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Ethical challenges in working with trauma needs in secure services

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Why do we need to consider ethical challenges in working with trauma needs in secure services

- Exposure to adverse or traumatic events, especially in childhood, is highly prevalent in those who come into contact with the CJS
  - This relationship is dose responsive
  - This figure increases in populations who are particularly marginalised

- Rates of PTSD and CPTSD are also elevated in CJS populations

- Moreover, there is an association between PTSD symptomatology, including severity of offending and when controlling exposure to the number of adversities with offending behaviour

- There ***may be*** association between PTSD symptoms and the risk of recidivism -
  - non significant relationship when the following are considered
    - criminogenic needs
    - Generalised anxiety

- Forensic services pose an unexhaustive list of ethical challenges, which can lead to
  - Nihilism - I can't change the system
  - Externalised focus for ethical challenges - "Its the system.. not my practice" - but what are our responsibilities?
  - Do we reflect on our own practice?

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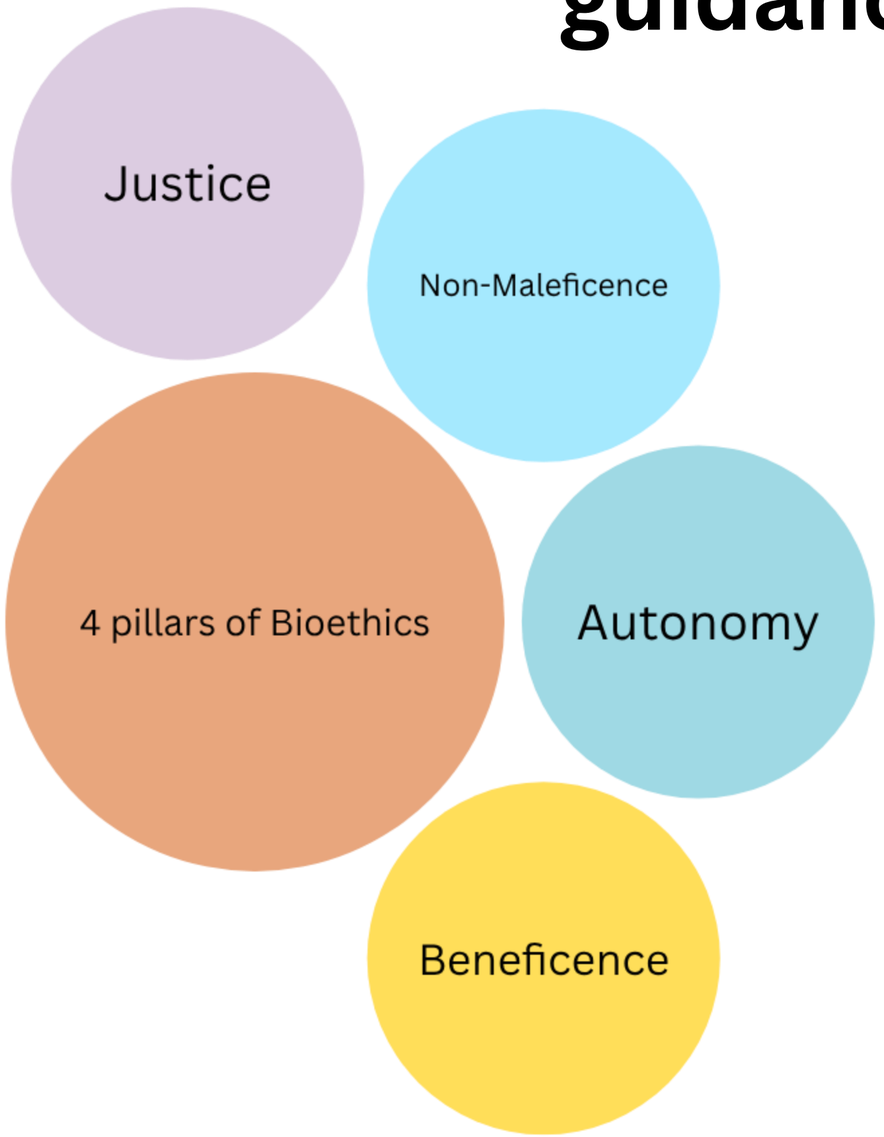
In the first instance Ethics and practice guidance:



APA additional considerations: , Fidelity, Integrity, and Respect for People's Rights & Dignity

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Ethical debates: Trauma focused care in secure services

Limited efficacy of treatments

limited evidence for TIC models

high rates of drop out from treatments

Harmful impacts of therapy

high rates of re emergence of symptoms following therapy

Efficacy of trauma interventions across different groups

Informed consent (Voluntarism)

limits of confidentiality

Conflicts of interest

Therapist competency

Professional Boundaries

Therapist wellbeing

using symptom reduction as evidence of treatment efficacy

Conceptual clarity of CPTSD, and its relationship with comorbidities and risk

Which adversities do we address in therapy

lack of investment in trauma responsive structures in secure services

Replication of early harmful environments

therapy may extend or delay discharge, or it may accelerate it

Positioning trauma therapy as risk reduction therapy

Service users being moved mid therapy

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Ethical challenges: This presentation - focusing on what we can change

What types of adversity we consider and assess for in our practice

Which (childhood) traumas / adversities count?

Therapeutic considerations

How we position the relationship between trauma therapy and offending behaviour

Iatrogenic impacts of trauma therapy


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Which (childhood) adversities are we curious and attentive to in Secure services?

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Which traumas / adversities count and why does it matter (ethically)?

- Research both drives and mirrors our clinical practice
- We base our understanding on the types of trauma / early adversities people in secure care experience, on research finding
- What we prioritise for treatments and service frameworks is guided by research findings
- What we research has a significant impact on trauma practice, including in secure services and therapeutic input offered
- Assumption that our knowledge of trauma and the prevailing needs of forensic populations is based on an absence of bias and omissions in the literature
- Adverse or traumatic experiences explored within the literature are not inclusive especially of the experiences of neurodiverse, ethnic minority or displaced populations, and within this, some adversities are explored more than others

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Two recent reviews and meta-analyses of ACEs in secure services

- Two systematic reviews and Meta analyses recently explored the questions of what adversities are those in secure care exposed to and what are we researching
- Prison (Umpunjun, et al., 2024) 50 papers (N=48,648)
- Forensic settings (Webb et al., 2025) 19 papers (N=16,353) - most studies were low quality

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Which traumas count?

Prevalence in Prison	ACE	Frequency rank Studied
38%	Emotional Neglect	4
36%	Parental Seperation	10
36%	Intimate Partner violence	7
36%	Household Substance Use	6
36%	Physical Abuse	2
34%	Parental Incarceration	7
32%	Emotional abuse	3
28%	Physical Neglect	5
12%	Sexual Abuse	1
10%	Household Mental Illness	8

Prevalence in Forensic Services	ACE	Frequency rank studied
51.9%	Parental Seperation	10
42.7%	Emotional Neglect	4
38.6%	Household substance use	4
38%	Physical Abuse	2
28.3%	Emotional Abuse	3
26%	Household mental illness	8
25%	Sexual Abuse	1
20%	Physical Neglect	4
18.1%	Intimate Partner violence	4
11.2%	Parental Incarceration	8

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What does this mean?

- There is a discordance in what people experience and what we chose to study… what we are curious about…
- We focus significantly more on exploring direct (Abuse) ACEs than neglect and household ACEs
- Is parental separation so ‘normalised’ that we no longer consider it pernicious and explore comparatively less?
- We ‘over study’ the least prevalent ACEs and ‘neglect’ the most likely ACEs to be experienced
- How does this translate and impact on clinical practice?
  - Service models
  - Assessment
  - Intervention (design and priorities)
  - Psychoeducation
  - Staff training
  - Are we ‘missing’ or not noticing the symptoms / sequalae or impacts of neglect or household adversities as they mall fall outside of classic PTSD symptomatology

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Relevance to the care we provide

Prevalence of exposure to different ACEs of males in forensic services

- 51.9% Parental Separation
- 42.7% Emotional Neglect
- 38.6% Household Substance misuse
- 38.0% Physical Abuse
- 38.3% Emotional Abuse
- 26.0% Household mental Illness

Ward environments

- high turnover of staff and use of agency and locum staff ‘lean models’ of working
- Lack of consistency and provision in clinical supervision
- Witnessing substance misuse or witnessing reliance on PRN
- Peers and professionals
- Peers, professionals and family members?
- Witnessing the distress and mental health problems of peers

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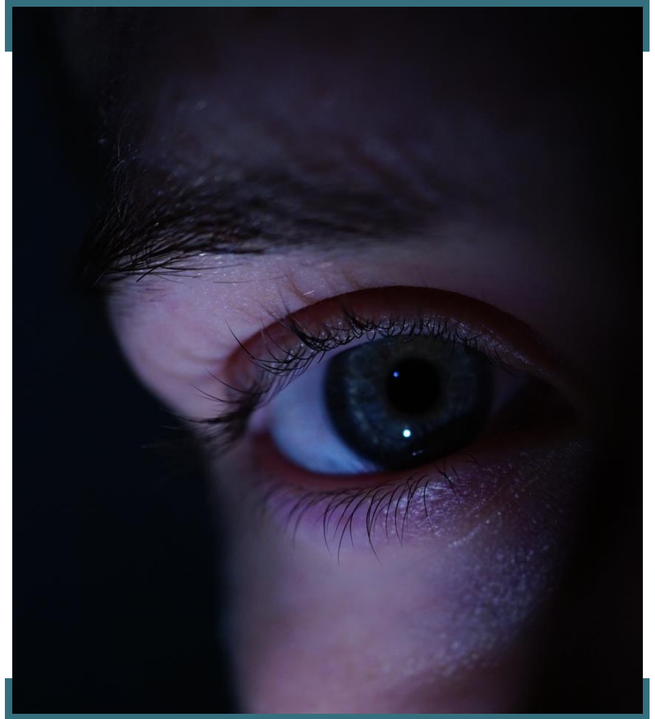
Which traumas count: Lets go a little deeper…



- what drives our focus on direct abuse, especially sexual abuse
- What drives our lack of focus on household adversities
- What drives our lack of focus on neglect
- What would be different in our systems and therapies if we widened our lens from direct harms to neglect and household harms?

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The impact of neglecting emotional neglect & how to counter this

Impact of neglect

- Emotional neglect is an interpersonal experience strongly associated and predicts
  - Mental Health
    - Depression
    - Anxiety
    - Eating disorders (53% recent MA)
    - generalised emotional regulation difficulties
    - Interpersonal difficulties
    - Negative sense of self
    - Problems with attachments
  - Physical Health
    - Cardio Vascular Disease
    - Obesity
    - Diabetes
    - Inflammation
    - Reduced health protective behaviours

Countering bias

- Building curiosity about own relationships with adversity
- Neglect may not manifest in ‘classic’ PTSD symptoms - hence the impact is easily missed
- Reflecting on what we prioritise in assessments
  - Consider using emotional neglect interviews / questionnaires to build up a formulation
  - Consider introducing models that address emotional neglect in service models or individual therapy (CBP, Grossman et al, 2017)
  - 1. Name and acknowledge emotional neglect / debasement and its impact (life narrative), sense of self and social identity (strengths based)
  - 2. Acknowledging the power and position of the therapist and their identity (Giving therapy a strong relational context and approach)
  - 3. work on emotional regulation (emphasis on the content of emotions, especially shame / guilt) and navigating relationships
  - 4. Working with dissociation

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How we position the efficacy / impact of trauma therapy in secure services

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How we position the efficacy / impact of trauma therapy in secure services

Trauma therapies are increasingly being positioned as addressing criminogenic needs, including in legal forums: Two key areas of significance

1.**Trauma therapies being 'mandated' for discharge** -
"The service user must complete trauma therapy to be eligible for parole / discharge"

2. Trauma therapies have risk reductive qualities

"Completing trauma therapy has reduced the risk of re offending"

"By completing trauma therapy they have addressed their risks"

"No other treatment to address risk is needed as trauma work has been completed"

"addressing his childhood sexual abuse has reduced the risk of sexual re offending"

"The ITQ scores falling below the clinical cut off show that therapy has been successful and the risk of future sexual offending has been reduced"

The relationship between childhood trauma and sexual offending is highly complex

- For trauma therapies to have risk reductive qualities a number of assumptions need to be confirmed
  - There is a relationship between sexual abuse and offending behaviour (for that individual)
  - That there is a relationship between sexual abuse and *that specific* individuals PTSD / CPTSD needs
  - That PTSD / CPTSD needs mirror / map onto factors / mechanisms that account for the relationship between trauma exposure and risk of offending
  - That reducing PTSD / CPTSD symptoms leads to a reduction of risk

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Do trauma therapies address the mechanisms / factors accounting for this relationship

- Is there evidence to support that trauma therapies addresses criminogenic needs or mechanisms that account for the relationship between CSA and sexual offending?

Hypothesised mechanisms of the pathway between childhood sexual abuse and Sexual offending (Mann et al, 2010)

- Sexual pre-occupation
- Sexual preferences
- Sexualised violence
- Paraphilic interests
- Resistance to rules
- Lack of emotionally intimate relationships with adults
- Hostile beliefs about specific demographic groups (e.g. Women)
- Offence supportive cognitions/ beliefs
- Lack of concern for others / callousness
- Lack of empathy
- Hostility (cognitions, emotions and behaviours)
- Sexualised coping
- Poor problem solving
- Negative social influences

- Do trauma therapies address these needs?
- Do trauma therapies evaluate changes in these needs in clinical trials?
- Do individual therapists evaluate changes in these areas of need for their patients?
- Are these conclusions assumptive, rather than driven by evidence?
  - addressing PTSD symptomatology reduces future risk
  - ‘processing own abuse experiences reduces future risk’

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Some key questions

If childhood adversity, rather than PTSD symptoms consistently predict offending and possibly re offending, should we prioritise PTSD (trauma) treatments as the our intervention priority to address the wider impacts of childhood adversity?

Trauma treatments are generally focused on processing specific events.... some adversities are not discreet events... such as neglect, parental separation, parental mental illness.. and not directly addressed all many trauma therapies

Key question: Are trauma treatments the most effective (and ethical) way of addressing this need? are we over stating the evidence for trauma therapies

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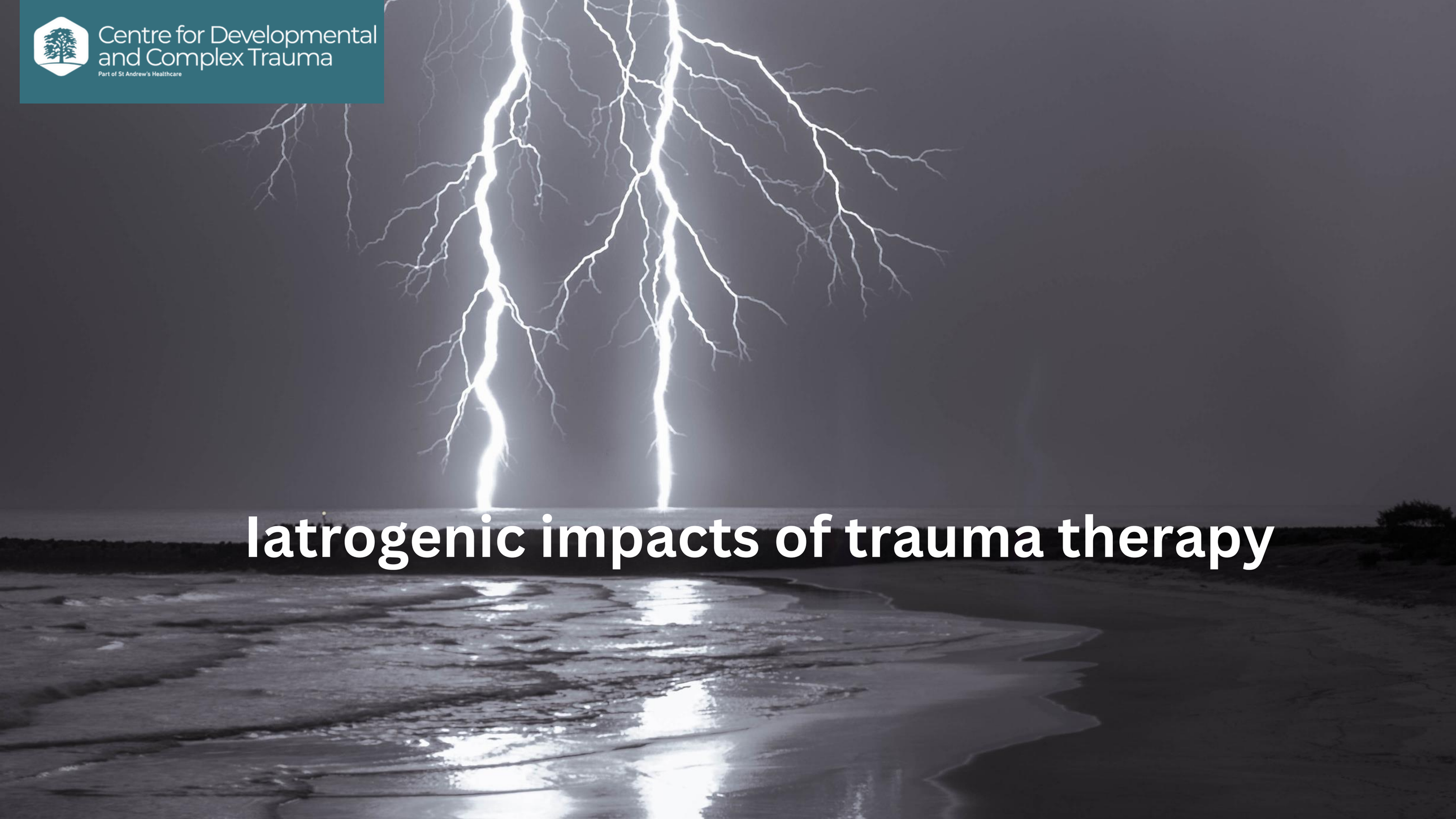
A quick poll!

Poll Questions

1. Does trauma therapy, in itself, reduce the risk of re offending?

2. Does trauma therapy replace the need for therapeutic work focused on criminogenic needs / risks

Add your comments in chat!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Iatrogenic impacts of trauma therapy

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Iatrogenic impacts of trauma therapy

What are iatrogenic effects of trauma therapy?

- McKay & Jensen-Doss (2021) - review
  - Deterioration of functioning
  - Deterioration of symptoms (including exacerbation of distress)
  - Drop out rates
  - Draining the financial and emotional resources of service users (Dimijidjian & Hollan, 2010)
  - False memories - false allegations of abuse (impact on familial relationships)

- APA review concluded that psychological treatments for trauma, have a overall higher level of burdens compared to pharmacological treatments
  - Homework tasks - especially exposure based therapies
  - length of therapy

- Data relating to adverse outcomes of trauma therapies largely stems from research trials, rather than 'practice as usual' and reflects clinician lens, not service user feedback

- Data also only typically records ***acute*** harms rather than longer term impacts

- Psychological therapies are generally poor at researching and sharing potential iatrogenic outcomes (only in 5 RCTS report AE's)

Significant gaps in our knowledge about the iatrogenic impacts of trauma therapy

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Iatrogenic impacts of trauma therapy

- Yet, for service users to provide informed consent, information about likely outcomes is needed

- Several trauma therapies e.g. exposure therapies have ‘conditional’ recommendations from the APA due to the risk of distress and require clear informed consent

- **Iatrogenic impacts may arise from**
  - poor fidelity to treatment models
  - Clinician specific behaviours - interpersonal behaviours
  - Deviating from standard protocols
  - Miss application of evidence

- **Unintended or not anticipated outcomes**
  - Possible that adverse outcomes may arise from appropriately delivered therapies by appropriately trained therapists

Key question: Could successfully or unsuccessfully completing trauma focused therapy increase the risk of re offending? - Answer: we don’t have the data

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Iatrogenic impacts of trauma therapy in secure services?

- Relevant factors to contextualise secure services specific risks
  - Many have already had 'unsuccessful attempts at engaging in therapy
  - Trauma therapy seeks to
    - Overcome avoidance (internal, external and relational)
    - Increase in relational skills / confidence
    - Reduces impulsivity / address negative sense of self (impact of sense of self)
    - The impact of doing so on wider personality or risk variables has not been quantified
  - Can these changes lead to the emergence of symptoms / needs that were previously overshadowed?

- Extended length of admission - due to the length of therapy
- ?Increased risk of institutional aggression in the context of increased distress
- The consequences of acknowledging, processing and accepting of sexual preferences
  - Increased risk of anti-libido medication / monitoring being suggested
  - Impact on discharge (parole / tribunal)

- Iatrogenic impacts influenced by co existing needs
  - Personality disorder
  - Paraphilias / Sexual Attraction to children

- Are there additional or differential risks to therapists in secure services, especially when working on PTSD arising from ones own actions (Autogenic PTSD) -distress and boundary violations?

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Iatrogenic impacts of trauma therapy

Individual / service level practice: Gaining informed consent

- **Practicing TIC principles: Safety and Trustworthy / transparency**
  - Balance of benefits vs harms / burdens
  - Different treatments and their evidence base (including potential harms)
  - give greater focus to Quality of life / functional when sharing information about the impact of therapy
  - Impact on comorbid presentations (70% of those with PTSD have at least one co existing mental health need)
  - and potential emergence of previously hidden needs and the potential re emergence of trauma symptoms
  - Be open about your own expertise
  - Discuss / review the therapeutic relationship
  - **Stick to the evidence base**

Recording Iatrogenic impacts of therapy

- Make a commitment to record and report therapeutic outcomes (individual and service level)
- Drop out / non complete rates
- Fidelity in the delivery of therapy
- Record Adverse Events
- changes in
  - Symptom patterns
  - Levels of distress

- Functional impact
- Time impacts of homework
- Financial impact
- Familial relationships
- Systematic recording of service user feedback data to plan, design and monitor iatrogenic impacts and progress and experiences of trauma therapy

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Summary

- Secure settings provide for ethical challenges, both related to our systems and to our own practice
- Whilst influencing systems can be challenging, we can address some ethical challenges through our own practice, in particular through being reflective and curious about the range of experiences our service users experience
- There is a discordance in the types of adversity we focus on and the adversities that are most commonly experienced. In doing so we an risk re enacting these traumas
- Positively we can address these challenges in our own practice
- Greater work is needed in understanding the relationship between trauma work and risk of re offending to ensure that we are not acting outside of the evidence base
- Equally we have some sense of the iatrogenic impacts that trauma therapy can generate and, in ensuring we secure informed consent to treat, that we are open about this and use this process to embody the principles of trauma informed care

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