people to develop and sustain positive support networks is crucial.
<b>Protecting the community</b>	The full range of agencies working with the young person needs to cooperate to strategise and manage risk. Safe, accountable and defensible practice must be delivered consistently by staff from all agencies.
<b>Ensuring staff safety</b>	The development of trusting relationships can be quite threatening to some young people – especially if attempts to control behaviour replicate aspects of previously abusive relationships. While it is important to encourage young people to develop (temporary) attachments to project staff, this needs to be approached carefully as getting it wrong can provoke abuse, aggression and violent behaviour. It is therefore highly important that staff develop skills in de-escalating and diffusing aggression.

Resettlement practitioners will also need to develop a strong understanding of the familial and community context of young offenders’ behaviour. Young people may need help to overcome their labelling as a ‘bad kid’, through the creation of a new ‘tolerable’ self and shared (family and community) acceptance of this positive new identity.

Key lessons about the content, delivery and partnership support of resettlement interventions can be summarised as follows:

### **Programme content**

- Programme content must be informed by an understanding of individual participant’s trauma issues to avoid inadvertently reinforcing problematic behaviour.
- “Start from where young people are at” – ‘misaligning’ programme content and individual need can cause retraumatisation.

### **Programme delivery**

- Work on the principle that services should ‘do no more harm’, using empathetic approaches rather than reactive/punitive ones.
- Provision of a safe and predictable environment is very important.
- Staff need to have realistic expectations and take longer-term approaches.
- A ‘whole system’ relationship-based approach is best.

### **Coordinated partnership delivery**

- The provision of services for these young people requires an integrated approach from all the agencies involved, including the Criminal Justice System, social services and mental health services.
- Greater awareness of trauma issues can lead provider teams to understand their own limitations and acknowledge when they need to access other specialists.

Therapy for young people can enable them to acknowledge their emotional needs and help improve their relationships, enabling them to develop fuller lives as citizens, parents and productive individuals (Bailey, 1996). Professionals overseeing and supporting young people to tell the story of their own trauma is a key positive step on the therapeutic journey towards recovery, enabling them to begin the process of, as Judith Herman puts it, ‘Undertaking remembrance and mourning’ (2001:175). Recovery is then followed by ‘reconnection’ – a stage that enables young people to develop a new identity and form new, positive relationships (Herman, 2001:196).

While the therapeutic literature is too enormous to be examined in detail in this report, it is worth highlighting some key concepts of relevance to the resettlement of young offenders.

#### **5.3.4 The use of attachment theory to help understand and resolve trauma**

Left unresolved, trauma can manifest itself at any point in the lives of children and young people, who may become depressed, disturbed, violent or all three (Boswell, 2013). There are gender differences here: girls tend to internalise and boys to externalise their responses (American Psychiatric Association, 2013). But the impact of trauma can be mediated by good attachment (Nilsson et al., 2011), so enabling young people to develop positive attachment strategies, thereby improving both how they deal with historical experiences of trauma and their potential to build strong and supportive relationships in the future, is imperative.

In the United States, awareness of the prevalence of trauma and its developmental impact upon young people in custody has led Inomaa-Bustillos (2012) to recommend that probation officers be sufficiently trained to recognise emotional and behavioural indicators that may attest to experiences of trauma when formulating their sentencing recommendations, planning and delivering interventions, and instituting any breach actions.

Renn (2002) examined the links between attachment patterns, unresolved childhood trauma, emotional detachment, substance misuse and violent offending in adulthood. This study demonstrates how attachment theory can help practitioners to better understand offending behaviour and more thoroughly assess risk. By helping offenders to develop their own ‘narrative intelligibility’ in relation to their life stories and relationships, such an approach can also help young people to integrate their dissociated thoughts and emotions, often resulting in a cessation of violent behaviour. By strengthening the offender’s capacity for reflective thought, each individual can rectify their previously ‘maladaptive, perceptually-distorted cognitive-affective internal working models’.

Attachment strategies can be enhanced even in adulthood, so it is highly important that interventions are delivered in an environment that provides a secure base and helps clients to work through unresolved traumas. A focus on attempting to facilitate progress towards clients developing a more secure attachment strategy in such a way that will improve their ability to handle close relationships in future is crucial (Purnell 2010).

### 5.3.5 The need for positive social support

It is loving that saves us, not loss that destroys us.

(George Vaillant, 1985)

Like adults, young people with support have better mental health (Green et al., 2013; Office of National Statistics, 2013) and ‘having someone to count on’ is known to significantly decrease violent offending among those who have been exposed to trauma (Maschi, 2006).

Levels of perceived social support are low among young offenders. This is of concern because having a small primary support group – defined as three close friends/relatives or fewer – has been associated with a greater risk of psychiatric morbidity (Brugha et al., 1993; Meltzer et al., 1995).<sup>41</sup> In a survey of psychiatric morbidity, 6% of women and 7% of men living in private households said they had a primary support group of three or less (Meltzer et al., 1995).<sup>25</sup> However, twice as many young offenders report this (13% of male remand and 11% of male sentenced young offenders and 19% of the females in custody); such rates are closer to figures reported by residents of institutions catering for people with mental disorder (Lader et al., 2000). So the development and maintenance of informal support networks is crucial for the facilitation of positive outcomes for these groups.

Maschi (2006) investigated the moderating role of social support on the relationship between male youths’ exposure to violence and other stressful life events and their violent behaviour. Self-report interviews from a nationally representative sample of male adolescents aged 12 to 17 and their caretakers were used to assess youths’ lifetime exposure to violence (i.e., being a victim and/or witness to physically abusive punishment, physical assault, sexual assault, and witnessing violence), past-year stressful life events (i.e., the loss of positively valued stimuli and the blockage of positively valued goals), levels of social support, and their violent offending behaviour. Having ‘someone to count on’ was found to have a positive mediating effect on the impacts associated with being a victim of physical abuse and witnessing violence on violent offending.

### 5.3.6 Consideration of the therapeutic window

Young people often move within the youth justice system between community and secure sites quite frequently, but there have been few longitudinal studies describing how their needs change. Such studies,

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<sup>25</sup> More than a quarter of respondents in custody reported a severe lack of social support compared with a little over one-tenth of those aged 16–24 in the private household survey. A further third reported a moderate lack of social support. There were no significant differences between remand and sentenced young offenders or between men and women in the proportions reporting a lack of social support.

although difficult to conduct, are vital when considering what mental health resources are necessary to meet their changing needs (Harrington et al. 2005).

In relation to work with traumatised young people, however, it is clear that psychological interventions will have a greater scope for effectiveness if they are provided during what has been usefully referred to as the ‘therapeutic window’; this is the stage when the participant is ready to address their difficulties but is also in a secure enough position not to feel overwhelmed by that process (Briere, 1996, 2003; Briere and Scott, 2013). It is a delicate balancing act between exposing them to challenges that promote psychological growth, and ensuring that those challenges are not so powerful as to reactivate the initial trauma and further diminish self-capacity. The trauma-informed notion of ‘safe environments’ is particularly important in this context.

Interventions that miss the therapeutic window can have negative consequences instead:

- **Overshooting** the therapeutic window (providing interventions that are too intense or fast-paced). This may lead to resistance, although in worst case scenarios can lead to self-harming and other avoidance behaviours such as substance misuse.
- **Undershooting** the therapeutic window (avoiding the issue of trauma despite a participant being able to tolerate addressing it) is rarely dangerous, but may waste resources when greater progress could be made.

So, resettlement practitioners need to exert careful control over the psychological intensity of their work – with a carefully managed, sequential approach to individual progress. Young people need to be given the opportunity to consolidate their psychological development before moving on to more challenging goals. It is important to maintain an appropriate balance between psychological security and development with the assumption that, when in doubt, the former is always more important than the latter.

## 5.4 Summary

There is now a substantial body of research evidence to suggest that:

- Offenders have a disproportionate amount of childhood and adolescent trauma in their backgrounds
- Offenders are more likely than non-offenders to have suffered adverse impacts from traumatic experiences in childhood and adolescence
- Some of the impacts of such trauma appear to be linked to offending behaviour
- Previous trauma can have an adverse impact on our scope for generating positive resettlement outcomes with young people and young adults

This is an extremely complex field of work and the stigma attached to experiences of trauma makes it difficult for many people to disclose what has happened to them. Having developed detrimental methods of dealing with their distress – perhaps including distrust and rejection of those in authority – these individuals tend not to engage with services. In doing so, they run the risk of further negative consequences for breaching criminal justice requirements. Without tailoring interventions in a way that acknowledges young people’s traumatic experiences and supports them in learning new coping skills, the long-term impact of any intervention may be quite short-lived.

Most young offenders have experienced adverse (if not traumatic) childhood experiences and so it is important for resettlement work to build their personal resilience and social support systems. Where multiple or chronic adversity has been experienced, the young person’s health and development will be

impeded – a situation that can be exacerbated by a lack of protective factors. The emotional consequences of such experiences of trauma can limit the effectiveness of direct work with them and also have implications for their potential progress and longer-term outcomes.

However, our own research has highlighted the extent to which it is possible even for highly traumatised people, with appropriate support and guidance, to re-shape their life trajectories, to be successful in accessing opportunities and achieving positive life outcomes. Indeed, some of the individual case studies that BYC has developed and presented count as examples of how individuals with even some of the most negative stories of childhood and adolescent trauma, can successfully navigate the kind of change processes which are the very definition of effective resettlement.

For those who work with young offenders, the scope for generating positive outcomes of that sort can be aided by an understanding of the prevalence and impacts of trauma, and by an understanding of how resettlement outcomes can be affected by trauma.

Specialist medical rehabilitation can also reduce the propensity for violence among young people who have suffered brain injury (Williams, 2013). Significant long-lasting positive impact can still be achieved even with highly traumatised young people whose development has been severely constrained. This is because the brain's neuroplasticity – its ability to 'rewire' itself – lasts at least into an individual's late thirties (Bailey, 2013). A focus on helping young people to build their personal resilience and social support systems can form an important part of that work.

As Bowlby comments more generally on the scope for change:

'Change continues throughout the life cycle, but changes for better or worse are always possible. It is continuing potential for change that means that at no time is a person invulnerable to every possible adversity, and at no time is a person impermeable to favourable influence.'

(Bowlby, 1988)

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