Psychological Trauma: Theory, Research, Practice, and Policy

What does Trauma-Informed Care Mean to People Admitted to a Forensic Mental Health and Intellectual disability Service? A Reflexive Thematic Analysis

--Manuscript Draft--

Manuscript Number:	TRA-2022-3378R2
Full Title:	What does Trauma-Informed Care Mean to People Admitted to a Forensic Mental Health and Intellectual disability Service? A Reflexive Thematic Analysis
Article Type:	Article (unmasked)
Corresponding Author:	Eavan McKenzie, Professional Doctorate in Forensic Psychology Kent and Medway NHS and Social Care Partnership Trust Kent, UNITED KINGDOM
Keywords:	Trauma-Informed Care; secure service; intellectual disability; positive adaptation after trauma; secure attachment
Corresponding Author Secondary Information:	
Corresponding Author's Institution:	Kent and Medway NHS and Social Care Partnership Trust
Corresponding Author's Secondary Institution:	
First Author:	Eavan McKenzie, Professional Doctorate in Forensic Psychology
First Author Secondary Information:	
Order of Authors:	Eavan McKenzie, Professional Doctorate in Forensic Psychology
	Dr Alethea Charlton, Doctorate in Clinical Psychology
Order of Authors Secondary Information:	
Manuscript Region of Origin:	UNITED KINGDOM
Abstract:	Objective: Driven by research demonstrating the pervasiveness of trauma, forensic mental health and intellectual disability services are increasingly adopting a trauma-informed approach to caring for patients. However, there has been limited attention to exploring what trauma-informed care means to patients in these settings and what practices enable or restrict them in adapting positively after experiences of trauma. This study aimed to understand how trauma-informed care is conceptualised by people admitted to a forensic mental health and intellectual disability service. Method: Focus groups were facilitated with 10 people residing in three low secure hospitals in the South East of England. Focus groups explored participants' perceptions and experiences of trauma-informed care with reference to Fallot and Harris' guiding principles of safety, trustworthiness, choice, collaboration, and empowerment. Audio recordings of the focus groups were transcribed and analysed using reflexive thematic analysis. Results: Three themes were generated to capture participants' perceptions that a trauma-informed approach in a forensic mental health and intellectual disability service should entail promoting a sense of safety, fostering a sense of belonging, and encouraging the development of an autonomous identity. Conclusions: The findings indicate that prioritising social-interpersonal relationships is crucial to providing care that enables people admitted to forensic mental health and intellectual disability services to adapt positively after experiences of trauma. The findings support previous research regarding recovery in secure settings, indicating the value of creating sufficiently safe conditions for people to connect with others and develop a positive and independent sense of self.

Powered by Editorial Manager® and ProduXion Manager® from Aries Systems Corporation

 Click here to access/download;Response to Reviewers (without author information);Response to reviewer #5.docx

Dear Reviewer #5,

Thank you for taking the time to review our revised transcript to Psychological Trauma, Theory, Research, Practice and Policy. We are pleased that our work will be accepted for publication. We hope that we have addressed your outstanding question below.

'Most of the suggestions and questions are sufficiently addressed. Thank you for all the effort and sharing great work. Although, I don't think that the authors addressed my question about- that the findings seem to reflect "general" well-known themes of trauma informed care and it is hard to find unique themes that come from people in FID units. Including this discussion may enhance originality of this work.'

We feel that we have addressed your question in the following ways;

1. As we have explained in the Analysis section (page 9), we used both an inductive and deductive approach to data analysis. An inductive approach was used to explore participants' perceptions of the practices that enable or restrict people to adapt positively after experiences of trauma, while a deductive approach was used to explore what the guiding principles of TIC mean to participants and how they experience them. Using a deductive approach to explore what the guiding principles of TIC mean to people in FID units may have contributed to the findings reflecting general well-known themes of TIC.

2. As we have acknowledged in the Discussion section (page 19), the methodology of the study potentially contributed to the findings reflecting general well-known themes of TIC. It is acknowledged that a significant portion of each focus group was spent discussing the guiding principles of TIC. This is likely to have occurred for several reasons. Firstly, the units where the study took place were not considered trauma-informed. Thus, the focus group is likely to have been participants' first introduction to TIC, and those with ID found it difficult to grasp the abstract nature of it. Additionally, two of the research questions focused explicitly on participants' perceptions and experiences of the principles of TIC. These factors led to some premature bounding of the focus group discussions to a rather narrow focus, limiting exploration of participants' experiences of TIC outside of these principles. Introducing the participants to the concept of TIC prior to the focus groups would have allowed more time for exploration of their experiences of TIC outside of pre-existing principles. The focus group guide utilised the original conceptualisation of TIC by Fallot and Harris (2009) because it is well-established in both theory and practice. The authors acknowledge that SAMHSA (2014) conceptualises TIC slightly differently and incorporates the principles of peer support, and cultural, historical and gender issues. Although not included in the conceptualisation of TIC used in the focus groups, these principles were clearly relevant to participants because they are reflected in the themes generated in this study. Reducing the length of time discussing the principles of TIC, explicitly acknowledging other conceptualisations of TIC, extending the length of the focus groups or facilitating further focus groups may have been beneficial.

3. Data from the focus groups were analysed using reflexive thematic analysis (RTA) to facilitate flexible exploration of participants' experiences of TIC in FID services. Thus, the themes reflect the experiences of people with ID, providing further evidence for the importance of using TIC principles in FID units. Our general discussion includes participants' suggestions for action to implement TIC in FID units.

Thank you again for taking the time to review our revised transcript.

Yours Sincerely,

Dr Eavan McKenzie and Dr Alethea Charlton

What does Trauma-Informed Care Mean to People Admitted to a Forensic Mental Health and Intellectual disability Service? A Reflexive Thematic Analysis

Dr Eavan McKenzie[1] and Dr Alethea Charlton[2]

[1] Forensic and Specialist Care Group, Kent and Medway NHS and Social Care Partnership Trust

[2]Department of Psychology, University of Southampton

Author Note

Eavan McKenzie https://orcid.org/0000-0002-3009-0647

Alethea Charlton https://orcid.org/0000-0002-4551-289X

We have no conflicts of interest to disclose.

Correspondence concerning this article should be addressed to Dr Eavan McKenzie, Forensic and Specialist Care Group, Kent and Medway NHS and Social Care Partnership Trust, Greenacres, Dartford, Kent, DA2 6PB, United Kingdom. Email: eavan.mckenzie@nhs.net

Manuscript

Abstract

Objective: Driven by research demonstrating the pervasiveness of trauma, forensic mental health and intellectual disability services are increasingly adopting a trauma-informed approach to caring for patients. However, there has been limited attention to exploring what trauma-informed care (TIC) means to patients in these settings and what practices enable or restrict them in adapting positively after experiences of trauma. This study aimed to understand how trauma-informed care is conceptualised by people admitted to a forensic mental health and intellectual disability service.

Method: Focus groups were facilitated with 10 people residing in three low secure units in the South East of England. Focus groups explored participants' perceptions and experiences of trauma-informed care with reference to the guiding principles of safety, trustworthiness, choice, collaboration, and empowerment. Audio recordings of the focus groups were transcribed and analysed using reflexive thematic analysis.

Results: Three themes were generated to capture participants' perceptions that a trauma-informed approach in a forensic mental health and intellectual disability service should entail promoting a sense of safety, fostering a sense of belonging, and encouraging the development of an autonomous identity.

Conclusions: The findings indicate that prioritising social-interpersonal relationships is crucial to providing care that enables people admitted to forensic mental health and intellectual disability services to adapt positively after experiences of trauma. The findings support previous research regarding recovery in secure services, indicating the value of creating sufficiently safe conditions for people to connect with others and develop a positive and independent sense of self.

Keywords: trauma-informed care, secure service, intellectual disability, positive adaptation after trauma, secure attachment

Clinical Impact Statement

The findings from this study indicate that, in order to adapt positively after trauma, people admitted to forensic services need to feel physically and emotionally safe, and have opportunities to connect with others and develop a positive and independent sense of self. Thus, environments that emphasise the role of attachment are likely to be effective in ameliorating the impact of trauma. Providing staff in forensic services regular opportunities to reflect and become cognizant of the ways in which they can incorporate the common factors of safe therapeutic relationships in their practice might enable them to engage with TIC more effectively.

What Does Trauma-Informed Care Mean to People Admitted to a Forensic Mental Health and Intellectual Disability Service? A Reflexive Thematic Analysis

Forensic mental health (FMH) units provide assessment and treatment to people who have been charged or convicted of a criminal offence and subsequently detained under the Mental Health Act (1983, 2007). Forensic intellectual disability (FID) units provide adapted assessment and treatment to people with intellectual disabilities (ID). Bertelli et al. (2016) define ID as "a group of developmental conditions characterised by a significant impairment of cognitive functions, which are associated with limitations of learning, adaptive behaviour and skills" (p. 2). People admitted to FMH and FID services have experienced trauma at a disproportionately higher rate than the general population (Mueser et al., 1998; Razza et al., 2011). In addition, a proportion of people admitted to FMH and FID services have experienced chronic trauma, contributed to by factors such as their diagnosis, disability, offences, and involvement with the criminal justice system (Kruppa et al., 1995). Definitions of trauma vary, but broadly, trauma results from "an event or series of events that are experienced as harmful or life threatening and that have lasting impacts on mental, physical, emotional and/or social well-being" (Substance Abuse and Mental Health Services Administration; SAMHSA, 2014, p.7). After exposure to a potentially traumatic event, some people develop symptoms associated with posttraumatic stress disorder (PTSD), including intrusion, avoidance of

thoughts and behaviours, negative changes in mood, and changes in arousal and reactivity. For some people, these symptoms meet the diagnostic criteria for PTSD, while others may develop symptoms of depression or anxiety, or be relatively unaffected (Needs, 2018). A person's response to a potentially traumatic event appears to depend largely on their unique psychobiological response, level of social support, and the meaning they ascribe to the event (Park, 2010; Van der Kolk, 2003). In addition, it can depend on whether they are exposed to interpersonal or non-interpersonal trauma, and single or multiple traumas (Ebert & Dyck, 2004). Exposure to multiple/sustained interpersonal trauma is often associated with more complex presentations. Recognising this, the 11th edition of the International Classification of Diseases (ICD-11; World Health Organisation, 2021) defined a new diagnosis of complex PTSD. This perspective is particularly relevant to forensic populations who have experienced chronic interpersonal trauma (Rogers & Law, 2010).

For people with trauma histories, admission to forensic services can cause further traumatisation. Trauma-informed ideas are novel and radical for many forensic services in the United Kingdom (UK). This is because they are in conflict with conventional practices, which include forcibly medicating, searching, restraining, secluding, and pressuring people to accept medication or engage in treatment. For some people, these practices can mirror the dynamics of a traumatic event, including pain, powerlessness, mistrust and confusion, which can lead people to re-experience the original traumatic event, either consciously or unconsciously (Sweeney et al., 2016). Admission to forensic services can be equally traumatic for people without histories of trauma exposure due to loss of autonomy; dislocation from support networks; and being victims or witnesses to violence, sexual violence and/or peer suicide attempts (Muskett, 2014). Furthermore, people working in forensic services may have trauma histories of their own. Rogers and Law (2010) suggest that if staff are experiencing symptoms related to a traumatic stress response (e.g., hyper-vigilance or high anxiety), it is unlikely that they will be able to develop and sustain an attuned, emotionally sensitive caregiving environment. A great deal has been written about potential therapeutic modalities that can offset or prevent replication of the dynamics of previous trauma through redesign of the social

climate (Muskett, 2014). There have been promising findings in environments where the entire regimen promotes good quality relationships between people admitted to services and people working in them, through careful consideration of safety, boundaries and belonging (Shuker, 2018). These core values stem from the notion of secure recovery (Drennan & Alred, 2012) and have been successfully adopted in therapeutic communities (TC) and psychologically informed planned environments (PIPE). Trauma-informed care (TIC) is an emerging framework which recognises the presence of trauma symptoms and acknowledges the role that trauma may play in a person's life (Jones, 2018). The original conceptualisation of TIC by Fallot and Harris (2009) includes the guiding principles of safety, trustworthiness, choice, collaboration and empowerment. The breadth of these principles makes TIC applicable to a range of health and social care settings. There exist two studies that have explored the experiences of people receiving TIC in health and social care settings using qualitative methods. One study, conducted by Kusmaul et al. (2019), interviewed people accessing agencies in the USA providing care to refugees, older adults, pregnant women, and people who use substances. Kusmaul et al.'s (2019) findings indicated that participants' experiences of TIC were shaped by their interactions with others, thus highlighting a social aspect of TIC. Although Kusmaul et al.'s (2019) findings extend our understanding of TIC from the perspective of people receiving it, the transferability of their findings is limited for a number of reasons. Firstly, the findings were derived from community services with which peoples' involvement was voluntary. Due to their detention under the Mental Health Act (MHA; 1983, 2007), peoples' admission to FMH and FID services is not voluntary. Therefore, peoples' experiences of TIC in these settings are likely to be different. Secondly, in order to protect their identity, Kusmaul et al. (2019) did not record their participants' demographic information. This is problematic because it limits the reader's ability to draw conclusions about the transferability of their findings. A second study, conducted by Isobel et al. (2020), utilised focus groups to explore TIC from the perspective of individuals who identified as current or previous recipients of care from public mental health services in Australia. Isobel et al. (2020) analysed their focus groups using thematic analysis. Their themes captured participants'

perceptions that TIC requires increased awareness of trauma amongst staff members, opportunities for people admitted to mental health services to collaborate in their care, active efforts by services to build trust and create safety, the provision of a diversity of models, and consistency and continuation of care. Isobel et al.’s (2020) findings present clear direction from previous recipients of care about what is required to progress TIC in public mental health services in Australia. However, similar to Kusmaul et al. (2019), Isobel et al. (2020) did not record their participants’ demographic information, which limits the reader’s ability to draw conclusions about the transferability of their findings. In addition, it is possible that cultural differences exist between mental health provision in Australia and the UK which further limits the transferability of their findings.

Despite some evidence that TIC has been operationalised in public health services in other countries, it remains an ideal rather than a reality in most forensic services in the UK. Auty et al.’s (2023) attempt to operationalise TIC in two UK prisons for women is both radical and disheartening. In describing their attempt, Auty et al. (2023) identify several challenges that impeded the successful operationalisation of TIC in the prisons. These include the presence of drugs, womens’ fear of victimisation, staff’s lack of confidence in providing emotional support, a troubled relationship between therapy and punishment, and an unclear definition of TIC. In addition, conventional practices in the prisons such as rigid rules, restrictive practices, lack of personal space, risk of violence, body searches, restraint and seclusion, the use of authority, and vicariously traumatised staff further impeded the operationalisation of TIC. Despite these challenges, Auty et al. (2023) conclude that adhering to the guiding principles of respect and humanity can improve staff-prisoner relationships. While the challenges and lessons identified by Auty et al. (2023) are extremely informative, they suggest that they may be specific to prisons for women due to the “exceptional rates of trauma that women bring into the environment, combined with the inherent features of imprisonment” (p. 734). Females represent around eighteen percent of the forensic psychiatric population in the UK (Tomlin et al., 2021), and there are gender differences related to the

prevalence, impact and treatment needs of trauma survivors (Kubiak et al., 2017). Therefore, it is unclear how transferable Auty et al.’s (2023) findings are to adult male forensic units.

The current study aimed to answer the following research questions;

1. What do the guiding principles of TIC mean to people admitted to a FMH and FID service?
2. How do people admitted to a FMH and FID service experience the guiding principles of TIC?
3. What practices in the FMH and FID service enable people to adapt positively after trauma?

Method

Ethical Approval

The study was approved by the NHS Health Research Authority (REC Ref: 19/LO/1359).

Design

The study used a qualitative method to construct meaning from people’s experience of TIC in a FMH and FID service. Focus groups were used to promote interaction among participants, allowing them to build on one another's responses and generate ideas that they might not have thought of in an individual interview. Data from the focus groups were analysed using reflexive thematic analysis (RTA). The authors’ ontological and epistemological position comprise that of social constructivism, which assumes that knowledge is constructed through interaction with others (Benton & Craib, 2010), and interpretivism, which presumes reality that is socially constructive and subjective (Blaikie & Priest, 2019). RTA is theoretically flexible and thus compatible with the authors’ positionality, the exploratory nature of the research questions and the method of data collection.

Setting

The study took place within three male low secure units in one NHS trust in the South East of England. None of the units in the study had explicit trauma-informed philosophies of care or trauma-informed treatment models, nor did they provide TIC training to staff.

Participants

Twelve people across all three units expressed an interest in participating and their suitability was discussed with their clinical teams. Two people were excluded from participating due to the risk of harm they posed to others. Thus, the final sample comprised 10 people. Nine participants identified as cisgender males and one participant identified as a trans woman. Eight participants identified as White British and two identified as Indian. The average participant was 44.7 years old (*SD* = 7.4, range = 37-58). The average length of time they had been in the service was 55.3 months (*SD* = 47.4, range = 2-146). Information about the low secure units, and the participants' diagnoses and legal status is displayed in the supplementary information. Participants are referred to by pseudonyms in order to preserve their anonymity. The presence of trauma histories was not screened for because TIC is considered to be a universal approach to care that does not require explicit awareness of trauma to be relevant (Isobel & Edwards, 2017).

Materials

The participant information sheet and consent form used in the study were developed for use with people with ID, in line with guidance produced by Mencap (2002). After potential participants had read the participant information sheet, an adapted version of Arscott et al.'s (1998) questionnaire was used to assess their ability to understand the aim and nature of the study; the alternatives, risks and benefits; their involvement in the decision-making process; and their ability to express a clear decision. To ensure consistency, a semi-structured focus group guide was developed by the first author (please see supplemental material).

Procedure

The study was advertised to all residents in the unit's community meetings. Residents who expressed an interest and were deemed eligible to participate were invited to meet with the first author to discuss the participant information sheet and ask questions about the study. After a

cooling off period of forty-eight hours, the residents were invited to meet with the first author again to consent to participate in the study. All participants gave written consent to participate and be quoted in any publications. Separate focus groups were facilitated by the first author at each of the units to enhance comfort and confidence in participation (Krueger & Casey, 2000). Thus, three focus groups were facilitated in total. One group comprised two participants from an acute FMH unit, another comprised three participants from an acute FID unit, and another comprised four participants from a rehabilitation FID unit. The facilitator followed the focus group guide; however, they were flexible in their approach to allow further exploration of participants' experiences. The focus groups lasted approximately one hour and were audio recorded to allow the facilitator to immerse themselves.

Analysis

Data from the focus groups were transcribed and analysed using Braun and Clarke's (2019) six phases of RTA; familiarising oneself with the data, generating codes, constructing themes, reviewing potential themes, defining and naming themes, and producing the report. A deductive approach was used to explore what the principles of TIC mean to participants and how they experience them. An inductive approach was used to explore participants' perceptions of the practices that enable or restrict people to adapt positively after experiences of trauma. The concept of 'trustworthiness' (Lincoln & Guba, 1985) has aided qualitative researchers to delineate the merits of their findings by accounting for the concepts of credibility, transferability, dependability and confirmability in their work (Nowell et al., 2017). The authors undertook several steps to meet these criteria, including prolonged engagement with the data and detailed note taking about potential themes and reflective thoughts in the initial stages. The first author established and reviewed themes utilising an audit trail of code identification and diagrams of the relationships between themes. Following more detailed analyses, themes and subthemes were scrutinised by both authors.

Finally, themes and subthemes were tested for referential adequacy by returning to raw data and reviewing them with seven of the focus group participants.

Results and Discussion

The first research question aimed to understand what the guiding principles of TIC mean to participants. The findings indicate that participants perceived the principles of safety and trustworthiness as interconnected. Safety and trustworthiness mean that staff are present; protect them from harm; communicate, explain and consistently honour boundaries; and respect their privacy. The findings indicate that participants perceived the principles of choice, collaboration and empowerment as interconnected. Choice, collaboration and empowerment mean that staff use their power and authority legitimately; notice, offer and create opportunities for participants to act autonomously; and validate their experiences of trauma, coping strategies, feelings and identity. The second research question aimed to understand how participants experience the guiding principles of TIC. The findings indicate that participants experience TIC as a relational and interactional process between staff and their peers. Participants experienced the principles of TIC inconsistently due to the perceived illegitimate use of power and authority in the FMH and FID service. The third research question aimed to understand the practices that enable people to adapt positively after experiences of trauma. Three themes were generated to address this research question; promoting a sense of safety, fostering a sense of belonging and encouraging the development of an autonomous identity. Please see supplementary information for a table of themes, subthemes and example quotes.

Promoting a Sense of Safety

This theme captured participants' perceptions that experiences of TIC were enhanced by interactions that reduced feelings of vulnerability and promoted a sense of physical and emotional safety. Conflict was evident within this theme because although participants experienced staff as empathic and trusted staff members to protect them from threats in their environment, they felt

that they were inconsistent in their maintaining of boundaries which negatively influenced their feelings of safety. Participants described being exposed to interpersonal violence within the service:

"One of them [patient] got me round my neck. I felt scared, worried, confused. He tried to attack me. I thought, 'Why have you done that, what's going on?'" [Liam]

In situations where they perceived potential threats to their physical safety, participants described feeling protected by staff:

> "I feel safe when staff are around. Sometimes they can, if there's like a serious problem on the ward, they can sort it out." [Simon]

Whilst participants expressed that their physical safety was enhanced by staff members' actions in response to perceived threats, they expressed that their emotional safety was enhanced by their non-judgemental attitudes and empathic approaches:

> "They [staff] listen to your problems and try to face the reality of what you're facing, so that they can understand." [Danielle]

Linehan (1997) defines empathy as "perceiving the internal frame of reference of the other" (p. 360), and suggests that it is the most effective way to make an individual feel safe. She also suggests that empathy is the foundation upon which trust can be built. Participants' feelings of physical and emotional safety were heavily influenced by feelings of trust, defined by Gillespie (2011) as a willingness to accept vulnerability and uncertainty in relation to the intention of others. For many people admitted to forensic services with histories of trauma, trusting others can be difficult given their past experiences (Ardino, 2012). Despite this, participants expressed that they could trust staff to keep them safe:

> "They [staff] are like family. You can trust them, you know? They're here to keep you safe." [Peter]

Peter's experience exemplifies the notion, suggested by Adshead (2002), that relationships between patients and staff in secure services can resemble secondary attachment relationships. In the general population, secondary attachment relationships have been shown to increase an individual's capacity to revise insecure models of themselves and others, leading to increased feelings of safety and trustworthiness (Cohen, 2005). In addition, there is some evidence to support a link between secondary attachment relationships and an individual's confidence in engaging in prosocial behaviours (Carter & Almaraz, 2014). This finding is particularly pertinent for forensic populations given that the purpose of secure forensic services is to reduce peoples' risk of harm to others. Participants expressed that their feelings of safety were enhanced when boundaries were clearly communicated, enforced with explanation, and honoured consistently. However, participants felt that staff were inconsistent in their maintaining of boundaries:

> They [staff] should explain the rules properly. When I got shown around, no one told me no rules, no nothing. I sat in the lounge and had a cup of coffee and I didn't realise, until someone goes, 'You're not allowed to do that', and I was like, 'I didn't know'. [Simon]

In addition, participants expressed that their feelings of safety were enhanced when their rights to privacy were respected. However, participants felt that staff often encroached on their privacy:

> It's like when they [staff] do room searches and all that lot, yeah? You say to them, you've got your own private life, yeah? And like they turn around and say, 'No, when you're in here you have not got a private life' or 'you have not got control over your life'. [Danielle]

When boundaries and their rights to privacy were breached, participants reported feelings of uncertainty, confusion and mistrust. Stillman and Baumeister (2009) suggest that environments that induce feelings of uncertainty can detract from perceptions of safety, control and belonging. In addition, Adshead (2002) suggests that for patients with previous experiences of maladaptive attachments, where care is provided in an unpredictable manner, unclear and inconsistent boundaries have the potential to re-enact attachment difficulties. Conversely, environments that are

highly structured, comprise clear and consistent boundaries, alongside firm swift consequences, are thought to be experienced as psychologically safer than those which are not (Adshead, 2002).

Fostering a Sense of Belonging

This theme captured participants' perceptions that experiences of TIC were enhanced by interactions that reduced feelings of isolation and fostered a sense of belonging. Conflict was also evident within this theme because although participants felt connected to their peers through shared experiences and activities, they felt that staff were not thoughtful about the formation of new relationships or the loss of established relationships which negatively influenced their feelings of belonging. In this sense, participants expressed that their experiences of attachment extended beyond the staff-patient relationship:

> "I get on well with staff, but I get on with patients better" [Peter]

Participants recognised that their peers had similar backgrounds and experiences to their own. They explained that these shared experiences meant that they felt understood by their peers without having to explain themselves:

> I've got like a patient that I've known for eight years and we've never had one fall-out. Whenever I need to chat to him, I chat to him, I find it more helpful than … staff. Because he can listen and, like, when you talk to the staff and that, they're like, 'Yeah? And?', you know? But when I talk to him about it, he understands straight away. [Danielle]

Danielle's experience illustrates the notion, suggested by Chandler (2008), that "patients are perceived by other patients as a resource, helping one another manage symptoms and develop coping skills" (p. 366). Haigh (2013) suggests that through the process of sharing experiences, knowledge, understandings, and expectations with their peers, patients enter a 'transitional space' within which they can experiment with new behaviours, emotions, relationships and ideas. Researchers propose that sharing in these reciprocal exchanges, referred to by Stevanovic and Koski

(2018) as the 'sharing of minds', can lead to the emergence of new perspectives through a process of intersubjectivity. Participants indicated that they could share experiences by talking to their peers, and by engaging in social activities with them:

> "We can play cards. We can play board games. We can listen to music as a group, there are always things to do with other patients." [Liam]

Through participation in social activities, participants described experiencing a sense of connection and belonging:

> "It doesn't matter what we're doing, I always feel connected, as if I'm a part of something." [Simon]

Needs (2018) suggests that a sense of belonging is especially important in the context of trauma because traumatic events and their aftermath often involve isolation from others. In addition, Adshead (2002) suggests that a sense of belonging is particularly pertinent for people admitted to forensic services because few of them have experiences of positive, affirming and non-abusive relationships. Although participants described experiencing a sense of connection and belonging amongst their peers, they felt that this did not extend to staff. Participants felt that staff were not thoughtful about the ways in which they were introduced to new members of their care team:

> I had a meeting today, you know? I forgot the name of the meeting, but I know I had a meeting. There were two nurses there and some other woman. I've never met her before, she's not from this place. They ought to introduce themselves a bit better. [Peter]

Haigh (2013) suggests that an alienating experience early in the therapeutic relationship, similar to those described by Peter and Danielle, can trigger persecutory feelings and negatively impact feelings of inclusion. In addition, Adshead (2002) suggests that peoples' initial contact with others has a significant impact on how they feel about attaching themselves to new environments. Research conducted in TCs has found that joining new environments can precipitate a resurgence of

early attachment experiences including rejection, judgement and abuse (Coakes et al., 2007). In light of these findings, Needs and Adair-Stantiall (2018) suggest that "conveying a sense of safety, with at least the possibility of trust should begin at an early stage of contact" (p. 46). In addition to nurturing the early stages of a relationship, researchers suggest that the way in which a relationship ends has important implications for trust and attachment (Adshead, 2002). Unfortunately, participants felt that staff were not thoughtful about the ending of relationships either:

> "I used to be friends with [patient], but now he's gone. He promised before he went that he'd say goodbye to me, but he didn't. I don't think staff would let him come over." [Liam]

Adshead (2002) suggests that active prevention of abrupt terminations and facilitation of appropriate mourning are considered necessary in the protection and survival of attachment relationships. Furthermore, Haigh (2013) suggests that services that deliberately engender a culture of belonging, such as those marking the joining and leaving of residents, allow people to invest socially and emotionally in the life of the community to which they can become strongly attached.

Encouraging the Development of an Autonomous Identity

This theme captured participants' perceptions that experiences of TIC were enhanced by interactions that reduced feelings of powerlessness, and encouraged autonomous identities. Conflict was also evident within this theme because although participants felt that they lacked autonomy due to external restrictions and staff's tendency to infantilise them and invalidate their identities, they acknowledged that staff could inspire hope and support them to develop new skills and coping strategies which would allow them to live independently in the future. Participants described feeling that their freedom of choice, self-expression, and potential were restricted by their section:

> It's not my decision to be here. I'm detained under a section of the Mental Health Act. I'm not free to choose where I am, who I am, or what I can do. I'm locked in here against my will. If that's not a violation of my human rights, I don't know what is. [David]

Participants' experiences are consistent with other studies that indicate that people admitted to institutional settings report greater perceptions of others being in control (Livingston et al., 2012). Perceived control is especially pertinent to trauma survivors because events that appear to render people powerless often damage their sense of agency, autonomy and identity (Budden, 2009). Despite being subject to restrictions, participants described being encouraged by staff to engage in activities to develop their autonomy:

> You've got to think about it. In hospital, it's time to improve yourself, you know you've done what you've done, but they [staff] can help you to read, write and all that kind of stuff, because when you're out you've got to pay for all that. [Simon]

Participants' experiences indicated that staff believed in their abilities and potential, which Perkins (2006) suggests is necessary for developing hope-inspiring relationships. Through their relationships with staff, participants came to experience themselves as capable of understanding and managing their responses to trauma:

> I used to wreck my room quite a lot. They [staff] sat down and talked to me, tried to calm me down, they told me to breathe. They helped me to understand why I was getting so angry. Then I started thinking to myself, like, 'Is there any point in me smashing my room up?'. And then, after the talk, they [staff] asked how I was feeling and helped me set goals to achieve in here. [Simon]

Simon's experience exemplifies the notion, suggested by Erdmann and Hertel (2019), that people can learn to develop self-regulation skills through co-regulation. Co-regulation is defined as warm and responsive interactions that provide the support, coaching, and modelling that people need to understand, express, and modulate their thoughts, feelings and behaviours (Murray et al., 2019). Self-regulation skills are particularly pertinent to people admitted to forensic services as they often have reduced problem-solving and reasoning abilities (Ehring & Quack, 2010), which have been

found to be related to reoffending risk (Andrews & Bonta, 1998). Participants stressed that the provision of support from staff had to be intersubjective or else it made them feel infantilised:

> "Sometimes they [staff] treat me like a child. They [staff] tell me what to do. They say 'Come on, do this, do that'." [Toby]

The association between disability and infantilisation is common (Robey et al., 2006) and removes peoples' choice and perceptions of control. One participant gave a stark description of her experience of having her choice removed:

> I have a choice what to wear and that, yeah? Because I'm going through gender issues at the moment, yeah? But at the beginning, they [staff] were like, 'Oh you can't wear this, you can't wear that'. Even when I've been shopping recently, yeah, and I've gone into Primark, they [staff] are like 'Oh, male clothing over here', and I say 'I want to go to the female'. And they [staff] are like, 'Oh, if you don't go to the male then we're walking out'. [Danielle]

For Danielle, her experiences exemplified a sense of separateness and further served to feed the power imbalance as she felt that some identities within the service were more likely to be excluded, invalidated and discriminated against than others. SAMHSA's (2014) sixth principle of TIC, cultural historical and gender issues, encourages services to "actively move past cultural stereotypes and biases (e.g. based on race, ethnicity, sexual orientation, age, religion, gender-identity, geography, etc.); and offer access to gender responsive services'' (p. 11). The distress caused by a lack of openness, acceptance and validation of people's gender has been noted in other studies (Hall & Delaney, 2019).

General Discussion

This study is the first to attempt to understand TIC from the perspective of people admitted to a FMH and FID service in the UK. The findings indicate that in order to adapt positively after trauma, people admitted to forensic services need to feel physically and emotionally safe, and have

opportunities to connect with others and develop a positive and independent sense of self. Participants expressed that services can increase feelings of physical and emotional safety by placing greater emphasis on key aspects of service delivery. These aspects include ensuring that staff members are visible and accessible in communal areas; act to protect people from harm; offer people time to talk; respond with empathy; and clearly communicate, explain and consistently honour peoples' boundaries and rights to privacy. Previous studies have found that feeling unsafe can impede peoples' recovery (Muir-Cochrane et al., 2013). Thus, promoting a sense of safety is critical to enable people to adapt positively after experiences of trauma. In addition, participants expressed that fostering a sense of belonging is vital to TIC, and can be achieved by providing people opportunities to get to know members of their care team, mark staff and peers joining and leaving the service, and socialise with their peers. These suggestions support SAMHSA's (2014) third principle of TIC; peer support. Furthermore, participants expressed that encouraging the development of an autonomous identity is central to TIC, and can be attained by inspiring hope; validating peoples' choices, abilities and individuality; and providing people with opportunities to acquire new skills and coping strategies. Encouraging self-determination is pertinent to people admitted to forensic services because a positive change to their identity, through the adoption of pro-social values and a more adaptive and healthy way of relating to others, can predict desistance from crime (Maruna, 2001).

The themes generated in this study are clearly interrelated, which suggests that the construct of TIC may be unidimensional. Whilst this possibility has been suggested by other researchers (Hales et al., 2017), none have postulated what the underlying dimension of TIC may be. The findings from the current study indicate that the underlying dimension may be the social-interpersonal relationship. However, even within a concept that is essentially unidimensional, it is acknowledged that different facets may exist, namely empathy, congruence and unconditional positive regard (Crits-Christoph et al., 2013). The origins of these aspects can be traced back to the work of Carl Rogers (1957) and arguably underpin the core foundational elements of effective

therapy. Thus, some researchers suggest that principles of TIC are core elements of culturally competent professional therapeutic work (Allen, 2013; Auty et al., 2023). Consequently, Auty at al. (2023) suggest that “framing trauma-informed practice in terms that are already meaningful to staff might enable them to engage in it more effectively” (p. 18). One way in which this can be achieved in FMH and FID services is by providing staff members with regular opportunities to reflect and become cognizant of the ways in which they are already incorporating, or can endeavour to incorporate, the common factors of safe therapeutic relationships in their practice. Only when they are aware of the impact of their practice on their relationships with residents can staff in FMH and FID services be considered ‘trauma-informed’. These findings indicate that there is a need for forensic services to shift their perspective of trauma from a medicalised and cognitive conceptualisation to a psychosocial, relational and interactional one. Needs (2018) warns that an oversimplified conceptualisation of trauma emphasises deficits at the individual level and in doing so neglects important social processes. Current therapies for PTSD, including trauma-focused cognitive behaviour therapy (CBT), Eye Movement Desensitisation and Reprocessing (EMDR) therapy and exposure therapy, emphasise deficits at the individual level. Although the evidence base for these therapies in forensic settings is emerging (Every-Palmer et al., 2023; Malik et al., 2024), there is evidence to suggest that building interpersonal relationships and healthy attachments using a trauma-informed approach is a strong component of effective trauma therapies. Thus, the findings raise questions about the utility of the role of attachment in helping people adapt to major life events more generally, for example after transgressions in relationships, betrayal, and/or morally injurious events. Future research could focus on identifying the factors that help people adapt during transition/change. In addition, future research could examine the perceptions of people admitted to forensic services that have trauma-informed policies and procedures (e.g., TCs and PIPEs), in order to determine whether the findings from this study are transferable.

This study has several limitations, many of which relate to its methodology. It is acknowledged that a significant portion of each focus group was spent discussing the guiding

principles of TIC. This is likely to have occurred for several reasons. Firstly, the units where the study took place were not considered trauma-informed. Thus, the focus group is likely to have been participants' first introduction to TIC, and those with ID found it difficult to grasp the abstract nature of it. Additionally, two of the research questions focused explicitly on participants' perceptions and experiences of the principles of TIC. These factors led to some premature bounding of the focus group discussions to a rather narrow focus, limiting exploration of participants' experiences of TIC outside of these principles. Introducing the participants to the concept of TIC prior to the focus groups would have allowed more time for exploration of their experiences of TIC outside of pre-existing principles. The focus group guide utilised the original conceptualisation of TIC by Fallot and Harris (2009) because it is well-established in both theory and practice. The authors acknowledge that SAMHSA (2014) conceptualises TIC slightly differently and incorporates the principles of peer support, and cultural, historical and gender issues. Although not included in the conceptualisation of TIC used in the focus groups, these principles were clearly relevant to participants because they are reflected in the themes generated in this study. Reducing the length of time discussing the principles of TIC, explicitly acknowledging other conceptualisations of TIC, extending the length of the focus groups or facilitating further focus groups may have been beneficial.

Further limitations of the study relate to its sample, which was limited in diversity, especially in relation to race/ethnicity. Research on the disparities in adverse childhood experiences (ACEs) by race/ethnicity is in its infancy (Mersky et al., 2021). However, it is acknowledged that BAME individuals are likely to have experienced greater adversity than white individuals in the form of racism, discrimination, social and economic inequalities, poor physical and mental health care, and detainment in secure settings (Mental Health Foundation, 2021). Thus, future research should consider the potential impact of race/ethnicity on people's perceptions of TIC in forensic services. A further limitation of the study relates to the wide range of time that participants were admitted to the forensic units (from 2 months to 14 years). It is acknowledged that this is likely to have impacted the quality of their attachment to staff and other residents, and their sense of belonging to the unit.

In order to explore the role of the duration of detention on peoples' perceptions of TIC in secure services, future research could study samples of new residents and established residents separately. Furthermore, including both people with mental health difficulties and people with ID in this study will have impacted on the findings. Whilst the experiences of people with mental health difficulties and people with ID were presented together in this study and their perspectives thematically combined, it is acknowledged that their experiences are not always shared. Focusing sampling on either people with mental health difficulties or people with ID in the future could allow for the exploration of the role of mental illness and ID on peoples' perceptions of TIC in forensic settings. Similarly, it was beyond the scope of the study to explore the role of gender on peoples' perceptions of TIC in forensic services. Whilst previous research has applied a TIC framework to explore trans peoples' experiences of mental health and community support services (Hall & Delaney, 2019), further research exploring trans peoples' experiences of TIC in forensic settings is needed.

References

Adshead, G. (2002). Three degrees of security: Attachment and forensic institutions. *Criminal Behaviour and Mental Health, 12*, 31-45. https://doi.org/10.1002/cbm.2200120605

Allen, J. G. (2013). Treating attachment trauma with plain old therapy. *Journal of Trauma & Dissociation, 14,* 367-374. https://doi.org/10.1080/15299732.2013.769400

Andrews, D. A., & Bonta, J. (1998). *The psychology of criminal conduct.* Anderson Publishing.

Ardino, V. (2012). Offending behaviour: The role of trauma and PTSD. *European Journal of Psychotraumatology, 3*(1), 1-5. https://doi.org/10.3402/ejpt.v3i0.18968

Arscott, K., Dagnan, D., & Kroese, B. S. (1998). Consent to psychological research by people with an intellectual disability. *Journal of Applied Research in Intellectual Disabilities*, *11*(1), 77–83. https://doi.org/10.1111/j.1468-3148.1998.tb00035.x

Auty, K. M., Liebling, A., Schliehe, A., & Crewe, B. (2023). What is trauma-informed practice? Towards operationalisation of the concept in two prisons for women. *Criminology & Criminal Justice, 23*(5), 716-738. https://doi.org/10.1177/1748895822109498

Benton, T., & Craib, I. (2010). *Philosophy of social science: The philosophical foundations of social thought.* Palgrave Macmillan.

Bertelli, M. O., Munir, K., Harris, J., & Salvador-Carulla, L. (2016). "Intellectual developmental disorders": reflections on the international consensus document for redefining "mental retardation-intellectual disability" in ICD-11. *Advances in Mental Health and Intellectual Disabilities*, *10*(1), 36-58. https://doi.org/10.1108/AMHID-10-2015-0050

Blaikie, N., & Priest, J. (2019). *Designing social research: The logic of anticipation*. John Wiley & Sons.

Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. *Qualitative Research in Sport, Exercise and Health*, *11*, 589–597. https://doi.org/10.1080/2159676X.2019.1628806

Budden, A. (2009). The role of shame in posttraumatic stress disorder: A proposal for a socio-emotional model for DSM-V. *Social Science & Medicine, 69*(7), 1032-1039. https://doi.org/10.1016/j.socscimed.2009.07.032

Carter, J., & Almaraz, J. (2014). *Multiple attachment relationships: More caregivers may mean more confidence to behave prosocially* [Poster]. Salk Lake City.

Chandler, G. (2008). From traditional inpatient to trauma-informed treatment: Transferring control from staff to patient. *Journal of the American Psychiatric Nurses Association*, *14*(5), 363–371. https://doi.org/10.1177/1078390308326625

Coakes, J., Miles, M., & Lawson, K. (2007). From Outsider to Insider: The Residents' Experiences of Joining the Acorn Programme Therapeutic Community. *Therapeutic Communities, 28*(3), 287–300.

Cohen, D. L. (2005). *Exploring the role of secondary attachment relationships in the development of attachment security* [Unpublished doctoral dissertation]. University of North Texas. https://digital.library.unt.edu/ark:/67531/metadc4891/m2/1/high_res_d/dissertation.pdf

Crits-Christoph, P., Gibbons, C., & Mukherjee, D. (2013). Psychotherapy process-outcome research. In M. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (pp. 298–340). John Wiley and Sons.

Drennan, G., & Alred, D. (2012). Recovery in forensic mental health settings: From alienation to integration. In G. Drennan & D. Alred (Eds.), *Secure recovery: Approaches to recovery in forensic mental health settings* (pp. 1-22). Routledge.

Ebert, A., & Dyck, M. J. (2004). The experience of mental death: The core feature of complex posttraumatic stress disorder. *Clinical Psychology Review, 24*(6), 617-635. https://doi.org/10.1016/j.cpr.2004.06.002

Ehring, T., & Quack, D. (2010). Emotion regulation difficulties in trauma survivors: The role of trauma type and PTSD symptom severity. *Behavior Therapy, 41*(4), 587-598. https://doi.org/10.1016/j.beth.2010.04.004

Erdmann, K. A., & Hertel, S. (2019). Self-regulation and co-regulation in early childhood–development, assessment and supporting factors. *Metacognition and Learning, 14*(3), 229-238. https://doi.org/10.1007/s11409-019-09211-w

Every-Palmer, S., Flewett, T., Dean, S., Hansby, O., Freeland, A., Weatherall, M., & Bell, E. (2024). Eye movement desensitization and reprocessing (EMDR) therapy compared to usual treatment for posttraumatic stress disorder in adults with psychosis in forensic settings: Randomized controlled trial. *Psychological Trauma: Theory, Research, Practice, and Policy*, 1-6. https://doi.org/10.1037/tra0001643

Fallot, R., & Harris, M. (2009, April). *Creating cultures of trauma-informed care (CCTIC): A self-assessment and planning protocol.* https://www.theannainstitute.org/CCTICSELFASSPP.pdf

Gillespie, N. (2011). Measuring trust in organizational contexts: An overview of survey-based measures. In F. Lyon, G. Möllering & M. Saunders (Eds.), *Handbook of research methods on trust*, (pp. 175-188). Edward Elgar Publishing Limited.

Haigh, R. (2013). The quintessence of a therapeutic environment. *Therapeutic Communities: The International Journal of Therapeutic Communities, 34*(1), 6-15. https://doi.org/10.1108/09641861311330464

Hales, T. W., Kusmaul, N., & Nochajski, T. (2017). Exploring the dimensionality of trauma-informed care: Implications for theory and practice. *Human Service Organizations: Management, Leadership & Governance, 41*(3), 317-325. https://doi.org/10.1080/23303131.2016.1268988

Hall, S. F., & DeLaney, M. J. (2019). A trauma-informed exploration of the mental health and community support experiences of transgender and gender-expansive adults. *Journal of Homosexuality*, 1-20. https://doi.org/10.1080/00918369.2019.1696104

Isobel, S., & Edwards, C. (2017). Using trauma informed care as a nursing model of care in an acute inpatient mental health unit: A practice development process. *International Journal of Mental Health Nursing, 26*(1), 88-94. https://doi.org/10.1111/inm.12236

Isobel, S., Wilson, A., Gill, K., & Howe, D. (2020). 'What would a trauma-informed mental health service look like?' Perspectives of people who access services. *International Journal of Mental Health Nursing, 30*(2), 495-505. https://doi.org/10.1111/inm.12813

Jones, L. (2018). Trauma-informed care and 'good' lives in confinement: Acknowledging and offsetting adverse impacts of chronic trauma and loss of liberty. In G. Akerman, A. Needs & C. Bainbridge (Eds.), *Transforming environments and offender rehabilitation: A guide for practitioners in forensic settings and criminal justice* (pp. 92-114). Routledge.

Krueger, R. A., & Casey, M, A. (2000). *Focus groups: A practical guide for applied research.* Sage.

Kruppa, I., Hickey, N., & Hubbard, C. (1995). The prevalence of post traumatic stress disorder in a special hospital population of legal psychopaths. *Psychology, Crime & Law, 2*(2), 131–141. https://doi.org/10.1080/10683169508409771

Kubiak, S., Covington, S., & Hillier, C. (2017). Trauma-informed corrections. *Social Work in Juvenile and Criminal Justice System, 4*(7), 92-104.

Kusmaul, N., Wolf, M. R., Sahoo, S., Green, S. A., & Nochajski, T. H. (2019). Client Experiences of Trauma-Informed Care in Social Service Agencies. *Journal of Social Service Research, 45*(4), 589–599. https://doi.org/10.1080/01488376.2018.1481178

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Sage.

Linehan, M. M. (1997). Validation and psychotherapy. In A. C. Bohart & L. S. Greenberg (Eds.), *Empathy Reconsidered: New Directions in Psychotherapy* (p. 353–392). American Psychological Association.

Livingston, J. D., Nijdam-Jones, A., & Brink, J. (2012). A tale of two cultures: Examining patient-centered care in a forensic mental health hospital. *Journal of Forensic Psychiatry & Psychology*, 23(3), 345-360. https://doi.org/10.1080/14789949.2012.668214

Malik, N., Facer-Irwin, E., Dickson, H., Bird, A., & MacManus, D. (2023). The effectiveness of trauma-focused interventions in prison settings: A systematic review and meta-analysis. *Trauma, Violence, & Abuse*, *24*(2), 844-857. https://doi.org/10.1177/15248380211043890

Maruna, S. (2001). *Making good* (Vol. 86). American Psychological Association.

Mencap. (2002). Am I making myself clear? http://www.accessibleinfo.co.uk/pdfs/Making-Myself-Clear.pdf

Mental Health Foundation. (2021, September 30). Black, Asian and minority ethnic (BAME)

communities. https://www.mentalhealth.org.uk/explore-mental-health/a-z-topics/black-asian-and-minority-ethnic-bame-communities

Mersky, J. P., Choi, C., Lee, C. P., & Janczewski, C. E. (2021). Disparities in adverse childhood experiences by race/ethnicity, gender, and economic status: Intersectional analysis of a nationally representative sample. *Child Abuse & Neglect, 117,* 1-12. https://doi.org/10.1016/j.chiabu.2021.105066

Mueser, K., Goodman, L. A., & Rosenberg, S. D. (1998). Trauma and posttraumatic stress disorder in severe mental illness: A Danish twin study for schizophrenia liability view project. *Journal of Consulting and Clinical Psychology, 66*(3), 493-499. https://doi.org/10.1037/0022-006X.66.3.493

Muir-Cochrane, E., Oster, C., Grotto, J., Gerace, A., & Jones, J. (2013). The inpatient psychiatric unit as both a safe and unsafe place: Implications for absconding. *International Journal of Mental Health Nursing, 22*(4), 304-312. https://doi.org/10.1111/j.1447-0349.2012.00873.x

Murray, D. W., Rosanbalm, K., Christopoulos, C., & Meyer, A. L. (2019). An applied contextual model for promoting self-regulation enactment across development: Implications for prevention, public health and future research. *The Journal of Primary Prevention, 40*(4), 367-403. https://doi.org/10.1007/s10935-019-00556-1

Muskett, C. (2014). Trauma-informed care in inpatient mental health settings: A review of the literature. *International Journal of Mental Health Nursing, 23*(1), 51-59. https://doi.org/10.1111/inm.12012

Needs, A. (2018). Only connect: Implications of social processes and contexts for understanding trauma. In G. Akerman, A. Needs & C. Bainbridge (Eds.), *Transforming environments and offender rehabilitation: A guide for practitioners in forensic settings and criminal justice* (pp. 63-91). Routledge.

Needs, A., & Adair-Stantiall, A. (2018). The social context of transition and rehabilitation. In G. Akerman, A. Needs & C. Bainbridge (Eds.), *Transforming environments and offender rehabilitation: A guide for practitioners in forensic settings and criminal justice* (pp. 31-62). Routledge.

Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic analysis: Striving to meet the trustworthiness criteria. *International Journal of Qualitative Methods*, *16*(1), 1-13. https://doi.org/10.1177/1609406917733847

Park, C. L. (2010). Making sense of the meaning literature: an integrative review of meaning making and its effects on adjustment to stressful life events. *Psychological Bulletin, 136*(2), 257–301. https://doi.org/10.1037/a0018301

Perkins, R. (2006). First person: You need hope to cope. In G. Roberts, S. Davenport, F. Holloway & T. Tattan (Eds.), *Enabling recovery: The principles and practice of rehabilitation psychiatry* (pp. 112-126). Cromwell Press Limited.

Razza, N. J., Tomasulo, D. J., & Sobsey, D. (2011). Group psychotherapy for trauma-related disorders in people with intellectual disabilities. *Advances in Mental Health and Intellectual Disabilities, 5*(5), 40–45. https://doi.org/10.1108/20441281111180655

Robey, K. L., Beckley, L., & Kirschner, M. (2006). Implicit infantilizing attitudes about disability. *Journal of Developmental and Physical Disabilities, 18*(4), 441-453. https://doi.org/10.1007/s10882-006-9027-3

Rogers, A., & Law, H. (2010). Working with trauma in a prison setting. In J. Harvey & K. Smedley (Eds.), *Psychological therapy in prisons and other secure settings* (pp. 150-175). Willan.

Rogers, C. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology*, *21*, 95-103.

SAMHSA. (2014, July). *SAMHSA's concept of trauma and guidance for a trauma-informed approach.* https://ncsacw.samhsa.gov/userfiles/files/SAMHSA_Trauma.pdf

Shuker, R. (2018). Relationships, social context and personal change: The role of therapeutic communities. In G. Akerman, A. Needs & C. Bainbridge (Eds.), *Transforming environments and offender rehabilitation: A guide for practitioners in forensic settings and criminal justice* (pp. 213-226). Routledge.

Stevanovic, M., & Koski, S. E. (2018). Intersubjectivity and the domains of social interaction: Proposal of a cross-sectional approach. *Psychology of Language and Communication, 22*(1), 39–70. https://doi.org/10.2478/plc-2018-0003

Stillman, T. F., & Baumeister, R. F. (2009). Uncertainty, belongingness, and four needs for meaning. *Psychological Inquiry, 20*(4), 249-251. https://doi.org/10.1080/10478400903333544

Sweeney, A., Clement, S., Filson, B., & Kennedy, A. (2016). Trauma-informed mental healthcare in the UK: What is it and how can we further its development? *Mental Health Review Journal, 21*(3), 174–192. https://doi.org/10.1108/MHRJ-01-2015-000

Tomlin, J., Lega, I., Braun, P., Kennedy, H. G., Herrando, V. T., Barroso, R., ... & Völlm, B. (2021). Forensic mental health in Europe: some key figures. *Social Psychiatry and Psychiatric Epidemiology*, *56*, 109-117. https://doi.org/10.1007/s00127-020-01909-6

Van der Kolk, B. A. (2003). The neurobiology of childhood trauma and abuse. *Child and Adolescent Psychiatric Clinics*, *12*(2), 293-317. https://doi.org/10.1016/S1056-4993(03)00003-8

World Health Organization (2021). International statistical classification of diseases and related health problems (11th ed.). https://icd.who.int/

Click here to access/download
Supplemental Material
Supplemental material semi-structured focus group guide.docx

Participant Demographic Information

Click here to access/download
Supplemental Material
Supplemental material participant demographic information.docx

Click here to access/download
Supplemental Material
Supplemental material themes, subthemes and quotes.docx