HMP Grendon
Assessing suitability for treatment and supporting change in a prison-based therapeutic community
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Developing Therapeutic Community (TC) Assessment Unit Services:

A treatment readiness analysis

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Aims

• To explore the purpose and aim of the treatment readiness analysis
• To consider the method of the analysis
• To explore the findings of the analysis
• To reflect upon the discussion points and practical implications of the analysis
What is the purpose of conducting a treatment needs analysis?

- Treatment readiness can be broadly defined as the presence of characteristics within either the client or the therapeutic situation, which are likely to facilitate engagement in therapy, and likely to increase the process of therapeutic change (Howells and Day, 2003).

- Enhancing treatment readiness is a reoccurring issue, especially in terms of cost efficiency, motivation for service providers to deliver, and treatment outcome (McMurrnan, in press; Tetley, Jinks, Huband, Howells and McMurrnan, 2012).
What is the purpose of conducting a treatment needs analysis?

- Non-completion of treatment has been explored in a number of forensic settings, and the overriding outcome appears to suggest this is a common occurrence.

- A meta analysis of psychotherapy dropout conducted by Wierzbicki and Pekarik (as cited in McMurrnan and Ward, 2010) indicated a mean non completion rate of 47%, suggesting a number of participants are often insufficiently invested in the process of changing behaviour.
What is the need for a treatment readiness analysis at HMP Grendon?

- HMP Grendon has been developing an enhanced assessment unit.
- The purpose of this analysis was to explore how the assessment unit services can be enhanced to help residents feel more prepared for therapy.
- Understanding and enhancing treatment readiness should help to improve treatment outcome.
Aims of the treatment readiness analysis

- To explore ways of enhancing assessment unit services
- To explore relevant psychological literature available on treatment readiness
- To explore the opinions of residents and staff (through focus groups and interviews)
- To make recommendations based on the findings to the relevant bodies
- To contribute to the development of the enhanced assessment unit policies and resources
Method of the treatment readiness analysis

- A psychological literature was used to guide relevant themes for qualitative discussions.

- Literature review
  - Review of all current psychological literature was performed.
  - Key areas of interest when exploring treatment readiness were:
    - Models of treatment engagement
    - Psychometric assessments of treatment readiness
    - Pre-treatment preparation procedures
    - Strategies that address barriers to engagement
Method of the treatment readiness analysis

- Focus groups and interviews – discussions were conducted with residents (n=33) and staff members (n=4) within sessions that lasted approximately 45 minutes.

- The qualitative data was collected and a thematic analysis was performed using McMurrnan and Ward’s (2010) spheres of treatment readiness and engagement.
Findings - Theoretical framework for assessment services

- A conceptual framework model such as the MORM or TreMoPeD was suggested to underpin the pre-treatment assessment period (although both require further empirical testing). Other treatment models are considered as not being broad enough.

- A broad range of internal (i.e. motivation) and external (i.e. treatment setting) factors were identified as important considerations for treatment readiness.
Findings - Psychometric measures

- To review current battery and include psychometrics that measure treatment readiness.

  • The Corrections Victoria Treatment Readiness Questionnaire (CVTRQ) (Casey, Day, Howells and Ward, 2007) - measure of ‘readiness to change’. May be used for selection into treatment or for measuring changes in readiness over time.

  • Personal Aspirations and Concerns Inventory for Offenders (PACI-O) (Campbell, Sellen, and McMurrnan, 2010) - focus on life goals, and may enhance motivation. Requires empirical testing for robustness.
Findings - Psychometric measures

- Treatment Engagement Rating (TER) scale (Drieschner and Boomsma, 2008, as cited in McMurrnan and Ward, 2010) - measures a client’s desirable or necessary behavioural contribution to treatment. Rated ‘quick and reliable’. Explore strengths and weaknesses for treatment readiness.

- Qualitative discussions found residents appreciated feedback from the psychometrics but felt more support could be given post-testing.
Findings - Pre-treatment preparation services

– Before arriving at HMP Grendon:

• Additional information for residents before they come to HMP Grendon, about barriers to treatment, how the therapeutic regime functions, logistically, and clarity on length of time required to undertake therapy.

• Building therapeutic relationships with assessment unit staff before arriving at HMP Grendon.
Findings - Pre-treatment preparation services

- Whilst on the assessment unit:
  
  • A workshop for understanding what therapy is (information on the what therapy is, examples of therapy, and practice target setting)
  
  • Motivational Interviewing (MI) training for all staff members to aid in motivating residents.
  
  • Additional support for residents in recognising and understanding emotions.
Findings - Pre-treatment preparation services

• Treatment environment

  – Developing and maintaining a therapeutic culture was a key role in creating the right treatment setting, which is encouraging considering the work TCs do.

  – Qualitative discussions suggested developing more social events on the assessment unit, and further involvement from representatives from the core TC units, and perhaps a mentoring system (supporting the TC principle of instillation of hope)
Findings - Pre-treatment preparation services

- Qualitative discussions highlighted more integration with other services such as education was helpful in the past to aid in developing treatment plans, and encouraging team working.

- The majority of residents seemed satisfied with the development of relationships with assessment unit staff members, and had little to say in relation to improving this.

- Strong indication that residents who are not engaged in assessment for core therapy should not be housed on the assessment unit.
Findings - TC intervention

– Qualitative discussions and literature review highlighted the need to keep the treatment multi-modal, with emphasis placed on therapeutic alliances.

– Literature review highlighted ongoing clinical supervision and training is critical to maintain therapeutic culture relationships.
Findings - TC intervention

- Qualitative discussions suggested help and support in understanding risk factors.

- Literature review and qualitative discussions highlighted further help with problems in group work (such as anxiety and embarrassment).
Findings - TC intervention

- Qualitative discussions highlighted that a closer regime between the assessment unit and the main core TCs could help with culture change.

- Qualitative discussions suggested longer assessment unit process to plan more carefully for how a resident joins a TC (for example, gradual involvement with a TC to help with developing relationships).
Findings - Individual characteristics

- Literature review highlighted explicit use of Good Lives Model (GLM) (Ward and Maruna as cited in McMurrnan and Ward, 2010). Focus on setting and reaching goals. Also helpful for psychopathic residents in terms of goal setting.

- Qualitative discussions suggested workshops which explored the understanding of emotions
Conclusions

• A number of recommendations were made from the findings to key policy makers and multi-disciplinary teams.

• The literature review provided a theoretical basis to ensure psychological approaches to enhancing treatment readiness are empirically supported.

• The qualitative discussions found a number of ways to enhance the services provided, which supports the findings from the literature review.
Limitations of the treatment readiness analysis

- Relatively low response rate in terms of participants; Therefore generalisability could be questionable to HMP Grendon population.

- Generalisability to wider TC units within the prison service could also be questionable, given analysis was conducted at HMP Grendon with the current population only.

- Qualitative data relied on self-report data, which can subsequently have a bias effect on the data produced.
Services developed on the assessment unit

• The assessment process has been extended to a maximum of 26 weeks. This allows for the implementation of new elements of assessment in response to the analysis.

• Additional elements included are as follows:
  ➢ The Corrections Victoria Treatment Readiness Questionnaire – CVTRQ
  ➢ Therapy Awareness Course - TAC
  ➢ Treatment Engagement Rating Scale – TERS
  ➢ Personal Concerns Inventory – PCI
  ➢ Thinking About Feelings – TAF
Services developed on the assessment unit

• To assist with implementation of the additional elements of the assessment the staff team has expanded to include an additional Registered Forensic Psychologist, Specialist Mental Health Nurse, Occupational Therapist and Facilitator. Further training / a refresher was undertaken in the use of motivational interviewing (MI).

• All elements of the assessment remain multi disciplinary with longstanding staff working alongside new staff.
Implementation into the TC Journey

- The CVTRQ is completed as part of the psychometric test battery
- TAC completed soon after their arrival and prior to their first formal meeting with staff for a Progress Review.
- TERS completed at each Progress Review, approximately weeks 5, 10, 15 of their stay on the assessment unit
- TAF completed after their first Progress Review, usually between weeks 5 and 10
- PCI completed between first and second Progress Review
What are they – and what do we know about their use / outcomes?

- TAC – currently being piloted, a six session workshop to help men understand the environment and the work they will complete during their time at Grendon, both on the assessment unit and a core TC unit.
- It is planned to include representatives from the core TC units (as indicated in the analysis)
- Based on the four pillars of
  - Community Living
  - Democracy
  - Reality Confrontation
  - Tolerance
What are they – and what do we know about their use / outcomes?

- The TER was created for assessment of forensic outpatients and is interpreted for the Grendon population and prison service constraints.
- The TER is used at all Progress Reviews and completed by at least three people to gain an overview.
- With the data collected and analysed so far the TER is providing a statistically significant indication of who is successful in the assessment process.
TER analysis outcomes

- The average TER score at the first progress report for residents later allocated to a wing was 3.3, the average score for those found unsuitable for therapy was 2.7.

- The average TER score at the second progress report for residents later allocated to a wing was 3.6, the average score for those found unsuitable for therapy was 2.5.

- The average TER score at the third progress review for those allocated to a wing was 4, the average score for those found unsuitable for therapy was 2.2.
Personal Concerns Inventory, PCI

- Bringing in the Good Live Model (GLM) and focusing on goals that are important to the men. Encouraging them to consider improving the quality of their life to make offending less appealing.

- Completed in a interview with staff the aim of the PCI is to enhance men’s motivation to engage in therapy, and see the ‘process’ of therapy as helpful in building a more personally fulfilling life.

- The men identify their valued personal goals and consider obstacles to goal attainment. They consider how the process of therapy at Grendon can help them overcome the obstacles and achieve the goals.
Personal Concerns Inventory, PCI

- The men who move to a wing revisit the areas they have chosen as important and are encouraged to use the document as live goals for their time at Grendon. The process of living within a community has intrinsic value.

- “Continual referral to it has helped me remember what I am trying to achieve, the areas I need to target and what I need to achieve. It has given me both drive and focus.”

- “It’s hard to know what you want. It’s a little harder to know how to achieve it but by looking at what stops you and makes you fail I could see much clearer why I fail.”

- Encourages taking responsibility and seeing change is possible.
Thinking About Feelings, TAF

• Six session ‘workshop’ on exploring emotions from an educational and experiential point of view. Focusses on learning skills, not their offences.

• Four key areas: the role of emotions, recognising emotions, mindfulness, what to do next.

• Making links between thoughts, feelings and actions.

• Helping them consider how feelings may have had influences across their life / their decisions.
Moving On

• Higher deselection rates at the assessment stage have been seen, more time will be needed to see the longer term outcome of this in terms of success on the wings.

• Core wing staff have indicated the men are now better prepared for work once they have been assessed as suitable.
References


• McMurran, M. (in press). *Readiness to Engage in Treatments for Personality Disorder*. Institute of Mental Health, University of Nottingham, Nottingham, UK.


Assessing attrition in a therapeutic community using the Personality Assessment Inventory

Sue Jamieson (Trainee Forensic Psychologist)
Aims

• To explore if any personality characteristics as assessed by the PAI influence whether or not an offender is selected as suitable to engage in therapy at HMP Grendon.
• To consider if any personality characteristics as assessed by the PAI influence whether or not an offender completes therapy at HMP Grendon.
• To explore the usefulness of the PAI as an assessment tool at HMP Grendon.
What is the purpose of assessing attrition?

- Research indicates that those who show a predisposition to be critical of others, have high levels of paranoid hostility, and externally directed hostility have significantly reduced length of stay within prison TC’s. This is compared to those with a tendency towards displaying self-criticism and symptoms of guilt and who are introverted and anxious (Shine, 2001).
What is the purpose of assessing attrition?

- Treatment non completion may make some offenders more likely to reoffend, which is suggested to be due to the fact that removal from treatment programmes could increase anti-authority and antisocial attitudes (Harper & Chitty, 2005; Olver et al., 2011).

- In TC’s due to the intense nature of the treatment process there may also be ethical considerations relating to engaging an individual in therapy if they are not suitable.
What is the purpose of assessing attrition?

• If an individual has begun to explore difficult issues relating to their lives within the supportive environment offered by TC’s and they are suddenly removed then psychological harm is a real possibility.

• Therefore it is important to be able to accurately identify such individuals both in terms of preventing adverse outcomes and in informing selection procedures.
The Personality Assessment Inventory

• A self report inventory of adult personality
• It provides information that can assist in offender treatment planning, classification and assessment.
• It consists of 344 items which comprise of 22 non-overlapping scales: 4 validity scales, 11 clinical scales, 5 treatment scales and 2 interpersonal scales
• The respondent is required to indicate the extent to which 344 item statements accurately describe them on a 4-point Likert scale, ranging from 1 (very true) to 4 (false).
• The scores are transformed to T scores which have been calibrated with reference to a national census-matched community sample of 1000 adults, so that they have a mean score of 50T and a standard deviation of 10T
Constructs identified in the literature

The following are associated with treatment non completion/attrition and their PAI scale equivalents:

- Poor motivation **RXR** (Treatment Rejection) **NON** (Non Support) **STR** (Stress)
- Significant History of offending **ANT-A** (Antisocial Behaviours)
- Drug addiction **DRG**
- Aggression **AGG-A** (Attitude) **AGG-V** (Verbal) **AGG-P** (Physical) (**VPI**, Violence Potential Index)
- Lack of empathy **ANT-E** (Egocentricity) **WRM** (Warmth) **MAN-G** (Grandiosity)
- Blaming cognitive style **PAR-R** (Resentment)
- Distractible **ANT-S** (Stimulus Seeking)
Constructs identified in the literature

The following are associated with treatment non-completion/attrition and their PAI scale equivalents:

- **Controlling of others DOM** (Dominance)
- **Emotionally flat SCZ-S** (Social Detachment)
- **Polarised rigid thinking PAR-R** (Resentment) **PAR-H** (Hyper-Vigilance) **PIM** (Positive Impression Management) **DEF** (Defensiveness Index)
- **Borderline personality Disorder BOR** (Affective Instability/Identity Problems/Negative Relations/Self harm)
- **Suicide/Self harm SPI** (Suicide Potential Index)
- **Neuroticism ANX** (Anxiety) **ARD** (Anxiety Related Disorders)
Other scales of interest

• One potentially useful feature of the PAI within treatment settings is The Treatment Process Index (TPI) which is a configuration of 23 PAI scales and sub scales which have been theoretically linked to the following 12 features of treatment amenability in the psychotherapy literature; a lack of psychological mindedness, likability, motivation, self discipline, impulse control, defensiveness style, internalisation, empathy, parental factors, social support and conscience factors.
Other scales of interest

- The PAI scale of Treatment Rejection (RXR) has been designed to identify individuals at risk of non-compliance with treatment regimes and encompasses the following themes; ‘a refusal to acknowledge problems; an unwillingness to participate actively in treatment or to accept responsibility for changing and a lack of introspectiveness’

- Unlike the TPI the RXR scale is related to treatment motivation and not prognosis.
Participants

496 men admitted to HMP Grendon between 2007–2012

395 valid PAI profiles

78 returned to sending prison within 12 weeks (RTU)

108 Completers (C) in therapy for 24 + months

60 Non-completers (NC) Allocated to a therapy wing but left between 6-12 months

14 voluntary leavers

46 agency initiated leavers

23 voluntary leavers

14 voluntary leavers

31 agency initiated leavers

149 still undergoing therapy (3-24 months)
Analysis

• Multivariate Analysis of Variance was used to compare mean T-score differences between the three participant groups.

• Further Analysis of Variance was performed on each chosen scale of the PAI to determine which scales showed significant differences in their mean T scores between the three groups.
## Mean T scores of Relevant Personality Assessment Inventory (PAI) Full Scales across Samples

<table>
<thead>
<tr>
<th>PAI Scale</th>
<th>RTU (A) n = 78</th>
<th>Non Completers (B) n = 60</th>
<th>Completers (C) n = 108</th>
<th>Cohen's d (For significant results only)</th>
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<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>M</td>
<td>SD</td>
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<tr>
<td>Positive impression management (PIM)</td>
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<td>Borderline features (BOR)</td>
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<td>Antisocial features (ANT)</td>
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<td>Drug Problems (DRG)</td>
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<td>Aggression (AGG)</td>
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Mean T scores of Relevant Personality Assessment Inventory (PAI) Sub Scales and Indices across Samples

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Mean T scores of Personality Assessment Inventory (PAI) RXR Scale and TPI in the Attrition groups (RTU only)

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<td><strong>SD</strong></td>
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<td><strong>SD</strong></td>
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Mean T scores of Personality Assessment Inventory (PAI) Scales, Subscales and Indices in the groups defined as RTU or Allocated

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<th>PAI Scale/subscale/index</th>
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‘Area Under the Curve’ (AUC) scores in the groups defined as RTU or Allocated for PAI scales where there was a significant difference between the means of the ‘RTU’ and ‘A’ groups.

<table>
<thead>
<tr>
<th>PAI Scale/subscale/index</th>
<th>Total sample (N=395)</th>
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<tr>
<td>Positive impression management (PIM)</td>
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<td>Anxiety (ANX)</td>
<td>.59</td>
<td>.036**</td>
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<tr>
<td>Anxiety Related Disorders (ARD)</td>
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<td>Depression (DEP)</td>
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<td>.039*</td>
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<td>Borderline features (BOR)</td>
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<td>Drug Problems (DRG)</td>
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<td>Treatment Rejection (RXR)</td>
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<tr>
<td>Cognitive anxiety (ANX-C)</td>
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<tr>
<td>Traumatic Stress (ARD-T)</td>
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<tr>
<td>Cognitive Depression (DEP-C)</td>
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<tr>
<td>Activity Level (MAN-A)</td>
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<tr>
<td>Persecution (PAR-P)</td>
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<tr>
<td>Affective Instability (BOR-A)</td>
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<td>Identity problems (BOR-I)</td>
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<td>Negative relationships (BOR-N)</td>
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<tr>
<td>Self Harm (BOR-S)</td>
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<td>.035*</td>
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<tr>
<td>Physical Aggression (AGG-P)</td>
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<td>.037*</td>
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<tr>
<td>Defensiveness index (DEF)</td>
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<td>.037*</td>
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<tr>
<td>Suicide Potential Index (SPI)</td>
<td>.61</td>
<td>.038**</td>
</tr>
<tr>
<td>Violence Potential Index (VPI)</td>
<td>.58</td>
<td>.037*</td>
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</table>
Summary of main findings

In this study prisoners whose T scores on the PAI clinical scales of Positive Impression Management (PIM), Aggression (AGG), Borderline Features (specifically, Affective Instability (BOR-A), Negative Relationships (BOR-N) and Self Harm (BOR-S)), Antisocial Features (specifically Egocentricity (ANT-E) and Stimulus Seeking (ANT-S)) and the sub scale of Hypervigilance (PAR-H), as well as the indices of Potential Suicide (SPI), Violence (VPI) and treatment amenability (TPI) are significantly higher in those who fail to complete therapy compared to those who complete therapy.
Summary of main findings

• These findings have a small to medium effect sizes (0.3-0.6).

• Only the Violence Potential Index was found to be moderately predictive of likelihood of completing therapy with higher VPI indicative of non completion.

• However contrary to expectations and findings from other studies (Jones, 1997; Miller et al, 2004; Shine, 2001) Anxiety (ANX), Anxiety Related Disorders (ARD), Grandiosity (MAN-G), Social Detachment (SCZ-S), Dominance (DOM), Stress (STR), Non Support (NON), Resentment (PAR-R) and Treatment Rejection (RXR) did not differ between the two groups.
Summary of main findings

• Treatment rejection (RXR) was not higher in those prisoners who chose to leave as opposed to those who were asked to leave and that treatment amenability (TPI) was not less (i.e. higher scores) in those prisoners who were asked to leave as opposed to those that left voluntarily.

• When only the prisoner’s who left prematurely from the assessment unit (RTU) scores were analysed, RXR was significantly higher in those who’s leaving was voluntary as opposed to those whose leaving was agency initiated, indicated that these prisoners may lack motivation.
Summary of main findings

- Whether by their own choice or agency initiated confirmed the hypothesis that those not selected as suitable were higher in treatment rejection (RXR) and the effect size was medium (0.4).
- The differences in the scales of PIM and DEF indicate that participants who are higher in positive impression management and more defended are more likely to return to their sending prison (RTU).
- Other variables (ANX, ARD, DEP, BOR, DRG, MAN-A, PAR-P, SPI and VPI are all significantly higher in the group of participants allocated to a therapy wing, and as observed as part of this study participants who score higher in some of these variables (BOR, DRG, SPI and VPI) are less likely to complete therapy than those who are lower.
Conclusion

- The PAI has shown potential utility in determining differences between groups of successful or non-successful participants at HMP Grendon and if used in combination with other determinants of these outcomes it could prove to be useful in the selection of prisoners who are more likely to succeed in therapy.

- In isolation its utility may lay in the fact that it is a comprehensive assessment of personality and clinical need (Morey, 1996) and in the context of a therapeutic community model where self efficacy is encouraged using the PAI as one tool to engage offenders in discussion and set collaborative treatment targets is valuable.
References


Tolerating the intolerable: Working with transference and counter-transference with toxic material in a prison-based therapeutic community

24th Annual DFP conference
Manchester Metropolitan University
1st-3rd July 2015

Dr. Geraldine Akerman
Therapy Manager HMP Grendon/Doctoral Researcher
University of Birmingham

Kate Geraghty
Psychologist in Training/Doctorate student University of Birmingham
HMP GRENDON

- Category ‘B’ prison (215 prisoners) also takes Category C
- 5 Therapeutic Communities and an enhanced assessment unit
  - High re-offending risk
  - 26% > 30, 47% >25 (Psychopathy checklist Revised)
  - High % personality disturbance
  - 81% of those assessed have at least 1 personality disorder
  - Experience significant levels of emotional distress, anxiety, depression, histories of abuse
  - Following treatment residents have shown reduction in anti-social behaviour, reoffending, and increased psychological well-being, (Newberry, 2011; Newton, 2010; RSG, 2010; Sullivan & Shuker, 2010) and ability to discuss and understand offending behaviour (Akerman, 2010).
Guiding Principles of Democratic TCs

- Therapeutic alliances
- Safety, boundaries and containment
- Involvement, participation and responsibility
- Decision making and democratisation
- Debate, exploration and enquiry

(Interconnected with arrows showing relationships between the principles)
THERAPEUTIC COMMUNITY MODEL
LINKS BETWEEN DIFFERENT THERAPEUTIC ACTIVITIES

- THERAPEUTIC CULTURE
  - THERAPY GROUP
    - RESIDENT FEEDBACK
      - COMMUNITY MEETING
        - CASE REVIEW
    - STAFF FEEDBACK
  - WING RELATIONSHIPS
    - COMMUNITY RESPONSIBILITY
      - OFFENCE ACCOUNT

- WORK
  - EDUCATION
  - LEISURE ACTIVITIES
  - CORE CREATIVE PSYCHOTHERAPIES
Residents arrive carrying their past experiences
- From home life
- From school
- From chaotic lifestyle
- From offending history
- Of the index offence itself

Need to process all of these emotions within the living-learning environment of a TC
Abuse history (current population)

- 50% report self-harm history
- 52% Report history of physical abuse
- 32% Report history of sexual abuse
- 69% report loss of or separation from a primary care giver
Vicarious traumatisation

• The impact on the therapist as a result of empathising with the clients traumatic material (McManus 2010) known as ‘vicarious trauma’ (Pearlman & Saakvitne 1995) empathising with the trauma experienced by clients. How is this different for group members?

• Tolerating the intolerable
Impact on the therapists

Consistently across studies between a fifth and a quarter of facilitators report (Farrenkopf, 1992;) negative effects broadly divided into:

- Cognitive
- Emotional
- Behavioural
- Impact on family life
Some General Stressors of Facilitating Groups

- Working in a prison environment (Freeman-Longo, 1997) similarly causes stress to residents
- Lack of public understanding of the role and having to justify career choice (Brodsky, 1977, McManus 2010): residents challenged by peers for opting for therapy
- Working as a therapist exposes practitioner to emotions of others e.g., suicidal statements/actions, expressions of anger towards the therapist (Deutsch, 1984); likewise residents have such projections
- Feeling unable to speak of therapeutic work to friends and family (Farber, 1983), similar to residents
- Dual role of therapist/officer (McManus 2010): residents find shift in beliefs uncomfortable
Stressors continued

• Facing challenges from friends/colleagues who work with victims of crime (Ellerby, 1997): Residents speak of guilt they feel at receiving support when victims/family do not

• Conflict of providing therapy to those who have committed violent and/or sexual offences (Akerman, 2010; McManus 2010): Residents have to challenge their views of others while challenging their own views

• Prison officers having to complete frontline work with client group which may include confrontation (Launay and Miller, 1989): residents likewise face confrontation of their own and others beliefs
Impact on group members

- **Cognitive** - challenging long held beliefs
- **Emotional** - experiencing long-repressed emotions - also those of others
- **Behavioural** - learning put into words not actions
- **Family** - some families still offending/or fear what is being spoken about in therapy
• Emotions (hurt, pain, rage, despair, sadness) that have previously been defended against, stunted, or acted out in offending are re-experienced and processed in a safe environment.
• Discussion of subjects that are more difficult to explore, such as sexual feelings, masturbation, violent fantasies are encouraged in a sensitive manner.
• Therapy is often the longest relationship they have ever had and survived the turmoil and conflict rather than leaving as has been the pattern of behaviour in the past.
• Learning to bear their own shame guilt, horror, repulsion, remorse helps them empathise with others and tolerate their material.
How is it different/similar for group members

Many community members have been involved in offending behaviour work for a number of years. How do they manage the material?
Tolerating the intolerable

• Focus group method

• Less threatening and useful for discussing perceptions, opinions and thoughts (Krueger & Casey, 2000)

• Enables exploration of complex research as a precursor to quantitative research (Lunt, 1996)
Tolerating the intolerable

- Experiential group within a conference held at HMP Grendon in April 2015
- Participants: male violent and sexual offenders, >25 years
- Prisoners $n = 10$; Wing Therapists $n = 2$
- Ethical considerations
- Data analysed using thematic analysis (Braun & Clark, 2006)
Three main themes

• Types of material that affect residents during therapy

• Impact of the material on group members

• How to manage it
Material that has an impact

1. Reflecting on own past experiences/Previous Trauma

“Before Grendon I was a victim of domestic violence...on hearing it in group it riles me up.”

“Talking about being victimised in [the] past is difficult to tolerate”
Material that has an impact

2. Hearing others offence histories

• “It’s difficult managing hearing others’ offence[s]… it’s linked to criminal values…not being able to handle it…leads to little outbursts”

• “[I] struggle with hearing others [stories] I can link in [with]. Feel like they’re talking about my past, my history, my offending. Constantly reminded of what I’ve done by listening to others. [It’s] never easy
Material that has an impact

3. Reflecting on own offending
   • “Tolerating own material and work. [it’s] hard. When your understanding increased it is a bitter pill to swallow”

4. New experiences
   • “I find it hard to tolerate good feelings and feeling good about myself”
Impact of material on the individual

1. Facing reality - Guilt; Shame; Self loathing;
   Acknowledging unpleasant aspects of self;
   Recognising self in others

   • “.I couldn’t admit to myself what I’d done. When I faced reality
     by being arrested I wanted to cut my throat.”

   • “When someone with a similar offence went through their
     offence I didn’t see how their offence was similar to mine. We
     had a difficult relationship. I realised I saw myself in him. I
     realised that I wasn’t angry with him, I was angry with me”

   • “Feeling shit about what I’ve done allows me to work through
     it”
Impact of material on the individual

2. Feeling vulnerable; exposed; judged
   - “I know everyone’s sitting there judging me, hating me. I hate myself.”
   - “Sometimes wake up feeling good, go to group and feel depressed for two weeks”
   - “Sitting in the grey area - it felt like I wasn’t doing enough. It was burning me out, doing my head in”

3. Aggression:
   - “I want to attack”
Impact of material on the individual

4. Enmeshed in others material

- When I connect with others and hear their stories, this is intolerable. It’s intolerable as I can link in with it.”

- “Sometimes I get caught up in other people’s stuff”

- “Listening to others is a struggle itself, you don’t want to hear it”
How to manage it

1. Comparing self to others

- “I felt my past, my history, my offending was better than anyone else”

- “self-imposed hierarchy of ‘he’s worse than me’”
How to manage it

2. Understanding why it affect me
   • “I realised that my previous aggressive behaviour was counter-transference of aggression... I viewed my victim as my perpetrator”
   • “I recognised that I transferred all my stuff to others. It’s important to understand where it [negative emotions] come from”

3. Talking about feelings
   • “...talk about it. If I can admit feelings I can find out where they’ve come from and share them”
   • “It’s always about dialogue... [I] will always have strong desires to act out... surely this is the remedy, to speak about it”
How to manage it

4. Developing new skills

• “I try to think of more positive stuff… nice times with my family to distract me”

• “Trying to deal with things in a way I have never dealt with it, it’s alien”

• “Trying to push myself in different ways”
How to manage it

5. Trust/ acceptance
   - “It was the developing trust that makes me feel safe. I could not do it without that trust”

6. Shared experiences
   - “What makes it tolerable is people going through it with you”

7. Healthy detachment
   - “Sometimes it’s good to detach yourself. I try to look from outside the box and see exactly what’s going on”
How to manage it

8. Motivation:

• “My family spurs me on and motivates me”
• “[This is].. part of my transition of who I want to become”

9. Food/Humour

• “Some people use food or have a laugh about it, make a joke about it. When things become difficult I think how can I make it funny”
Reflections

• Group members process transference and counter-transference in much the same way that staff do.

• Residents may also experience vicarious traumatisation.

• The residents described many of therapeutic factors outlined by Yalom (1995) as helpful, i.e., Universality; Altruism; Instillation of Hope.
How do we support group members to process this material?

- Validate this experience
- Explore why it may be affecting your client
- Formulate how this links to their offending and/or past experiences
- Are there any parallel behaviours that the client is engaging in? (e.g. using food to self-soothe)
- Adopt strengths based approach when material is becoming overwhelming
Reflections

Strengths

• Unexplored area of research
• Use of “free association” limits the bias that predetermined questions can have on research (Boddy 2005)

Limitations

• Generalisability
• Impact of observers on quality of data?
• Is talk the only way to cope with toxic material?
Future Directions

• Need to consider this within research given the impact therapy can have on clients

• Further research using groups to develop theme/theory

• Individual data
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If you would like to visit HMP Grendon

We have regular open afternoons and you would be welcome to attend:

September 10th 2015  Thursday Social Event  A
September 17th 2015  Thursday Social Event  D
October 22nd 2015  Thursday Social Event  B
November 5th 2015  Thursday Social Event  F (TC+)
November 26th 2015  Thursday Social Event  C

Contact any of the presenters in person or via email
Reductions in symptoms of post-traumatic stress following treatment in a therapeutic community prison

Richard Shuker
HMP Grendon
Dr Michelle Newberry
Sheffield University

Division of Forensic Psychology Annual Conference
Manchester Metropolitan University
1st – 3rd July 2015
Aims

• To assess prevalence of symptoms of post traumatic stress in a prison sample
• To explore whether forensic therapeutic communities are effective in treatment symptoms of trauma and PTSD
• To examine whether any personality or psycho social variables influence change
• To consider the relevance of TCs as an intervention for trauma and PTSD
Therapeutic Communities

• Origins from traditions of social psychiatry
• Refers to the culture within which treatment is delivered
• Attachment & belonging, safety and emotional containment, communication, full participation and empowerment
• Early TCs found to be effective in addressing trauma
Why of interest to us?

• High number of referrals report a primary reason for referral being to resolve distressing childhood experiences (Shine, 2000)
• 60% of population report history of physical abuse
• 40% report history of sexual abuse
• 69% loss or separation from key care giver
Previous research at HMP Grendon (Shuker & Kennedy 2012)
• 70% experienced clinical significant traumatisation
• 52% clinically significant levels of trauma re-experiencing
• 48% clinically significant levels of post traumatic stress
• 48% post traumatic impairment
• Negative relationship between levels of trauma and offence risk (OGRS)
• Post traumatic stress & severity of symptoms associated with certain thinking styles, particularly self-directed hostility & guilt
Why relevant....

• Gray et al. 33% forensic sample met diagnostic criteria for PTSD & 54% had significant PTSD symptomatology

• Lifetime posttraumatic stress disorder (PTSD) - rates of 67% have been found among young women in custody (Cauffman et al., 1998)
Trauma and risk - Overview

- Seems to be a well established connection between early adversity & aggressive behaviour
  Repeated experiences to threat & harm have an impact on functioning of the brain over time
- Child abuse & neglect – both associated with impaired cognition & academic functioning (Mills et al 2011)
- Exposure to violence results in pervasive psychological, affective and cognitive/learning deficits (Streeck-Fischer et al)
- Neurobiological development – abuse related to abnormal development in amygdala
Trauma and risk (cont)

- Violent men convicted for domestic violence reported significantly higher levels of PTSD symptoms *Dutton* (1995)
- Non clinical samples – those with PTSD symptoms report elevated symptoms of aggression, hostility and anger *Jakupcak* (2005)
- Aversive childhood experiences feature in SRA tools *i.e.* *HCR 20*
- ‘Sexually abused – sexual abuser’ hypothesis – association between experience of childhood sexual abuse & later sexual offending
- Sex offenders more likely to have been sexually abused than non sex offenders – *Jesperson* 2008
Suggested links between trauma & offending

- Primary trauma is a stressor which triggers maladaptive coping ie substance misuse
- Trauma & neurobiological abnormality
- PTSD – vulnerability to reactive aggression
- Abuse - insecure attachment – relating difficulties - offending
- Negative self concept leading to reckless, self defeating and irresponsible behaviour
- Hostile/hypervigilant appraisals leading to violent responding
Method. Measures 1

- Detailed Assessment of Posttraumatic Stress (DAPS)
  - 104-item test of trauma exposure and posttraumatic response
  - 2 validity scales
  - Measures trauma-relevant parameters;
    - Lifetime exposure to traumatic events,
    - Immediate cognitive, emotional and dissociative responses to specified trauma
    - Symptoms of Post Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD; DSM-IV-TR, APA, 2000)
    - Likelihood of PTSD or ASD diagnosis
    - Associated features of PTSD; posttraumatic dissociation, suicidal thoughts/behaviours and substance abuse
Demographic Characteristics

- $N = 150$
- Mean age on admission = 36.61 ($SD = 9.85$, range 21 to 69)
- Predominantly White British
  - 75.3% White British
  - 13.4% Black
  - 6.7% Mixed ethnicity
  - 4.6% Asian
- 92.0% life sentence and 8.0% determinate sentence
- Mean OGRS-3 score for risk of reconviction for any offence within 2 years = 46.87 ($SD = 24.25$, range 4 to 89)
## Change in DAPS Trauma scale scores
### 0-9, 0-18 and 9-18 mths

<table>
<thead>
<tr>
<th>DAPS Scale</th>
<th>0-9 mths</th>
<th>0-18 mths</th>
<th>9-18 mths</th>
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<tbody>
<tr>
<td>Trauma Exposure</td>
<td>-.44</td>
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<td>-2.64**</td>
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<td>-.14</td>
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<td>Peritraumatic Dissociation</td>
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<td>2.03*</td>
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<tr>
<td>Re-Experiencing</td>
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<td>Avoidance</td>
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<td>2.82**</td>
<td>1.20</td>
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<tr>
<td>Hyper Arousal</td>
<td>1.95*</td>
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<td>.74</td>
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<td>Post-Traumatic Stress</td>
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<td>Post-Traumatic Impairment</td>
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<td>Acute Stress Disorder</td>
<td>1.99*</td>
<td>2.18*</td>
<td>1.03</td>
</tr>
</tbody>
</table>

* *p < .05; ** *p < .01
Change in DAPS trauma scores

• Of the 13 DAPS scales there was significant change on:
  – 6 scales at 0-9 mths
  – 9 scales at 0-18 mths
  – 1 scale at 9-18 mths

• Suggests that 18 mths important for significant change
  – Consistent with previous literature which has shown that 18 months + in treatment is important in terms of a therapeutic career (Genders & Player, 1995; Taylor 2000; Shuker & Newton, 2007)
Correlations between variables

Strong significant correlations between the following DAPS scales and personality variables at 0 months ($p < .01$):

- Trauma Specific Dissociation + Negative Impression Management ($r = .57$)
- Trauma Specific Dissociation + Anxiety ($r = .53$) + Anxiety-Related Disorders ($r = .50$)
- Trauma Specific Dissociation + Depression ($r = .55$) + Suicide ($r = .57$)
- Trauma Specific Dissociation + Schizophrenia ($r = .54$)
- Re-Experiencing + Anxiety Related Disorders ($r = .52$)
- Re-Experiencing + Depression ($r = .50$) + Suicide ($r = .55$)
- Hyper Arousal + Anxiety ($r = .50$), Anxiety Related Disorders ($r = .52$)
- Hyper Arousal + Suicide ($r = .50$)
- Suicide + Depression ($r = .56$) + PAI Suicide ($r = .58$).
- Avoidance + Suicide ($r = .55$).
- Post-Traumatic Stress + Suicide ($r = .51$)
- Post-Traumatic Impairment + Suicide ($r = .51$)

- Also a number of significant moderate correlations between 12 of the 13 DAPS trauma scales and PAI scales.
Correlations between variables

- To summarise, there were strong significant correlations between 7 of the DAPS scales and 6 of the PAI scales at 0 months ($r = .50$ or above at $p < .01$):
  - Trauma Specific Dissociation, Re-Experiencing, Hyper Arousal, Avoidance, Post Traumatic Stress, Post Traumatic Impairment, and:
  - Negative Impression Management, Schizophrenia, Anxiety, Anxiety Related Disorders, Depression, Suicide
Correlations between total trauma and other variables

- Strong significant positive correlations between composite scores of total trauma at 0 months and total trauma at 18 months ($r = .61$, $p < .01$)
- Strong significant positive correlations between total trauma at 0 months and:
  - Suicidal Ideation ($r = .57$)
  - Anxiety-Related Disorders ($r = .54$)
  - Depression ($r = .54$)
  - Anxiety ($r = .53$)
  - Negative Impression Management ($r = .50$)
- as well as total trauma at 18 months and Suicidal Ideation ($r = .57$)
Mediational analysis

- Total effect between total trauma at 0 months and 18 months: $r = .61, p < .01$
- Explored whether any of the 31 personality/psychosocial/risk variables influenced reductions in trauma between 0 and 18 months
- 21 variables analysed using mediational analyses (Baron & Kenny, 1986)
- 11 had a significant indirect effect on the relationship between total trauma at 0 months and 18 months:
  - Suicidal Ideation
  - Depression
  - Anxiety + Anxiety Related Disorders
  - Negative Impression Management
  - Neuroticism
  - Schizophrenia
  - Somatic Complaints
  - Mania
  - Borderline Features
  - Treatment rejection
Conclusions

• Reductions in trauma occur - usually following 18mths in treatment

• Significant co-morbidity with other conditions

• Factors correlated with high levels of trauma post treatment – hostility, anxiety, ‘criminality’, borderline features, low motivation, somatic complaints
Conclusions

- Suggests factors which are associated with less likelihood of change – suicide, anxiety, depression, borderline traits, negative impression management
Conclusions

• How does TC treatment address trauma?
• Safety for emotional containment
• Element of sharing/disclosing, ‘reliving’ traumatic experiences
• Support to work through avoidant coping
• Developing secure attachment
• Disconfirming negative self appraisals
• Develop coping skills
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