Mentally disordered offenders' experience of offence-related post-traumatic stress disorder: Considerations for diagnosis and treatment

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June 2015

Research submitted in partial fulfilment of the requirements for the degree of Doctor in Clinical Psychology (DClinPsy), Royal Holloway, University of London

ACKNOWLEDGEMENTS

ABSTRACT

Despite high prevalence rates and the associated risks of non-identification for judicial injustices, reoffending and poor mental health outcomes, offence-related post-traumatic stress disorder (PTSD) remains under-diagnosed. This study aimed to explore how mentally disordered offenders experience offence-related PTSD and how closely these experiences match the current diagnostic criteria for PTSD (American Psychiatric Association, 2013) and the key components of Ehlers and Clark's (2000) cognitive model of PTSD. A qualitative approach was employed in order to meet these aims.

Participants were recruited via referrals from their responsible clinician or psychologist at a medium secure forensic service. Following screening for inclusion and exclusion criteria using standardised measures of PTSD, individual, semi-structured interviews were conducted with six adult males. The data were analysed using Interpretative Phenomenological Analysis, which generated three superordinate themes: *Responses to an identity shift, Ineffective memory processing,* and *Appraisals of the consequences of offending.*

These themes are discussed within the context of existing literature and recommendations are made for clinical practice and further research.

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CHAPTER ONE: INTRODUCTION

This chapter first provides an overview of the literature relevant to this study. Appendix A details how previous research was collated for this review. The chapter begins by introducing the diagnostic criteria and cognitive model of post-traumatic stress disorder (PTSD), and then moves on to outline treatment approaches commonly used in adult trauma services. The rationale for studying offence-related PTSD among mentally disordered offenders (MDOs) is then explored and the research with this population is examined.

The chapter then gives an outline of the aims of this study and research questions, the chosen methodology, including a rationale for the selection of a qualitative approach, and an explanation of the researcher's epistemological position. Finally, the advantages of using Interpretative Phenomenological Analysis (IPA) are discussed.

1.1 Diagnosing PTSD

According to the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V; American Psychiatric Association (APA), 2013), PTSD may develop following exposure to actual or threatened death, serious injury or sexual violence. Exposure may occur as a result of direct experience, witnessing an event, indirectly through learning about a loved one's exposure to trauma, or by repeated indirect exposure in a professional context. A diagnosis should be given where experiences cause significant

distress or functional impairment, and where symptoms have persisted for at least one month. This must include at least one intrusive re-experiencing symptom, one avoidance symptom, two negative alterations in cognitions and mood, and two alterations in arousal and reactivity.

1.1.1 Intrusion symptoms

Intrusion symptoms refer to the persistent re-experiencing of a traumatic event in the form of recurrent intrusive memories, nightmares, dissociative flashbacks, and extreme distress and/or physiological reactivity following exposure to trauma-related stimuli.

1.1.2 Avoidance

Avoidance refers to the continuous and intentional circumvention of trauma-related stimuli anticipated to cause distress. This may include internal experiences, such as cognitions and emotions, and/or external triggers, such people, places, activities, objects and situations.

1.1.3 Negative Alterations in cognitions and mood

This criterion refers to possible cognitive and affective changes following the traumatic event. This includes an inability to recall elements of the event, negative beliefs and expectations about oneself, others and the world, distorted blame attributions, negative trauma-related emotions such as fear,

horror, anger, guilt and shame, diminished interest in previously significant activities, a sense of alienation, and an inability to experience positive emotions.

1.1.4 Alterations in arousal and reactivity

Previously termed 'hyperarousal' (APA, 2000), this criterion refers to symptoms indicative of increased negative emotions. For example, irritability and aggression, self-destructive or reckless behaviour, difficulties with concentration and sleep, hypervigilance, and an exaggerated startle response.

1.2 Theories of PTSD

Since the inclusion of PTSD in the 3rd edition of the DSM (DSM-III; APA, 1980), a number of increasingly refined and complex theories have been developed in response to the ever-growing body of literature examining the intricacies of the condition. The key theories that have informed current models of clinical formulation and treatment will be briefly outlined.

1.2.1 Social cognitive theories

Social-cognitive theories propose that trauma violates existing mental structures resulting in the activation of innate processes for unifying conflicting information with past beliefs. Their strength lies in their ability to

provide accounts of the range of emotions and beliefs triggered by trauma, as well as the process of adjustment to new information. However, they neglect the differentiation between PTSD and other trauma reactions, such as depression, and fail to account for responses to trauma reminders.

Horowitz (1986) was the first to highlight the importance of considering the impact of trauma on beliefs about the self, others, the world and the future in his stress response theory. He proposed two opposing but simultaneous processes, which cause a fluctuating presentation of intrusions and avoidance in traumatised individuals. The first works to protect the individual from an informational overload by suppressing, avoiding and denying trauma information in order to slow the rate of recall, while the other attempts to encourage processing of traumatic material in order to integrate new information with prior knowledge by bringing it to the surface in the form of intrusive symptoms.

The theory of shattered assumptions (Janoff-Bulman, 1992) is based on the idea that people live according to an internal working model of core beliefs and internal schemas. Three common assumptions most relevant in predicting responses to trauma are proposed: the world is benevolent, the world is meaningful, and the self is worthy. That is, people are generally good, there are rules that enable us to predict the outcomes of behaviours, and we ourselves are generally good. Events that shatter these assumptions have the potential to be traumatic. It is suggested that beliefs can be updated either through a process of re-experiencing and avoidance, as described by Horowitz (1986), or by engaging in purposeful reflection. Bolton and Hill (1996) further expanded on the beliefs relevant to trauma and suggested that

traumatic events can create a sense of disbelief since the event appears to contradict one's core beliefs but according to those beliefs, the event cannot have actually happened.

1.2.2   Information processing theories

Information processing theories concentrate on how fear-provoking events and their associated stimuli and responses are encoded, stored and recalled. Early theories fail to acknowledge the impact of emotions other than fear and beliefs other than perceptions of danger in the wider social context (Brewin, & Holmes, 2003). Two more recent and expansive cognitive theories will therefore be discussed in detail.

1.2.3   The dual representation theory

Brewin (2001; 2003; Brewin, Dalgeish, & Joseph, 1996) proposed a distinction between verbally accessible memory (VAM) and situationally accessible memory (SAM) in order to answer questions raised by previous theories about the co-existence of ordinary and dissociated memories of a traumatic event and the process by which one type of memory is transformed into the other. The non-verbal SAM system is described as 'quick and dirty' (Brewin, 2003, p.10) as the sense organs are able to transmit rapid messages through subcortical pathways to the amygdala, triggering a fear response, but this information is only crudely analysed. There is limited processing of detail or context, meaning that relatively general stimuli rapidly

become associated with a fear response, and will produce the same response in the future, causing a sense of 'nowness' when memories are recalled.

The VAM system differs in that the sense organs instead pass signals to the cerebral cortex, where information is much more thoroughly analysed by the hippocampus. Processing of context allows memories to be encoded as past events, thus enabling them to be selected for voluntary recall. When presented with related stimuli, an evaluation of context enables the fear response to be adjusted as appropriate, as opposed to producing an automatic learned response. During traumatic events, the VAM system is believed to be enhanced at moderate levels of arousal, but inhibited at very high levels. This theory explains the fragmented and intrusive nature of trauma memories, as well as providing a rationale for current recommended treatments.

1.2.4 The cognitive model of PTSD

Ehlers and Clark's (2000) cognitive model of PTSD proposes two key contributions to a sense of current external threat to safety or internal threat to the self and the future: *negative appraisals* and the *nature of the trauma memory*. This highlights the role of cognitive processing and memory in experiences of current threat and feeling anxious about the future despite trauma being located in the past (Figure 1).

Individuals with PTSD are characterised by negative appraisals of the trauma and its consequences due to the impact of prior beliefs and

experiences, existing coping strategies, and characteristics of the trauma on one's ability to view the trauma as time-limited and without wider future implications.

Additionally, it is proposed that traumatised individuals display fragmented, incomplete and poorly organised memories for the event during intentional recall, particularly for contextual details. Sensory information and emotions, however, are involuntarily re-experienced and accompanied by a sense of current threat. It is suggested that this occurs as a result of poor incorporation of the traumatic event into the autobiographical memory system, making it hard to retrieve intentionally but more prone to being experienced without context from the associative memory system in response to trauma reminders. Maladaptive strategies, such as avoidance, thought suppression, distraction, safety behaviours and substance use, are adopted in an attempt to cope with this sense of threat, but instead prevent the trauma memory and its appraisals from being processed and incorporated into autobiographical memory. With treatment, trauma memories can be integrated with their context through a process of replaying events and attending to re-experienced fragments.

Figure 1: The cognitive model of PTSD (Ehlers, & Clark, 2000)
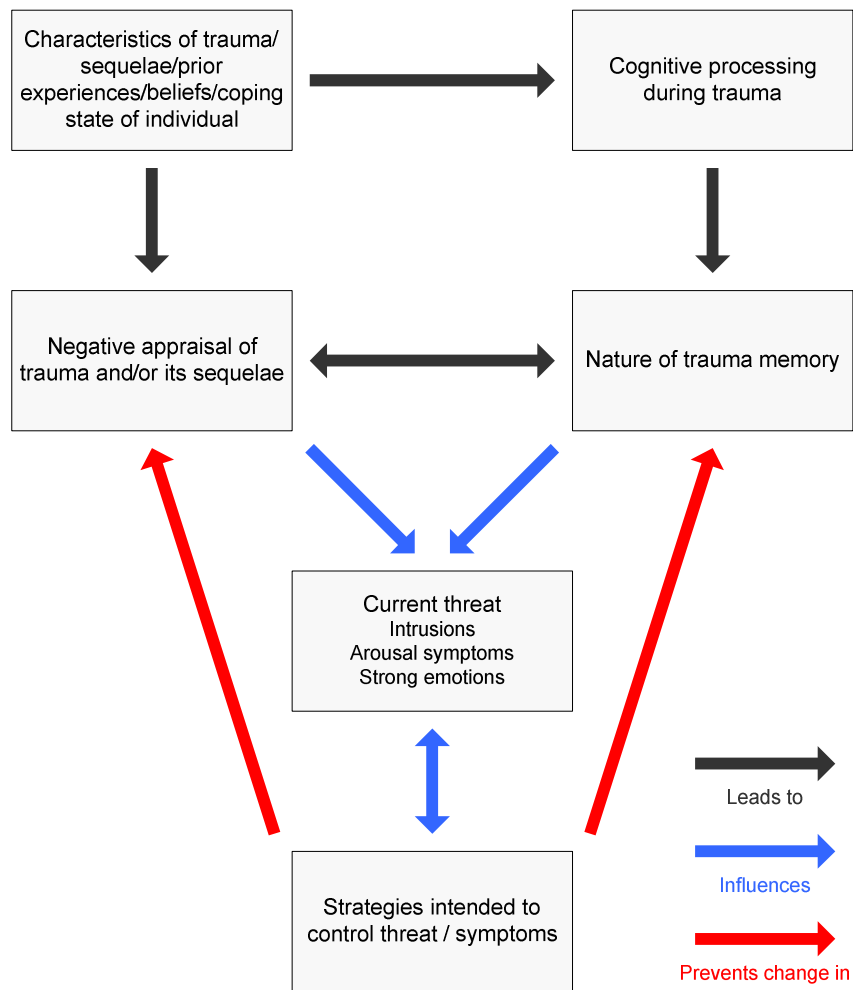
1.3   Treatment of PTSD

The National Institute for Clinical Excellence (NICE; National Collaborating Centre for Mental Health, 2005) recommends that adults with PTSD are offered trauma-focused cognitive behavioural therapy (TF-CBT) or eye movement desensitisation and reprocessing (EMDR). Seidler and Wagner's (2006) meta-analysis demonstrates that these treatments are indistinguishable in terms of efficacy. The authors therefore suggest that

research efforts should move away from determining the treatment with the best outcomes, and instead focus on which service-users are likely to benefit from one approach or the other. A meta-analysis by Watts, Schnurr, Mayo, Young-Xu, Weeks, and Friedman (2013) drew similar conclusions, but they point out that clinicians also have alternative approaches to consider. Narrative Exposure Therapy (NET; Schauer, Neuner, & Elbert, 2011) and Adapted Testimony (Grey, & Young, 2008), for example, adopt many of the same principles as TF-CBT. A moderate level of arousal is induced by talking about a traumatic event and context is added to this memory to allow it to be sufficiently processed. The aim of these approaches, however, is to construct a complete narrative rather than addressing only the most distressing and continually re-experienced discrete memory fragments. This approach may be more suitable for individuals who have experienced multiple traumas and are therefore unable to address each of them in a time-limited intervention of TF-CBT or EMDR (Grey, & Young, 2008; Schauer et al., 2011). Whichever approach is selected for an individual, it is suggested that the intervention also consider any secondary depression, shame, guilt and grief. These difficulties may be addressed alongside and in conjunction with the trauma work, which primarily addresses a fear response, using cognitive and/or compassionate techniques (Lee, 2009).

Bisson, Roberts, Andrew, Cooper, and Lewis's (2013) meta-analysis of 70 randomised controlled trials found that, despite greater drop-out, TF-CBT and EMDR were more effective in reducing the severity of PTSD symptoms according to clinician-rated measures at post-treatment than wait-list or treatment as usual, and were superior to other therapies at one- to four-

month follow-up. However, they highlight the poor quality of the evidence, including small sample sizes ranging from 9 to 360, underpowered studies and limited follow-up data from which to draw conclusions about the long-term impact of treatment, so recommend that the review is interpreted with caution. Both Bisson et al. (2013) and Watts et al. (2013) point out the significant heterogeneity present in their meta-analyses, making comparisons difficult to draw. This indicates a potential benefit of focussing future research on specific populations in order to determine the treatment approach that is likely to be most effective for individual service-users.

1.4 Why assess and treat offence-related PTSD in MDOs?

The term 'mentally disordered offenders' refers to individuals who have committed one or more illegal offences and have a mental illness and/or personality disorder, as defined by the Mental Health Act (2007). They are usually either detained in secure hospitals or closely managed in the community. A literature search on offence-related PTSD in this population indicates that, compared with PTSD in victims, this is a relatively under-researched area that has largely focused on prevalence rates and a limited number of case studies (e.g. Gray, Carman, Rogers, MacCulloch, Hayward, & Snowden, 2003; Lad, 2013; Pollock, 1999). There are several compelling arguments for expanding existing knowledge for the benefit of patients, the general public, and the wider national health and legal systems, which will now be considered.

1.4.1 Prevalence of offence-related PTSD

PTSD is well documented in both prison populations and among MDOs. Prevalence rates of PTSD in prison populations have ranged from 15% (Collins, & Bailey, 1990) to 32% (Steiner, Garcia, & Matthews, 1997), compared to a lifetime prevalence of 8.3% in the general population (Kilpatrick, Resnick, Milanak, Miller, Keyes, & Friedman, 2013). With regard to offence-related PTSD, Payne, Watt, Rogers, and McMurran (2008) reported that 31% of their sample of 26 life sentence prisoners met criteria for offence-related PTSD and that reported symptoms were positively related to the amount of trauma experienced prior to the index offence. This further increases among MDOs, 26-52% of whom are reported to show clinically significant symptoms of offence-related PTSD (Crisford, Dare, & Evangeli, 2008; Gray et al., 2003; Papanastassious, Waldron, Boyle, & Chesterman, 2004; Pollock, 1999). Gray et al. (2003) found that 33% of their sample of 37 MDOs met criteria for a PTSD diagnosis concerning an offence-related trauma. Similarly, Crisford et al. (2008) reported that 40% of their sample of 45 MDOs reported offence-related PTSD symptoms.

1.4.2 Comorbidity and exposure to multiple traumas

Comorbidity is often a concern for individuals with PTSD (Lee, & Young, 2001; O'Donnell, Creamer, Bryant, Schnyder, & Shalev, 2003). Studies have shown that PTSD and past exposure to multiple traumas are common among MDOs (Garieballa et al., 2006; Goff, Rose, Rose, & Purves, 2007). Spitzer,

Dudeck, Liss, Orlob, Gillner, and Freyberger (2001) reported that in their sample of 53 violent and sexual offenders, 64% reported at least one trauma other than their offence. Additionally, they reported that MDOs meeting diagnostic criteria for PTSD also had significantly higher levels of depression, anxiety, anger, obsessive compulsive symptoms and psychosis.

1.4.3 Under-diagnosis

Despite high prevalence rates, PTSD remains under-diagnosed in forensic populations (Garieballa et al., 2006; Kalyani, 2011; Sarkar, Mezey, Cohen, Singh, & Olumoroti, 2005).

The under-diagnosis of PTSD in MDOs may be attributed to a hierarchical approach to diagnosis, where severe and enduring illnesses are considered of greater importance (Sarkar et al., 2005). One of the clinicians at the recruitment site for the present study suggested an alternative hierarchy. He theorised that commissioners are currently only providing funds for treatment designed to reduced risk. Since PTSD is considered, perhaps mistakenly, as will be discussed below, to be more weakly associated with risk behaviour than severe and enduring illnesses, it is perhaps the case that PTSD is not being assessed, let alone treated.

Alternatively, PTSD may go unrecognised, symptoms may be attributed to other diagnoses with similar diagnostic criteria, or clinicians may be unsure whether the criteria applies to offenders, whether they can therefore make this diagnosis, and whether it can be treated (Ehlers, Gene-Cos, & Perrin, 2009). The current assumption is that DSM-V's (APA, 2013)

diagnostic criteria refer only to victims and those who fear for the victim. It is unclear whether MDOs can be given a diagnosis when experiencing symptoms only in relation to their offence. Without a diagnosis, access to appropriate treatment is unlikely, potentially resulting in more severe mental health presentations, an exacerbation of comorbid illnesses, and poorer prognosis (Gray et al., 2003).

1.4.4 Impact on outcomes of mental health and risk of reoffending

Collins and Bailey (1990) found that, after controlling for alcohol use, antisocial personality, and demographic variables in a sample of 1140 male prisoners, PTSD was associated with violent offending. Based on their finding that offending usually occurred in the year following the first presentation of PTSD symptoms, they propose that trauma symptomology has a causal effect on violent offending behaviour. Although this provides support for the assessment of offenders presenting with aggressive or challenging behaviour following their index offence, as well as those due to be discharged into the community, it is a significant limitation that this conclusion is based only on temporal ordering and a causal mechanism is not proposed. Additionally, the contribution of other factors beyond alcohol use, antisocial personality and demographic variables, particularly those occurring in the year prior to offending, have not been controlled for or evaluated.

Clark, Tyler, Gannon, and Kingham (2014) suggest that traumatised offenders released into the community may be at risk of reoffending due to

evidence that therapy involving trauma-related discussion has the potential to re-traumatise individuals (Doob, 1992; Mueser, Rosenberg, Goodman, & Trumbetta, 2002), and that unresolved trauma limits the benefits of talking therapies for other, non-PTSD diagnoses due to avoidance and an inability to process information (Gray et al., 2003; Rogers, Gray, Williams, & Kitchiner, 2000). This evidence largely consists of theoretical models based on systematic reviews of a limited number of studies and conclusions drawn from case studies rather than experimental research, and should therefore be interpreted with caution.

      Ardino, Milani, and Di Blasio (2013) assessed a sample of 75 male and female prisoners for exposure to childhood abuse and neglect, symptoms of PTSD, worry, perception of support and re-offending risk. They reported that 72% of participants demonstrated symptoms of PTSD, 30.7% were at risk of re-offending and that there was a strong correlation between PTSD symptoms and risk of reoffending. They further concluded that the relationship between PTSD and reoffending risk is mediated by worry and a negative perception of other people's support, thus warranting further research into the impact of cognitive and emotional states on the relationship between PTSD and reoffending. However, these results should also be interpreted with limitations in mind. The retrospective design leaves data vulnerable to inaccuracies in reporting of trauma details and PTSD symptoms. Variation in the nature of the reported trauma, uncontrolled differences between male and female prisoners and the lack of assessment for additional later trauma, comorbid illness, and details of previous offending

should all be taken into consideration. Additionally, the authors acknowledge the potential impact of a self-selection bias.

1.4.5 The potential for judicial injustices

Harry and Resnick (1986) highlight the potential for judicial injustices if PTSD remains unidentified. They raise the potential for difficulties in discussing a traumatic event during police interviews and with lawyers, and the increased likelihood of pursuing a plea bargain rather than going to trial in order to avoid further reliving of distressing events. One of the three case studies presented is an offender who was thought to have dissociated during homicide, resulting in an inability to remember killing his wife and mother-in-law. Flashbacks, nightmares and heightened arousal are also described but it is unclear whether the offender was diagnosed with PTSD.

1.5 Treatment of offence-related PTSD

Evidence for treatment efficacy in offence-related PTSD is currently limited to case studies. A report by Lad (2013) describes the implementation of TF-CBT using Ehlers and Clark's (2000) cognitive model with a male prisoner with a severe and enduring mental illness and PTSD. He had experienced multiple traumatic events but his PTSD symptoms were related to his index offence of murder. He no longer reported symptoms following 20 treatment sessions and at six-month follow-up.

Clark et al. (2014) also used a single case study design to investigate the efficacy of EMDR for the treatment of offence-related PTSD in a mentally disordered sexual offender with a diagnosis of paranoid schizophrenia. Treatment gains were made after just six sessions and were maintained at 1-, 3- and 12-month follow-up. The authors question whether the standard EMDR protocol used to treat their participant is entirely suitable for the treatment of offence-related PTSD due to differences compared to victim-related PTSD in the mechanisms of trauma resolution, perception of threat and understanding of guilt and shame, but are unable to suggest how the protocol may be adapted for this population based only on this case study.

Rogers et al. (2000) utilised a single case study experimental design to evaluate the use of a behavioural approach to treat offence-related PTSD in a female perpetrator of manslaughter with major depression. Outcome measures were administered nine times over 16 weekly sessions and follow-up: twice at baseline one month apart, in sessions 4, 8 and 12, at discharge, and at 3-month, 8-month and 30-month follow-up. Sessions consisted of imaginal and live graded exposure to reminders of the traumatic event, specifically knives. Analysis using ipsative Z scores based on the participant's mean and standard deviation, and an absolute critical difference score indicated significant decreases in symptoms of PTSD and depression between pre- and post-treatment and between pre-treatment and 30-month follow-up. It is reported that the participant was discharged to the community from a medium secure service three months following the successful treatment response. Although these results are promising, the use of an AB design is a considerable limitation as naturally occurring changes cannot be

controlled for and the cause of significant findings can only be hypothesised. Additionally, the use of atypical statistical methods impacts on one's ability to interpret the reported results and draw conclusions.

These case studies offer promising results but larger studies are needed to be able to draw generalisable conclusions. A deeper understanding of the presentation and mechanisms of offence-related PTSD is paramount in order to be able to structure interventions effectively.

1.6   The aims of the current study

In order to build on the existing case study literature, this research aimed to explore experiences of offence-related PTSD among a small sample of adult male MDOs. A gender difference in the prevalence of PTSD is well documented in the general, prison and MDO populations (Cauffman, Feldman, Watherman, & Steiner, 1998; Kilpatrick et al., 2013; Walsh, 2013). A male-only sample was therefore selected in order to maintain homogeneity and ensure that gender differences in experience were controlled for. The age limit of the sample was capped at 65 so as to reduce the possibility of capturing and misinterpreting experiences of age-related non-dementia cognitive decline, estimated at 16.8% among over 65s (Graham et al., 1997). Only individuals who had received a conviction were invited to participate so as to avoid legal conflicts arising from disclosures about their offence. Additionally, this ensured that those on remand or awaiting trial did not mistakenly understand participation to have any impact on sentencing. Only individuals with good comprehension and expression in English were invited

to participate due to data collection methods and the importance of interpretation of expression in IPA.

The research aimed to provide further insight in to how this population experiences, understands and makes sense of high levels of clinical distress in relation to their offence. Given the evidence that suggests that offence-related PTSD is under-diagnosed and under-treated, the researcher was interested in the possible explanations for the lack of recognition in the form of a clinical diagnosis and the appropriate treatment that may be offered to this population. This research therefore further aimed to explore how the reported experiences of offence-related PTSD were similar or different to DSM-V diagnostic criteria for PTSD (APA, 2013) and Ehlers and Clark's (2000) cognitive model. This model is currently considered the most detailed theory of the development and maintenance of PTSD (Brewin, & Holmes, 2003) and is routinely used in clinical practice, so was considered most beneficial for consideration in this research. The hope was that these explorations would assist clinicians in quickly and accurately identifying offence-related trauma through appropriate assessment, and would provide guidance on possible beneficial treatments.

1.7   Research questions

This research aimed to address and answer one primary and two secondary research questions.

1) How does a small sample of MDOs experience offence-related post-traumatic symptoms?

2) How are experiences similar or different to PTSD diagnostic criteria?

3) How are experiences similar or different from the processes described in Ehlers and Clark's (2000) cognitive model of PTSD?

1.8   The chosen methodology

1.8.1   Why choose a qualitative approach?

Qualitative research seeks to explore and enable an in-depth understanding of how people experience and perceive their world, and how they behave within the social world (Banister et al, 2011). Relatively little is known about offence-related PTSD and how MDOs experience this, so a qualitative approach was considered appropriate to explore this phenomenon beyond the existing literature.

Although it may seem unlikely to pair a medical diagnosis-based model with a qualitative approach, this allowed the identification of important aspects of the participants' experiences, followed by a cross-case comparison and an exploration of whether common constructs are similar or different to the symptoms and cognitive behavioural components common in victim-related PTSD. A quantitative approach aimed at testing specific hypotheses would be premature and would fail to capture personal experiences. The primary research question is therefore exploratory and allowed participants' own understanding to be expressed without the limitations of preconceived ideas. This facilitated both commonalities and idiosyncrasies in experiences to come to the fore. The secondary research questions required the researcher to

engage in a degree of interpretation, attempting to make sense of participants' experiences. This enabled qualitative data to be integrated and understood within the context of evidence-based diagnosis and treatment, thus making it clinically relevant and applicable.

1.8.2 Epistemology

Epistemological positions can be understood to exist on a continuum ranging from realist to relativist perspectives, with positions such as critical realism located between these extremes. Psychological research has typically been conducted from a realist position, which uses a cause and effect paradigm to discover an assumed single 'truth' about reality (Henwood, & Pigeon, 1992). In contrast, a relativist position primarily searches for meanings and contends that all knowledge is socially constructed through discourse and within systems of meaning (Willig, 2001). A critical realist position assumes that 'real' phenomena exist and can be examined, but that meanings are located within a particular framework of beliefs, assumptions and knowledge, and that context also influences how an experience is constructed. For example, factors such as race, gender, socioeconomic status, culture and education can influence and mediate how experiences are constructed, the meaning that is attached to them, and how they are represented linguistically to others (Larkin, Watts, & Clifton, 2006; Pilgrim, & Rogers, 1997).

1.8.3 The position of the researcher

Heidegger (1962) argues that all research is influenced by implicit and explicit beliefs, assumptions and knowledge, none of which can be completely put aside by either the researcher or the participants. The importance of researchers identifying and being transparent about their epistemological position has been emphasised by Willig (2001).

The researcher assumed a critical realist stance, which was suited to the research goals since the questions aimed to explore individual experiences and sense-making but acknowledged and attempted to locate this within the researcher's prior beliefs and knowledge, particularly in relation to the phenomenon of victim-related PTSD. Since IPA acknowledges the role of the participant-researcher relationship, it is important to acknowledge and reflect on the assumptions held by both the researcher and those that may be held by participants, and be explicit about one's position in relation to the research (Elliott, Fischer, & Rennie, 1999). The impact of the researcher's demographic identity, experiences and ability to be reflexive in acquiring an accurate understanding can then be considered (Kvale, 2007; Larkin et al., 2006).

The researcher is a 25 year old, heterosexual, white British female with middle-class economic status, no criminal record and no history of mental health difficulties. The research interviews were conducted during the final year of a doctoral degree in Clinical Psychology, amid academic assignments and clinical placements. Prior clinical work included assessment and treatment of victim-related PTSD, which inevitably influenced beliefs and

expectations about common symptoms, experiences and cognitive behavioural constructs. However, the researcher had been exposed to many variations of symptomatology and adopted a critical approach to understanding distress. The researcher had no prior experience of working in a medium secure service, but worked briefly on a low secure ward prior to clinical training. This was her only experience of working with offenders in a secure forensic setting.

1.8.4 Interpretative Phenomenological Analysis

IPA is an approach to qualitative research specifically committed to the exploration of personal lived experiences, the meaning individuals attach to these experiences, and how they make sense of them (Smith, Flowers, & Larkin, 2009). It has been informed by the ideas and discussions of three distinct but interlinking areas within the philosophy of knowledge: phenomenology, hermeneutics and idiography.

1.8.4.1 Phenomenology
Phenomenology is an approach to the exploration of lived experience and is concerned with how individuals perceive and come to understand their experiences. According to Husserl (1927, as cited by Smith et al., 2009; 1970; 1982), phenomenology involves the study of how individuals accurately understand experiences by examining and identifying the fundamental qualities of their conscious experience prior to making interpretations, reflections and attributing meaning to them. He argued that if it were possible

to identify the essential components of an experience, these would surpass the specific circumstances and context of their representation, and may also be common for others. Husserl suggested that, in order to identify the core features of experience, one needs to put aside, or 'bracket', their assumed realities in order to instead focus on one's perception of their reality. He described a process of 'reduction', which encourages individuals to redirect their focus away from their preconceptions and towards the elements and structure of their experience, by examining each component on both a descriptive and reflective level. Husserl's work on transcendental or descriptive phenomenology has influenced psychological qualitative research, and particularly IPA, in setting the agenda for detailed examination of lived experience, and emphasising the importance of reflection and bracketing.

1.8.4.2 Hermeneutics

Heidegger (1962) made a move away from Husserl's version of phenomenology towards hermeneutic or existential phenomenology, so is discussed here under the heading of 'Hermeneutics'. Heidegger challenged the notion of bracketing and questioned whether knowledge can exist separately to interpretation, personal perception and prior experiences, as he argued that human existence is always located within a social context involving language, culture, relationships and objects. He proposed that phenomenology is an overtly interpretative approach towards understanding people's meaning-making processes, and that bracketing may be better understood as a cyclical process. He warned that fore-understandings should not present an obstacle to interpretation, but that they may appear through

engagement with surface-level data. The latent assumptions that become apparent through interpretation can in fact be helpful in strengthening an understanding of a phenomenon by placing one's interpretations within the context of prior assumptions and scientific theory. Gadamer (1990) expands on the idea that assumptions may only become apparent once interpretation is underway by highlighting the dynamic multi-directional influence of preconceptions, interpretation and the phenomenon itself. Schleiermacher (1998) promotes an interpretative process involving a comprehensive and detailed analysis in order to achieve an understanding of both the individual and their represented experience. While Schleiermacher suggested that analysis has the potential to produce a better understanding than that already held by an individual about their own experience, IPA does not make this claim, but promotes the idea that value can be drawn from engaging in a holistic analysis of the text itself, an interpretation of that text, and by placing it within the context of psychological theory. Remaining open throughout the data collection and analytic process allows preconceptions to be identified both in advance and while engaging with data.

The concept of a hermeneutic circle is touched on by a number of hermeneutic writers and is concerned with the relationship between the part and the whole throughout the research process. To understand the part, the meaning of a single word for example, one has to consider the whole, the sentence in which the word is embedded; and to understand the whole, one needs to look at the parts. With regard to interpretation, the theory of a hermeneutic circle can be used to conceptualise the dynamics of preconceptions. A researcher will hold fore-understandings but through

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engaging with a participant's account of their experience, these will be revised based on new interpretations. A 'double hermeneutic' (Smith, & Osborn, 2003) refers to the cyclical process of the researcher attempting to make sense of the participant making sense of a particular phenomenon.

Heidegger, Gadamer and Schleiermacher have all influenced IPA in establishing phenomenology as a hermeneutic approach, and highlighting the importance of examining how a phenomenon appears and how the analyst is crucial in enabling and making sense of that conceptualisation.

1.8.4.3 Idiography

In contrast to the dominant nomothetic approach to psychological research, which strives for group- or population-level generalisability grounded in statistical data, IPA is concerned with the particular. Unlike descriptive phenomenology, IPA does not attempt to reveal the common essence or structure of an experience, but rather attempts to capture how specific experiential phenomena have been understood and perceived by particular individuals within a particular context. Sample sizes are therefore small and purposefully selected from within a context of interest. Idiography does not entirely disenable generalisations, but these are made cautiously, are located within smaller, homogeneic groups, and are grounded in detailed, idiographic data. The wider hermeneutic circle is apparent here and can be used to understand the importance of both qualitative and quantitative research into psychological phenomena in contributing an understanding of both the parts and the whole.

1.8.4.4 The advantages of IPA for this research

IPA was selected as the most appropriate approach as it is committed to a detailed exploratory examination of human lived experience from an idiographic perspective. This was suited to the aim of exploring the under-researched experience of offence-related PTSD among a small population of MDOs. The flexible and open-minded approach allowed participants to raise aspects of experience outside the parameters of the researcher's preconceptions and consequently unanticipated phenomena could therefore be revealed. The acknowledgement of hermeneutic theory within a framework of analysis grounded in the data is a further strength of IPA, in that it goes beyond both the respective emphases of description and interpretation in transcendental and hermeneutic phenomenology, thus allowing a more coherent and comprehensive narrative to be developed from the data.

Alternative qualitative approaches were also considered but ultimately rejected. Thematic analysis has the strength of revealing important themes but risks losing idiographic data and a detailed account of experiences due to larger sample sizes. Given the focused population and the complexity of PTSD, IPA was deemed more suited to drawing out themes while also taking an idiographic perspective on sense-making. Grounded theory was rejected on the basis that the research aims did not match the aim of generating a new theory that can be generalised based on a large, heterogeneous sample and theoretical saturation. Discourse analysis was also rejected because the research did not aim to use linguistics as a tool to understanding how individuals construct reality, but was instead interested in how linguistics is

used to reflect a personal reality and how individuals make sense of their

experiences.

CHAPTER TWO: METHOD

This chapter focuses on the specific methods of recruitment, data collection, and analysis. Reflections on the method are offered, along with ethical considerations. Finally, the practises used to address quality are highlighted.

2.1 Design

A qualitative approach was implemented in order to allow exploration of participants' experiences. Staged recruitment enabled selective sampling based on the relevance of the research for individuals. Firstly, clinicians were approached and asked to identify service-users based on the first four inclusion criteria listed below. Initially, it was thought that the sample would be limited to violent offenders, but this was expanded to include sexual offenders on the basis that their sexual offences were also violent and previous research in this area has included both groups (for example, Crisford et al., 2008). A screening stage using two standardised questionnaires was used to identify those individuals reporting clinically significant symptoms of post-traumatic stress disorder (PTSD) related to their offence. Those scoring above cut-off criteria were then invited to participate in a semi-structured interview, which allowed participants to convey their experiences and their understanding of these in their own words.

2.2 Inclusion and exclusion criteria

2.2.1 Inclusion criteria

- Male

- Aged 18-65

- Good comprehension and expression in English

- Committed a violent or sexual offence for which they had already been convicted

- Reported symptoms of offence-related PTSD in the moderate range or above, with a minimum score of 11 on the *Post-traumatic Diagnostic Scale* (PDS; Foa, Cashman, Jaycox, & Perry, 1997) and a score of 30 or above on the *Impact of Events Scale - Revised* (IES-R; Weiss, & Marmar, 1995)

2.2.2 Exclusion criteria

- Currently on remand or awaiting trial

- Did not report clinically significant symptoms of offence-related PTSD during screening

2.3 Recruitment procedure

For a flow chart illustrating the recruitment and data collection procedure, please see Appendix B.

2.3.1 Recruitment site

Participants were recruited from a medium secure forensic hospital in the English midlands. The service provides inpatient care to adults aged 18 and above, who are suffering from mental health conditions and, because of the nature of their offence and current behaviour, cannot be managed in less secure services. This particular service is split into three care streams: male mental illness, male personality disorder and female services. The male mental illness stream consists of three wards: one admission ward with 16 beds and two rehabilitation wards with a total of 26 beds. The male personality disorder stream consists of two wards totalling 24 beds and the female stream consists of two wards with a total of 22 beds. Referrals are accepted from courts, prisons, high and low secure hospitals, general mental health services and private hospitals.

2.3.2 Clinician referrals and consent to approach

Clinicians were initially informed of the research during a team meeting, following which they were provided with an electronic copy of the clinician information sheet and referral form (Appendix C). Clinicians tended not to make full use of the referral forms, instead choosing to discuss potential participants with the researcher. In instances where referral forms failed to provide sufficient information on offending history, mental health and risk, details were sought by referring to patient notes and by emailing clinicians for

more information. In most cases, the referring clinician discussed the

research with potential participants prior to making a referral.

2.3.3 Informed consent

Once referral details had been obtained and consent to approach was

received from the responsible clinician, the researcher approached the nurse

in charge on the relevant ward to arrange an appropriate time to meet

potential participants that did not clash with groups, other appointments,

booked leave or daily ward activities and meals. A handover was given by the

nurse in charge before meeting any potential participants. During this initial

meeting, a written information sheet was supplied as well as being explained

verbally (Appendix D). All potential participants were asked whether they had

any questions and were then given a minimum of 24 hours to consider

whether they would like to take part. Questions and concerns that were raised

included "will I be able to hear the results of the project?", "does it matter that

I'm not very good at doing questionnaires?", "I don't think I have PTSD; can I

still take part?". Questions such as these were answered fully and honestly

before participants were asked to confirm verbally and by signing a consent

form (Appendix E) that they understood the information given and agreed to

participate in the first stage of the research.

2.3.4 Screening for inclusion and exclusion criteria

The researcher met participants in a private room on the wards to administer two screening questionnaires.

2.3.4.1 Post-traumatic Diagnostic Scale

The *PDS* (Appendix F; Foa et al., 1997) is a 49-item self-report measure with four sections, which has been validated on a clinical population aged 18-65, and has shown good reliability (Foa et al., 1997). Foa, Riggs, Dancu, & Rothbaum (1993) reported a Cronbach's alpha of .91 for the total score of the *PDS* and test-retest reliability was calculated to be -.74. Foa et al. (1997) reported internal consistency alphas of .92 for total symptom severity, .78 for re-experiencing, .84 for arousal and .84 for avoidance.

Part 1 is a trauma checklist, which allowed the researcher to identify past traumas in addition to offending behaviour. Part 2 then asked participants to identify which of their traumatic experiences was most upsetting. Some individuals spontaneously identified their index offence but those who identified a victim-related trauma were asked to respond to the remaining questions in Parts 3 and 4 twice, once for the trauma they identified and once for their most distressing offence. Without exception, the most distressing offence was named as their index offence. Part 3 assesses the severity of PTSD symptoms by asking how often they occur, rated on a 5-point scale from 0-4, and Part 4 assesses interference of the symptoms. The following score ranges for Part 3 were used to indicate symptom severity: <10

– mild, 11-20 – moderate, 21-35 – moderate to severe, 36-51 – severe.

Those scoring 11 and over were considered to have met inclusion criteria.

2.3.4.2 Impact of Events Scale – Revised

The *Impact of Events Scale – Revised* (Appendix G; Weiss, & Marmar, 1995)

is a 22-item self-report measure that assesses subjective trauma-related

distress during the previous week. Weiss and Marmar (1995) and Creamer,

Bell, and Failla (2003) report high levels of internal consistency with a

Cronbach's alpha of .87-.94 for the total score, .79-.91 for hyperarousal, .84-

.87 for avoidance and .87-.94 for intrusion subscales. Test-retest reliability,

collected at a 6-month interval was calculated to range from .89-.94. Scale

scores from each of the three subscales were also reported to show a high

degree of intercorrelation ranging from .52-.87.

As the IES-R allows the identification of a specific event, the

researcher asked participants to consider only their offence that currently

bothers them the most. In all cases, participants identified their index offence

for this purpose. Items were rated on a 5-point scale from 0-4. The *Impact of*

Events Scale – Revised is not used to diagnose PTSD, but a cut-off score of

30 is typically used in clinical settings to indicate a preliminary diagnosis

(IAPT National Programme, 2011). This score was therefore used as the cut-

off for inclusion.

2.3.4.3 Reflections on the screening stage of participation

Several individuals raised concerns about answering questionnaires, which

for some meant that they chose not to participate. Worries were generally

about getting answers wrong or not feeling confident in using rating scales.

The researcher therefore tried to reassure participants that there were no

right or wrong answers and that they could take their time to think about their

response. Instructions were repeated where necessary. There was also a

sense that this process was 'boring' for participants and the questionnaires

failed to capture what they wanted to say. The first few participants provided

lengthy answers to some questions with rich information about their

experiences. It was disappointing that this data was lost since it was not

always provided at interview in as much detail, but notes were kept so that

the researcher could come back to topics if necessary. After several

frustrating experiences of not being able to use rich data, the researcher was

careful to explain that the purpose of this stage was not to collect detailed

information and that they would have an opportunity to tell their story in their

own words later if they would like. This encouraged participants to keep their

responses brief.

2.3.5 Invitation to participate and consent

Individuals who met inclusion criteria were invited to participate in the

interview stage of the research. The researcher reminded them of the details

on the information sheet and any questions were answered. All of those who

were asked agreed to participate and confirmed this verbally and by signing a

second consent form (Appendix H). They were usually seen for the interview

between one and three weeks after completing the questionnaires.

2.4 Participants

2.4.1 Participant numbers

The researcher aimed to recruit six to ten participants. Previous research using Interpretative Phenomenological Analysis (IPA) to investigate experiences of offenders has used sample sizes in this range. For example, Ferrito, Vetere, Adshead, and Moore (2012) interviewed seven male mentally disordered offenders (MDOs) on their experiences of recovery and redemption and Bellamy (2011) analysed six data samples to explore self-esteem in sexual offending and experiences of group therapy in a forensic learning disability service. Likewise, studies utilising IPA to explore experiences of victim-related trauma have also used small sample sizes within this range. Freh, Dallos, and Chung (2012) interviewed nine adults who had experienced bomb attacks in Iraq to explore how they make sense of this experience and the coping strategies they employ. Further to this, Smith et al. (2009) recommend a sample size of four to ten participants for Professional Doctorate research.

Eighteen people were referred and of these, eight did not consent to participate, four were excluded as they did not meet screening-based inclusion criteria, and six were recruited. It was possible to begin recruitment at a second site, which may have increased these numbers up to ten participants, but the researcher concluded that, in order to follow the aims of IPA and ensure a comprehensive narrative of idiographic data, increasing the sample size was less of a priority than maintaining homogeneity by limiting

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the variation in the sample as much as possible. Table 1 shows the

questionnaire scores of the ten people who consented to participate in the

screening stage.

Table 1: Questionnaire data.

Participant	Index offence	Time since offence (year of offence)	Post-traumatic Diagnostic Scale score and severity	Impact of Events Scale - Revised score	Met inclusion criteria?
James	Rape	9 years (2006)	19, moderate	41	Yes
Kristopher	Manslaughter	2 years (2013)	34, moderate-severe	57	Yes
Pete	Affray (threatening with a knife)	1 year (2014)	41, severe	52	Yes
Phil	Grievous Bodily Harm against a child	20 years (1995)	34, moderate-severe	47	Yes
Sean	Manslaughter	9 years (2006)	34, moderate-severe	62	Yes
Liam	Four counts of sexual assault, sexual activity with a child under 16 and sexual assault of a child under 13	5 years (2010)	21, moderate-severe	38	Yes
Jack	Sexual assault by penetration	3 years (2012)	27, moderate-severe	16	No
Matthew	Theft and two counts of attempted robbery	3 years (2012)	11, moderate	9	No
Adrian	Rape and Actual Bodily Harm	3 years (2012)	2, mild	4	No
Mike	Attempted robbery (with a pretend gun)	9 years (2006)	6, mild	29	No

2.4.2 Demographics

Appendix I gives the full demographic details of the ten people who consented to participate in the first stage of the research. Those who completed the questionnaires were aged between 22 and 39, and all but two participants identified as white British. The age range for the six interview participants was 23-36. Two of the six were convicted of sexual offences, while the other four were convicted of non-sexual violent offences. Offences occurred between two and 20 years ago.

2.5 Data collection procedure

2.5.1 Semi-structured interview

One-to-one semi-structured interviews were chosen as the most suitable data collection method for the research aims. Interviews enable researchers to gain an understanding of a participant's experiences as told in their own words (Kvale, 2007). The flexibility of semi-structured interviews encouraged participants to tell their story from the position of an 'experiential expert' (Smith, & Osborn, 2003, p.57), highlighting the aspects most important to their lived world, while also allowing the researcher to obtain rich data through engagement in a conversation led by the participant's responses. This method is therefore suited to the aims of IPA (Smith et al., 2009).

2.5.2 Interview schedule development

The interview schedule was developed over a process of refinement and reflection. The common clinical themes of PTSD central to the research questions were first considered and organised into a logical sequence. The researcher was open to the possibility that participants may describe novel and unexpected experiences so developed a series of broad, open questions, which would allow participants to talk about the experiences that were of importance to them (Banister et al., 2011). The researcher hoped to only ask the first question but intended that all the following questions were available as prompts, only to be used if a participant did not spontaneously volunteer information in that topic area. Briefer prompts were intended to obtain more detail and clarification. The schedule was reviewed as part of Royal Holloway's research proposal process, it was presented to peer-researchers at the London IPA group and to clinicians from the Traumatic Stress Clinic, London, and was circulated to a group of service-users at the recruitment site by the lead psychologist. Several suggestions were made regarding specific wording in order to ensure that questions were not leading or making assumptions, and that they were clear and accessible for service-users. All feedback was incorporated and amendments were made. The final schedule (Appendix J) acted as a guide during the interviews but was not rigidly adhered to and topics were discussed in varying orders.

2.5.3 Interview procedure

All participants were interviewed at a pre-arranged time in a private room.
Having previously met twice, the researcher engaged in some initial 'small-
talk' with participants, which assisted with the progression into a detailed
conversation. They were then reminded of the purpose of the research, the
limits of confidentiality and their right to withdraw from the study without giving
a reason, and were asked if they had any questions. They provided written
and verbal consent to participation before the audio recording device was
switched on.

According to Smith and Osborn (2003), interviews should start with a
broad, open question to encourage the interviewee to talk freely and
spontaneously offer details about the topic. Participants were therefore briefly
asked to think back to the questionnaires, which asked about their index
offence and their mood since then. If any other traumatic experiences had
been disclosed during screening, participants were reminded that, during the
interview, only their offence would be discussed. They were then invited to tell
the researcher more about this in their own words. The resultant
conversations were guided by participants as much as possible, and prompts
were used to enable them to give an in depth account. Topics not
spontaneously raised by participants were addressed later in the interview
once all volunteered avenues had been explored. Interview length ranged
from 17 minutes to 40 minutes, lasting an average of 26 minutes.

2.5.4 Reflections on the interview stage of participation

The researcher was careful to identify and make attempts to bracket preconceived ideas about the topics that would be raised. First impressions and thoughts were captured in a reflective journal following each interview. Although each participant differed in their willingness and ability to communicate detailed information, the reasons for which were considered during analysis and are returned to during chapters 3 and 4, the researcher was surprised by the shorter than anticipated length of interviews and the number of prompt questions that were required. Given that interviews were similar in length, it is possible that this is what was tolerable for this participant group, particularly since the content of discussions was emotive and potentially distressing. The repetitive nature of some responses following the earlier questionnaire stage was also considered, so the researcher made later participants aware of this possibility at the start and asked them to relay as much detail as possible as though they had not done so previously.

2.6 Ethical considerations and risk management

Ethical approval for this research was obtained from the Stanmore NRES Research Ethics Committee (Appendix K), the local NHS Trust Research and Development Ethics Committee (Appendix L) and Royal Holloway, University of London Ethics Committee (Appendix M). Following a change in recruitment site, minor amendments to documentation were approved by the Stanmore

NRES Research Ethics Committee, along with changes to the interview schedule following feedback from various sources (Appendix N).

2.6.1 Confidentiality

The limits of confidentiality were discussed when seeking informed consent to participate. Participants were aware that in the instance of suspected risk to self or others, their responsible clinician, psychologist and the nurse in charge would be informed and that this would be discussed with them first. They were also told that a brief note would be added to their patient notes with details of the risk so that this could be managed by the clinical team. Additionally, participants were informed that if they disclosed details of an offence for which they had not been charged, the police would be informed as well as the clinical team.

All research material, including questionnaires, audio recordings and transcripts, were anonymised by assigning each participant a pseudonym and omitting identifying details, such as names of family, friends, doctors, places, and services. Consent forms were kept in a locked cabinet separate from demographic data and electronic information was kept on a password protected computer.

2.6.2 Managing participant distress

As highlighted by Newman, Risch, and Kassam-Adams (2006), there is a potential for participant distress during any trauma-related research, which

needs to be given careful consideration in order to ensure that the benefits of participating outweigh the costs and that any risk of distress is minimised. Participants were made aware that agreeing to participate in the research would involve being asked a number of potentially distressing questions regarding their offences, any previous trauma, and their traumatic symptoms, but that they were free to withdraw at any time without giving a reason. All participants were debriefed following participation and were asked how they would manage any distress in the following hours and days should it arise. All participants said that they were feeling "ok" or "alright" and some gave examples of how they would manage particular symptoms. The researcher encouraged them to seek support from the nursing team, their responsible clinician and their psychologist if they were feeling distressed. Ward staff were consulted on participants' emotional states prior to meeting with them and were then given a handover following all stages of the research. The responsible clinicians and psychologists were also informed of any significant symptoms so that they could be considered in clinical discussions. Consent was sought for these discussions, which was given in all cases as participants expressed a desire to access support and treatment and thought that informing those responsible for their care would be helpful in achieving that.

2.6.2.1 Offence-related distress

During his interview, Kristopher experienced a dissociative flashback. The researcher encouraged him to try some basic grounding techniques, including stamping his feet and repeating some grounding phrases. A decision was then made to end the interview and Kristopher agreed to the researcher

informing the clinical team of his re-experiencing symptoms and the

management techniques he found helpful. Although it is critical for a

researcher who has clinical responsibilities in other contexts to be clear about

their role when collecting data, it was important in this instance for the

researcher to be able to use clinical skills in order to manage participant

distress safely. When the immediate distress had passed, the risk of further

distress was communicated to the clinical team, who then assumed clinical

responsibility for this. For details on how Kristopher's flashback was managed

during the interview, please see his transcript in Appendix O.

2.6.2.2 Victim-related distress

A number of participants disclosed victim-related trauma during questionnaire

completion. For Kristopher, this was closely linked to his offence so the

interview included additional questions designed to determine whether his

experiences were related to victim- or offence-related trauma. Sean disclosed

childhood physical abuse and told the researcher that the abuser is currently

a teacher at a school for children with special educational needs. The need to

break confidentiality for safeguarding purposes was discussed with Sean and

his disclosure was relayed to his responsible clinician and Social Services,

who then reported the concern to the local Child Safeguarding Team. Phil

also reported childhood trauma and informed the researcher that he was

experiencing a number of PTSD symptoms in relation to this. Following

questionnaire completion and prior to meeting again for the interview, Phil

experienced high levels of distress so discussed this with the nursing team

and his psychologist. He wanted to participate in the interview but it was

agreed that his psychologist would also be present so that she would be in a better position to support him should he feel distressed again. This interview included some direction from the researcher, the purpose of which was not to lead Phil to talking about particular experiences but to encourage him to talk about his offence rather than his childhood victim-related trauma, which could be more appropriately managed in his usual psychology sessions.

2.6.3 Maintaining researcher safety

Prior to commencing recruitment, the researcher was given mandatory training in risk management procedures. An alarm was worn at all times in clinical areas and the researcher was accompanied by another member of staff when travelling between wards. A handover was given by the nurse in charge prior to meeting with any potential participants. All individuals were seen 1:1 for data collection, with the exception of Phil.

2.6.4 Payment of participants

Participants who consented to completing the questionnaires were given £5 compensation for their time. Those who were then invited and consented to participating in the interview were given an additional £5. Participants were told that if they chose to withdraw from the research they would still receive this payment. This money was paid into their hospital account, managed by the hospital finance department.

2.7 Data analysis

2.7.1 Open engagement with the data and initial response

2.7.1.1 Transcription

Each interview was transcribed verbatim into tables, which allowed annotation corresponding to each line to be added on either side of the transcript. Identifying details were changed, but the researcher's questions, significant pauses, stumbling, sighs, laughter and significant gestures were all included as IPA requires some attention to non-verbal communication as well as verbal interaction (Smith, & Osborn, 2003). The process of transcription, which involves repeatedly listening to each interview, is an important part of engaging with the data and improving one's understanding of the participants and how they make sense of their experiences (Tilley, 2003).

2.7.1.2 Reading and re-reading

Similarly, following transcription, reading and re-reading each interview also increased familiarity with the data. This process ensured that the focus of the analysis was the participant and enabled early reflection on initial thoughts and responses to the data as well as the interview process and structure, which was used to inform how future interviews were conducted. The location of rich data, repetitions and contradictions were noted. This stage of analysis helps guard against the development of a summary based on a 'quick and dirty reduction' (Smith et al., 2009, p.82), and allows for assumptions and pre-

conceptions to be bracketed while attention is focused on the participant's understanding and sense-making (Willig, 2001).

2.7.2 Initial exploratory coding

During this stage of analysis, detailed and comprehensive notes were made in the right-hand margin of each transcript. A close analysis was conducted, including both descriptive and interpretative comments, which considered the elements that mattered to the participant, the meaning and context of these things within their lived world, the language that was used, and more abstract concepts and ideas that may only have been alluded to. The content of the exploratory coding can be broken down into three discrete focuses for the purpose of illustration but these were combined on the same transcript so as to ensure that the connections between them were not lost.

- Descriptive comments, which focus on the content and topic area of what has been said.

- Linguistic comments, which considers the use of language, pauses, repetitions and intonation.

- Conceptual comments, which aim to demonstrate curiosity about the meaning of what has been said and engage with the data at a more abstract and interpretative level.

Several questions were also held in mind during this initial stage of analysis: 'what does this experience mean to the participant?', 'what alternative meanings might these experiences have?', 'how can this be understood?' and 'what is the function of offering this understanding?'.

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2.7.3 Making connections

The increased data set including both the transcript and the exploratory notes became the focus for the next stage of analysis. 'Emergent themes' (Smith et al., 2009) were developed and noted in the left-hand margin. The researcher attempted to reduce the volume of rich data while simultaneously preserving the complexities of the connections and patterns in the exploratory notes. This process involved continuous movement between the transcript and exploratory notes in order to develop increasingly conceptual interpretations rooted in the data.

2.7.4 Clustering emergent[1] themes

Emergent themes were grouped into clusters based on an element of commonality using different coloured post-it notes for each participant. These cluster themes were then labelled, attempting to capture all the emergent themes, and transferred to a spreadsheet with corresponding emergent themes and quote line numbers. Supervision from senior colleagues and peers supported this process and encouraged reflection on whether themes reflected the researcher's assumptions and beliefs or remained grounded in the data. Similar cluster themes generated by multiple professionals indicated good internal validity, but allowed the researcher to consider and discuss

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[1] The use of the phrase *'emergent themes'* is used for flow and ease of reading. It should not be understood to represent a 'realist' epistemological position.

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alternative interpretations and categorisation of themes. This process was repeated for each transcript.

2.7.5 Cross-case analysis and developing superordinate themes

Every participant's cluster themes were then grouped into subordinate themes, again based on an element of connection. The use of colour-coded post-it notes allowed the origin of each theme to be tracked. If insufficiently represented or of marginal importance to the research questions, themes were discarded (Willig, 2001). Superordinate themes were developed and labelled following a process of abstraction, which involved identifying themes within themes and reaching a conceptual understanding of these. By raising the level of interpretations, the risk of under-synthesising data and generating a large number of superordinate themes was avoided. This is supported by Reid, Flowers, and Larkin (2005) and Hefferon and Gil-Rodriguez (2011), who advocate a 'less is more' approach at this stage in analysis. Three coherent themes were generated. For a worked example of the analysis process using Kristopher's interview, see Appendices O-S. Kristopher was the second interview conducted and has been included so as to remain transparent about reflections on the interview process itself. These then led the researcher to make changes to later interviews, including a clearer introduction to the interview and improved open-ended and simplified questions throughout.

2.7.6 Constructing a narrative account

The final stage of analysis was to develop a narrative account of the findings and how the researcher reached a particular understanding of participants' understanding, sense-making and perceived meanings of their experiences. Extracts from the transcripts are used to support the narrative, which in some cases have been refined for ease of reading. Appendix T shows the transcription key and gives an example of how quotes were transcribed and edited. Alongside these quotes written in italics, interviewer questions are included in normal text to provide context and aid understanding.

2.8 Addressing quality in qualitative research

Several authors have endeavoured to clarify a set of criteria to address questions of reliability and validity in qualitative research. Yardley (2000) outlines four key principles on which quality and value can be evaluated: *Sensitivity to context, commitment and rigour, transparency and coherence,* and *impact and importance.* Stiles (1993) makes recommendations based on enabling readers to assess whether or not a researcher has been open to alternative perspectives and the extent to which observations have shifted a researcher's understanding of the phenomenon in question. Brocki and Wearden (2006) point out the role that a researcher's ability to be reflective has on the interpretations and insights that are drawn from qualitative data. It is therefore vital that researchers engage in reflexive and reflective practice

throughout the research process in order to ensure quality analysis (Shaw, 2001).

The researcher made attempts to address each of the points raised by these authors. Personal orientation, values, expectations and theoretical perspectives have been disclosed from the outset, along with the social and cultural context of both the participants and the researcher. A reflective journal was kept from the time of research question formulation right through to analysis and the creation of a narrative account of the results. A multi-disciplinary group for IPA researchers and a peer reflective group were also utilised to discuss the assumptions and expectations that the researcher held about the participant group, their experiences and the data generated from the interviews. The aim was that this would help in the process of 'bracketing' preconceptions.

The researcher's interpretations were also checked with participants, supervisors and peer-researchers in order to assess for reliability and validity. The researcher periodically stated what was being understood during the interviews, giving participants an opportunity to confirm, correct or alter the meaning of observations. Following the interviews, transcripts were read and briefly analysed by supervisors and peer-researchers. The multiple analyses were then discussed in order to check that the researcher's exploratory coding and emergent themes were valid.

Additionally, the researcher adopted and has outlined the analysis methods used to fully engage with the research and the data generated, and demonstrate reflexive validity. The reflective techniques discussed above also serve to help with immersion and engagement with the data.

Despite adopting these strategies, it is acknowledged within the framework of IPA that it is impossible to completely remove oneself from prior assumptions, beliefs and knowledge. Only partial understanding of participants' experiences can be achieved and the analysis is a product of the researcher's interpretation of how the participants make sense of and express their experiences.

CHAPTER THREE: RESULTS

This chapter presents the findings of the analysis of the six transcripts. Each superordinate theme and the corresponding subordinate themes shown in Table 2 are discussed in turn and supported by quotations from the transcripts. Divergence within themes is also highlighted. It is important to note that these themes should not be considered as distinct features of experience but should instead be understood as being inter-connected, as illustrated in Appendix U. Appendix V illustrates participant representation across themes.

Table 2: Master table of themes

Superordinate Themes	Subordinate Themes
1) Responses to an identity shift	1) A changed self 2) Appraisals about the self
2) Ineffective memory processing	1) Memory disturbances 2) Current threat
3) Appraisals of the consequences of offending	1) The importance of social relationships 2) Hospital as a source of cognitive dissonance 3) Worry about the long-term consequences of offending

3.1 Responses to an identity shift

This theme illustrates the experience of struggling to recognise, process and adapt to a change in understanding of the self, following an offence previously not considered to be within one's capabilities. Appraisals and emotional responses to this new self are demonstrated.

3.1.1 A changed self

A common theme across all cases is the sense of a changed self following their offence. Most participants convey disbelief at what they have done and highlight the mismatch between the type of person they believe themselves to be and the nature of their offence.

> *It's just what I've done. I can't believe it. I can't believe that he's dead, you know. I didn't mean to kill anyone. Just it was revenge and I could not control myself. […] The fact that it really happened. I still don't believe myself that I done something nasty like this.* (Kristopher)

> *Basically I shouldn't have committed it. When I committed it I felt like it wasn't me to do a thing like that.* (James)

> *It was quite a shock, quite a shock, was shocking how I could do something so, so awful really. Yeah. But I mean I don't think I'm*

capable of doing that sort of thing really but I was very drunk and I was doing some drugs leading up to that offence. (Sean)

I feel like I'm a horrible person 'cause I was violent and aggressive an' all that and the young, the young lad didn't deserve what I did and that made me, that's made me now a violent person […] but like people says you're just a normal person and like you're a bright person, you get on with things and all that, you've got a good sense of humour and everything and stuff but sometimes I don't feel like that. (Phil)

I'm accused of saying to a baby on the bus "can I suck your pussy?". Why would I say that? I don't talk like that to little kids. You know what I mean? I would never do that to a kid. I'm not a paedophile, you know what I mean? So why, why…where did this come from? (Liam)

This suggests that they must now integrate their offence into their understanding of themselves, but for some this is a frightening prospect that causes distress. While Kristopher, James, Sean and Phil seem to be mourning the loss of their previous identity, indicating that they've reached a level of acceptance in the process of change, Liam's extreme denial and search for an alternative and more comfortable truth by questioning evidence suggests that he is at an earlier stage in this shift. His experiences of shock, distress and denial can be understood as a reaction to the appearance of multiple selves, particularly a possible identity that he wishes to reject.

I don't know how I can get accused of something like that, you know what I mean? Robbery, yeah. I can understand that, me doing a robbery or whatever. I wouldn't do that. I wouldn't do that like, other people, other people do that kind of stuff. […] *I don't talk like that and especially to a one year old because, because what, what in general am I going to get from a one year old? I'm not Jimmy Savile. You know what I'm saying? I'm not, I'm not these people that do that, you know what I mean?* […] *100%. 100% I wouldn't say that. What am I going to get out of saying that? What…why would I say that? I didn't do it. I'm not, that would make me a paedophile basically.* And then you told me earlier that what, what being a paedophile means and what that says about you. *Yeah. People are in for this kind, that kind of thing you know, but don't put me in that category please.* Hm. *Don't put me in that category please. I was begging everyone not to put me in that category.* […] *I'd rather be in the armed robbery category than be in a … Don't take that the wrong way. I'd rather be in for something… I just won't talk like that to a kid, man. I'm a grown up, man, I wouldn't talk like that to a kid.* (Liam)

Pete acknowledges a change in himself in a slightly different way to the other participants. There is a sense that he wanted to escape his past life and recognised the need for change, but he regrets how this change came about. This regret seems to be less central to his experience than the disbelief and challenge to one's identity described by the other five participants.

You said that your future doesn't look great at the moment. *No.* Is that different from the future that you think you would have had, had you not committed your offence? *No, 'cause where I was living then, well my health each day wasn't great so I needed, I know I needed a new place to live but the circumstances in which I, I end up with a new place isn't the way I wanted things to happen.* (Pete)

Several participants indicate that self-reflection is critical in being able to develop a complete understanding of one's identity that incorporates the changed self. Sean's choice of phrase suggests that reflecting on his offence is an on-going process that has helped him reach some conclusions about what was happening for him at that time, what his offence says about him, and the meaning of his current thoughts and feelings about the offence. His language also conjures up a child-like image of being instructed to think about a wrongdoing, which suggests that he may view this as part of his punishment.

So in your own words, what's been going on for you since then? *Um, well I've had seven years to think about it. I think most of it is due to, er, being young, immature, reck--, a bit reckless and my lifestyle which led up to my index offence. Er, and it has tormented me a little bit since, since as well. I've had nightmares about it and, er, sometimes I get a shiver down my spine.* (Sean)

Pete describes using time alone to engage in what appears to be voluntary and purposeful contemplation and reflection. This seems excessive, however, and rumination and worry about the future are repeatedly raised during his interview, so this will be discussed in more detail in the context of the final superordinate theme.

> *If I'm in my room I listen to the radio but I also think about things, think what would have happened if I hadn't done what I did. I think what would have happened if I hadn't have been here with things like that, was here, and if I hadn't have been hallucinating and things like that, you know. I just…contemplate things I suppose, you know? I think about things, what could have happened, what didn't happen and what, what could, what things could be I suppose.* (Pete)

Phil talks about the importance of using his treatment for reflection, both in groups and in individual sessions with his psychologist.

> How do you feel about the offence now? *[…] I've done some groups like life skills, some for skills, trust, self-awareness, anger management. I've got a lot out of anger management. Um with my viol--, me anger, violence and stuff. And I've just completed a group called 'Change'. How things was before, how things is now, and how things could be for the future when you get back out in the community. And er this er I said in that I enjoyed the group. It was a tough group, toughest group I've done since I've been here and er I really enjoyed the group*

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er but when I came here there was a psychologist. I had a couple of one to ones with her and then I had a couple of one to ones with another psychologist, but more with, mostly chats I've had has been with my psychologist now and I discuss more things with her, more in depth. Like mostly the way I'm, the way I feel now from then an' all that. I wish I didn't do it and […] if I knowed the people I should have gone to I wouldn't have been here now. So what I have, what I have learned as well I should have got help, asked for help when I was outside because I didn't ask for help, I didn't ask for help because I didn't know what to do. But what I think, but what I think about it now, I feel sorry for the victim like who I did it to and the victim was just young. (Phil)

For Liam, reflection seems to be a key part of his current experience. If his interview is interpreted to indicate that he is at an earlier stage in the process of integrating his new self with his previous sense of identity, it seems reasonable that, as a facilitator to a transformed sense of self, reflection is a central part of his current lived experience. For others, who are further in that process, reflection remains important and seems to be on-going but is a less dominant feature of their current experience. Engagement in reflection is the first thing Liam talks about, he comes back to it throughout his interview and he also appears to use the interview itself as an opportunity for reflection. This is demonstrated by the way his understanding of his offence and what that means shifts over the course of the interview and how labels that were initially rejected are later adopted to some degree. He also explains how

reflection has helped him develop an understanding of his other offending behaviour, with regard to the index offences he now admits and remembers.

> *But when I'm reflecting now I'm thinking to myself I could have said that because I was unwell and like, I might have said it, I might have said that.* […] What does it mean to be a sex offender? *That you've done a sexual crime. I haven't done a sexual crime though have I? Or have I? I have because I've touched her leg innit? So I have done a sexual crime.* And what does that say about you? *That just makes me sad that does like. It makes me really sad that does. That I'm in that category now. So that makes me really, really sad.* (Liam)

In summary, this theme highlights the cognitive struggle that these participants seem to face in coming to terms with a new self that does not match their understanding of their previous self. Reflection, engaged in either privately, through treatment, or through conversation similar to that during the interview, seems to play a key role in enabling these men to make sense of this new information and integrate it into their existing sense of self in order to form a new, changed sense of identity. The way participants speak about their self-perceptions indicate that they are at different stages in this process of adapting their understanding of themselves to accommodate their offence and what that says about them.

3.1.2 Appraisals about the self

This theme captures the range of thoughts and judgements participants make about their new, undesired self, the emotions that are raised as a result of this changed identity, and how they make sense of and understand who they are now.

Liam and James both talk about their experiences of shame and the impact that has on their social relationships in terms of being embarrassed by their offence and their resultant identity. It appears that they both place some value on other people's perceptions of them.

Every time I mention it, you know, I don't want people knowing about it. […] Are you able to tell me a little bit more about why it's so hard to talk about? *Because it's an embarrass-- …embarrassful, shameful thing. It's embarrassing to talk about it, to commit something like that.* […] *Sometimes when other patients in here ask me what section I'm on, that makes me more nervous because I don't want to talk about my past to them, you know, a bad offence like that; it's just shameful.* (James)

If you had done it, so I'm not saying that you did, but if you had, what would that say about you? *[Sighs] Just ashamed of myself. I think I'd have to move city and everything. I'd just be so ashamed…If I believed that I'd done it then, [sigh], I couldn't show my face around here again… [Sigh] No I wouldn't be able to show my face around here.* […]

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Because if I did do it, I tell you what, now I wouldn't be, I wouldn't be here, I wouldn't have lasted if I'd have done it. I wouldn't be able to hold my head up high in the community. I would have felt so ashamed of myself. I didn't do it so why should I feel ashamed of myself? If I've not done it, why? And I haven't. (Liam)

Liam's narrative of his experience of shame is hypothetical. He seems to understand shame as a feared truth, with potentially disastrous consequences including his tentative reference to suicide. It therefore appears that his dissociation and denial are functional in that they protect him against experiencing shame in the present.

Although James's comments could be interpreted to indicate avoidance of conversations about his offence, this was instead understood to reflect the sense of shame he feels and a desire to maintain his privacy among a group of other mentally disordered offenders (MDOs). This is supported by his willingness to discuss his history with the researcher and his clinicians, as well as his perceptions of patients' reactions to his particular offence.

It's not, it's not an easy thing to talk about. The prisoners and everything hate your guts for it. […] *It's good talking to you about it; it gets it, gets it all off my chest.* […] *There's patients and prisoners; I don't want to tell them my business like that. I don't want to know their business and I don't want them to know mine.* Sure. *…Best people to talk about it is yourself and psychologists.* (James)

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Kristopher alludes to experiences of shame but chooses to describe this as 'disgust' at himself and at his offence itself. His forceful and repeated use of this word during his interview gives the impression that while James and Liam emphasise the importance of other people's perceptions of them and their offence in informing their own appraisals, Kristopher places more emphasis directly on his own perceptions. Likewise, Sean uses the word "awful" to describe his offence, indicating that his own values and opinions have been the key influence in shaping his sense of shame and how he makes sense of this.

> *It's stressful, you know, it's stressful. It disgusts me. I can't believe myself that I've done something disgusting like this.* (Kristopher)

> *It was quite a shock, quite a shock, was shocking how I could do something so, so awful really.* (Sean)

The associated emotions of guilt, regret and remorse are also commonly represented across cases. James talks about guilt from the outset of his interview, which he seems to consider from both from an emotional and legal perspective. The researcher initially wondered whether he brought this up immediately because he thought it was what she would want to hear. However, he continues to express regret and guilt throughout the interview and, rather than being a tokenistic reference, these experiences appear to be

a strong emotional burden for him. This possible interpretation of seeking to please the researcher was therefore disregarded.

> *Basically I admitted my guilt to my offence. That's basically what everyone wants to know about. I feel absolutely bad what I did. And I feel like I've ruined my life.* (James)

Phil and Sean both express regret along with an element of remorse that suggests empathy for the victim or their loved ones. This is interesting given that both these participants have at least one personality disorder diagnosis and Phil is also known to meet criteria for psychopathy on the Psychopathy Checklist – Revised (Hare, 2003). The researcher wondered whether their expressions of remorse and empathy had been learnt as an appropriate response, particularly given the use of presumably learnt psychological terms, such as 'flashbacks'. It is also noted that despite expressing remorse, these two participants still keep the focus of their regret on themselves and their expressions of compassion may therefore be viewed as hollow within the context of a wider self-absorbed narrative.

> *I feel sorry for the victim like who I did it to and the victim was just young […] I regret what I didn't know, erm, like, I feel sorry because like now 'cause I know I'm in here but if I was in his shoes and everything, if it happened to me what I did to him and that, he might have had some, he would have, he's going to have flashbacks for the rest of his life, he's going to be frightened and everything, he's going to*

be, he's going to be panicking, is it going to happen again an' all that.
(Phil)

Well I did live a very violent life and, er, it was unfortunate that, that he, he got hurt because he was a friend of mine really. Yeah, it was, it was, er, a tragedy that he got hurt. […] What do you think the consequences of your offence have been? *There's been a death of a relative, someone's dad, someone's son. […] Er, yeah I've, um, wasted two lives.* (Sean)

Sean's use of the word "unfortunate" and his minimising of someone's death to "got hurt" seems to lack emotion, but nonetheless makes a suggestion of regret. Instead of using the phrase 'I hurt him', Sean depersonalises the situation seemingly to separate himself from the offence and therefore the new, undesired self. This could be interpreted as a further indication of his sense of shame and wanting to alienate himself from that unwanted version of his identity.

Liam, despite denying his offence, also talks about feeling guilty, although he is quick to reverse this. It appears as though he immediately realises he has made an error in admitting his experiences of emotional guilt in case he is understood to also be expressing legal guilt. Alternatively, perhaps he is afraid of admitting guilt to himself. Given that he appears to fear feeling ashamed and the consequences that could bring, as previously discussed, this interpretation is plausible.

> *I look at a kid and I think it's wrong for me even to look at a kid*
> *nowadays. Even though I've not done it I just feel guilty innit. Not*
> *guilty, I can't explain it because I've not done it.* (Liam)

Pete is the only individual not to express guilt or regret over his offence. He instead portrays a sense of regret over how the change he needed to escape his previous life, which he depicts as being destructive, was brought about. There is a sense that he did not intend for crime to be the instigator into a new life.

> *I know I needed a new place to live but the circumstance in which I, I*
> *end up with a new place isn't the way I wanted things to happen.*
> (Pete)

Sean also talks about his previous life. He appears to explain his offence as a demonstration of strength in an unsafe world.

> *I've had times of my life where I've felt really unsafe, and I think the*
> *reason why I've done what I done, now I remember now, is because I*
> *thought it was the only way out. I felt I had to do what I had to do to*
> *feel safe. […] So what I did was I stepped up a notch and made sure*
> *that everyone knew that, that… who my boys are, made sure what*
> *they're dealing with and that.* (Sean)

Although Sean and Pete's narratives about the causes of their offence could be understood as an expression of the discarded superordinate theme, *External blame,* they are instead discussed here because they appear to be relevant to the way in which these individuals construct their new sense of self and the appraisals they now hold about themselves. For example, Sean's recognition that he exists within a violent and unsafe world and his acknowledgement of the role that played in his offending allows him to hold the belief that he is not a violent person.

As is suggested, despite expressing negative self-appraisals and emotions, some individuals also speak about their positive qualities, beyond simply expressing that their offence was out of character. This can be understood to illustrate the desire to retain the previous sense of self and reject, at least to some degree, the new self. Sean, for example, emphasises his ability to feel empathy, despite others perhaps perceiving him as emotionless, uncaring and lacking understanding and compassion. His use of the phrase "not a nice feeling" fails to support his argument though, as he is unable to capture the apparent strength of his emotional distress as indicated in other parts of the interview. He also talks about his character prior to committing his index offence. It is interesting that this is spoken about in the past tense, as though he has accepted that he can no longer talk about himself in a positive light.

> *Because these people say that, er…, I, um, got no empathy. And that's*
>
> *bullshit because I know I have empathy, but I just don't think the, the,*
>
> *er, realisation or the extent of what I did has hit home yet. But*

sometimes it, it does and, er, and when it does it's not a nice feeling. […] Well I weren't no saint but deep down I had a good heart and I'd help people if I could. You know, I'd take them to my flat, you know what I mean, I'd let them have a bath, get something to eat, sleep even, wear my bloody clothes and people always threw it back in my face. […] What do you think your offence and what you've been experiencing since then says about you? *I think, I think it says that, that I'm not evil because if I didn't feel anything then I'd probably be evil or a psychopath, whatever you want, you lot want to call it. Er, but I do feel emotions, do you know what I mean?* (Sean)

As well as viewing his symptoms as confirmation of his perceived identity, Sean also seems to seek other forms of validation. For example, he talks about watching television documentaries and his inability to relate to the violent offenders they portray. These types of programmes might be expected to act as triggers for re-experiencing symptoms, but it instead seems that Sean finds these helpful in maintaining his sense of self.

I watch, um, these, um, these channels on telly like 'Behind Bars' or 'Britain's Most Evil' things like that, and er, they don't really faze me or anything but I look at it and I think, well at least I know that's definitely not me. (Sean)

This theme illustrates the range of emotional and cognitive responses to the new self. Shame, disgust, guilt, and regret are all prominent features of the

experiences of this sample of MDOs, with some also suggesting a remorseful

component. This indicates that these individuals currently hold negative

judgements of themselves in relation to their offence, but that they also retain

some of their positive self-judgement. This appears to be protective for their

mental health and general well being, as indicated by Liam.

In summary, the superordinate theme, *Responses to an identity shift,*

captures the range of experiences and challenges associated with coming to

terms with an offence that does not match one's understanding of

themselves. It appears that some level of acceptance may be reached

through a process of reflection, but this seems likely to involve a struggle to

maintain the desired self and reject the undesired self following the

appearance of multiple selves, so may be better understood as an on-going

process rather than a one off activity. A range of negative emotions and

cognitions about the self are expressed and illustrated within this theme.

3.2   Ineffective memory processing

This theme conveys the extent and psychological impact of memory

processing difficulties, as well as a range of possible causes. Variations in

experience of current threat are also illustrated.

3.2.1   Memory disturbances

Present in this theme is the experience of incomplete recall and a hazy

memory for both the offence itself and contextual information. Pete,

Kristopher and Sean all highlight the presence of extensive gaps in their memory.

> *I don't really remember, I was very drunk, all I remember is um just standing outside the door, the person that lived above me's door and I'm kicking it and I had a knife, kitchen knife and I remember looking up on the floor because I'd been Tasered, I don't remember being Tasered, I just remember looking up when I was lying on the floor and all I remember after that is being in hospital having an ECG. And I don't remember hardly anything then. I wish I did because then it would make things clearer.* (Pete)

> *You see, I can't remember. The police said that I barricaded the doors from both sides, from every side, and I went through the window, I can't remember that either. I can't remember, but I read it in the papers about the barricade.* (Kristopher)

> *I inflicted a lot of injuries. Only I can't remember infli--, I can't remember ever inflicting all them injuries.* (Sean)

Similarly, Liam, whose index offence consisted of multiple convictions, is unable to recall one of these events at all. This indicates that for these individuals, normal memory processing capabilities failed at the time of the offence for one reason or another.

In contrast, James and Phil both give information to suggest that they have retained some memory of their offence. Phil provides extensive contextual information, which, if accurate, suggests intact memory processing.

On the day of the offence, what happened, it was a Saturday morning, …er I woke up as normal, I spo--, I had my breakfast. I had er… got on with a few things then er, I had my dinner. I had my dinner, I had er… I went to er to the shed, got a golf club out of there, it was a seven iron […] I took him over to the other big bridge and that and I hit him with a golf club…three times, and then I just left him and that, […] and then er I went home, put the golf club into the shed, then after that my mum says to me, "Are you okay?" and I says er "Yes." […] Then half past one in the morning er I was still awake the, I looked out the um, the bedroom window 'cause my bedroom was at the front of the, er street and there was four police cars and a police van. And I said shit and they're here for me and all that. My dad went down, my dad went downstairs and er my dad came up for me. Then I went down and the police says, "Are you Phil Robbins?" I says, "Yeah." (Phil)

James simply states that he remembers everything but does not go into any detail.

No, no, I can remember the lot. (James)

It is of note, however, that, compared to events preceding and following his offence, Phil provides relatively limited detail for the actual incident. Likewise, the single-sentence account given by James is far from comprehensive. Memory disturbances are therefore still indicated, but do not appear to be of great importance to these two individuals. An explanation for why Phil and James may display more intact memory for the events surrounding their offence is not offered in the data. It is possible that during the greater number of years since their offence as compared to other participants, as shown in the demographics table in Appendix I, they have perhaps received additional treatment and have had more time to explore their memories and begin processing these in order to contextualise them. Data on treatment was not collected so this hypothesis is based only on length of time spent in forensic services.

Several participants refer to their offence by using nondescript terms such as "it", "that" and "that day". The researcher wondered whether this indicated avoidance of talking about their offences, whether this was further evidence of memory dysfunction, or whether it perhaps reflected their feelings of shame and guilt. Given that they then went on to talk about their experiences, avoidance was not thought to be the best interpretation, so their lack of specificity was understood to signify the difficult emotions and incomplete recall they experienced, as well as simply being an easier and more colloquial use of language.

Possible explanations for apparent memory processing failures are explored among the other participants. The impact of drug and alcohol use on

memory is raised as a possible cause, and four of the six participants talk about their history of substance use.

> *I was very drunk and I was doing some drugs leading up to that offence. A few days before that I'd done some acid. Er, crack cocaine and er, I was a bit reckless really.* (Sean)

> *I don't really remember, I was very drunk […]* Do you think is it because you were drunk that you've forgotten about it or do you think there were other reasons that you might have, might not remember? *It's just because I was drunk, yeah.* (Pete)

Kristopher offers an alternative understanding that his mental health diagnosis contributes to his impaired memory.

> *I'm schizophrenic since I'm seven years old, you know. So I've done some things that I can't remember.* (Kristopher)

He is able to convey some details, but this is limited to information provided to him following the event. The contextual information joining these points together in a narrative is lacking, which results in an incoherent and confusing illustration of his offence. This may indicate that his traumatic memories have been insufficiently processed, perhaps as a result of dissociation during the traumatic event.

It's manslaughter. I strike him with hatchet about twenty times […] You see, I can't remember. The police said that I barricaded the doors from both sides […] I read it in the papers about the barricade… Then the person I murdered is, um, they found like twenty different drugs in his system, and they said he's a dead walking man. The uh, prison officers said the man was dead anyway because he had so much drugs in his body that it could kill him any second. (Kristopher)

Kristopher further indicates that he experiences dissociation in response to reminders of his offence, and he appears to dissociate during the interview (see Appendix O). He presents as emotionless and disconnected, and describes feeling numb when he thinks about his offence.

What, if anything, goes through your mind when you think about it or talk about it? *Nothing.* Okay. …When you say you don't feel anything when you talk about it, how would you describe that? *Just numbness.* (Kristopher)

These experiences are interpreted as an indication that dissociation is another possible explanation for incomplete recall. Sean also appears to dissociate during his interview, although he denies this when asked and moves on with his response to the last question.

Although some participants express a sense of disbelief that they are capable of their offence, as discussed earlier in this chapter, they all seem to accept their conviction as truth, with the exception of Liam. Liam does not

only have incomplete memory for his most personally distressing index offence, he has no memory of it at all and denies it entirely.

> It sounds like you have no memory of your index offence at all? *Not that one anyway. I've got memory of the other ones that I was there but there was three, there was five index offences.* (Liam)

Throughout his interview, Liam appears to be struggling with a change in his identity, an issue which has already been explored in detail earlier in this chapter. He is concerned with preserving the version of himself that fits his understanding of who he is, and as a result, he appears to use dissociation and denial as functions that preserve his sense of identity. Selective memory and selective memory failure, as indicated in the quote above (Liam), may therefore be protective as it may give Liam a platform on which to maintain his innocence and his identified self. He appears to fear the alternative self. If he is to accept this new identity as someone who is capable of committing the offence he denies, he risks an anxious and uncertain future in terms of living arrangements, social relationships and experiences of shame and guilt. It is therefore understandable that he would wish to block such harmful memories and use this as a tool to deny and reject the new self and maintain a more agreeable sense of self.

> *Where could I live? Where would I have gone, what would I have done?* […] *Then they sent me to low secure and I got some leave but, but the time I was waiting for the leave, I was bricking it because I*

thought, I thought you know, what everyone's going to be starting

saying this? […] Because if I did do it, I tell you what, now I wouldn't

be, I wouldn't be here, I wouldn't have lasted if I'd have done it. I

wouldn't be able to hold my head up high in the community. I would

have felt so ashamed of myself. I didn't do it so why should I feel

ashamed of myself? If I've not done it, why? And I haven't. (Liam)

This theme illustrates that memory disturbances for a traumatic offence are common, but the reasons for this are unclear. Are drugs and alcohol to blame, does mental state at the time of the offence play a role in how much is remembered, or do MDOs experience dissociation in the same way that victims often do, with the hippocampus shutting down in response to increased fear? Additionally, this theme also raises questions about the protective function of an incomplete memory. Not only does it seem to protect individuals from the most traumatic moments of their experiences, as is seen in victim-related trauma, but it may also support MDOs to protect themselves from an alternative and unwanted identity by enabling rigorous denial and the maintenance of a sense of innocence.

3.2.2 Current threat

This theme, common across all cases, explores the variations in experience of current threat. A sense of heightened anxiety was raised by a number of participants, but while some focused on their current physical experiences and demonstrated these in the interview, for others, worries about the future

were more concerning. Appraisals and anxieties about the future will be discussed later in the chapter, so this theme concentrates only on participants' experience and understanding of increased arousal and re-experiencing symptoms in the present.

For James, his increased arousal and fear-based emotions, along with the associated physiological responses of the sympathetic nervous system, are particularly concerning. Although he acknowledges that anxiety is part of his mental health presentation, he has noticed that this has worsened since his offence and he considers himself to be more unwell now as a result. The phrases "dead nervous" and "dead scared" raised questions for the researcher about whether he meant this as a colloquialism or whether his nervousness and fear has meant that either he has thought about dying or that a part of him has died. His self-diagnosis of "nervous disorder" indicates that he believes his anxiety to be at a clinical level and in need of treatment. During his interview, his anxiety is expressed non-verbally through shaking, bouncing his legs and stuttering.

> *I'm dead nervous. I suffered from nervous disorder since, since I've committed that. […] I suffer from my nerves, seriously; I get the jumps and everything about it. […] I've suffered from my nerves anyway from my mental illness for years, but since I committed, committed rape I've been very, very nervous and anxious about it. Very scared for what I've been done for. […] I've become more mentally ill since then 'n' all, anxiety and phobias, paranoia. It's made me a bit more iller. I get nervous all the time; shaky and nervous. I suffer from a lot of fright in*

my body and anxiety. I get dead scared. […] It makes my stomach

turn. (James)

Sean also seems to focus on the physical sensations of anxiety and fear, but these tend to occur in the presence of re-experiencing symptoms. He is the only participant who is able to detail some specific strategies he utilises to help him manage his intrusions.

Er, and it has tormented me a little bit since, since as well. I've had nightmares about it and, er, sometimes I get a shiver down my spine. […] So what do you remember clearly, if anything? Er, waking up at about ten o'clock the next day and my flat being obviously in a real mess. And that's what stays with me sometimes. The dead body and the state of my flat. …In what ways does it stay with you? Er, it, it just scares me. …I get, um, sometimes I get like a tingling sensation goes through my body. In my sleep, I normally dream about it. And when I wake up, I don't feel too bad because I know there's people around. But when I lived by myself it shook me up a little bit. Is there anything that makes that better when you wake up in the night? Er, yeah I turn the lights on and… I turn the lights on, yeah. […] I have come out a couple of times and spoken to the staff. (Sean)

Intrusive thoughts and images are a common experience, although these vary in nature and content. Whereas James remains relatively vague about his flashbacks, Kristopher is able to identify a hotspot, a specific segment of

memory that is re-experienced and causes him significant distress. He describes heightened anxiety, panic attacks and intrusive thoughts. His panic attacks could be better understood as flashbacks. It is also noteworthy that, when talking about his hotspot, Kristopher uses the present tense, which could indicate current reliving.

> *I've had flashbacks, yeah. I see them quite a few times in my head. Basically just… just pops up, pops up. And, and I can't believe what I committed. It does play on my mind it does. I've seen it a few times remembering and felt absolutely sick.* (James)

> *I remember them during the day. It just comes any time. It's like déjà vu, like it's happened before, you know.* […] *I strike him with hatchet about twenty times.* […] So you said it's like déjà vu… *Yeah.* Do you go right back to the beginning to the bits that you can't remember, like barricading the door, or do you go back to just a very specific moment? *A specific moment. Um, when he drew a knife on me and cut my hand, and I strike him and I didn't stop striking him.* (Kristopher)

Phil is similarly able to identify two hotspots and he describes intrusive flashbacks when he is asked to recall his offence.

> *I do get flashbacks about that but, about the scene and I panic, I do panic and when, when I'm in my bedroom and like when I talk to people, talk to staff about things or talk, or talk to like psychology about*

my past and when I go to my bedroom and all that, I do get flashbacks.
Okay. What are the flashbacks to? *When I hit the er, when I hit*
someone with the golf club and everything an' all that and I shouldn't
have done that and I shouldn't have done that. And when I see, and I
see, and then when I've seen when I was in the police station and I've
seen the photographs when I was with my solicitor I er I was really…..
(Phil)

Sean talks about his nightmares changing in content and these therefore do
not appear to depict a specific hotspot. However, when he experiences
intrusive memories and flashbacks in response to triggers, the content of
these seems to be more constant and may refer to a specific fragment of
memory that is particularly distressing. Following a description of these
intrusions, Sean appears to have a dissociative flashback but denies this.

Er, sometimes I get scared when I watch a film. It reminds me a little
bit of my index offence. At first it used to scare me quite a bit but now
I've been a bit more rehabilitated and I feel a bit stronger. But it hasn't
completely gone yet. […] I can't explain it like. When, when bodies are
dead it's quite cold isn't it. And, er, I don't know, when I touch my skin
or something and I feel cold it does remind me of it. Yeah. And what's
going through your mind then? *The rigor mortis and that. His face*
looked all sort of puffy and that. […] What are the nightmares about?
Er, them flats I was telling you about. Um, I've has a couple of dreams
recently since I last see you and that was about burying dead people

alive…dead…burying people alive. It don't make no fucking sense at all. And, um, I remember feeling pretty shit after that. […] Do they all remind you of the same thing? Er, no because I got lots, er, dreams about, about the flats and other dreams are about dead people. (Sean)

Pete also describes nightmares but these do not seem to be directly related to his offence. They instead appear to mirror his distressing experiences of being in hospital. His nightmares convey a sense of being suffocated and feeling claustrophobic, an experience which is explored in further detail in the final superordinate theme. These nightmares, nonetheless, seem to be frightening for Pete and evoke a sense of current threat.

I have had the nightmares and night terrors or something like that. Sometimes it feels like I'm being, someone's sat on my chest and pushed me into the bed or if I'm lying on my stomach it feels like someone's lying on top of me. (Pete)

Even Liam, who claims to have no memory for his offence, describes experiences of intrusive thoughts in response to triggers, which he differentiates from a voluntary and active process of reflection.

I reflect on it, but when it comes to my mind, say like if I saw a baby on like the Pampers advert, it would come back to me like that. […] So when I do see a child, it sort of brings memories back like I'm supposed to have said that to, to the child. (Liam)

This theme illustrates the different ways in which participants experience

current threat. A range of intrusive experiences are described, including

thoughts, images, nightmares and dissociative flashbacks. It is of note that

not all participants are able to identify a hotspot that is repeatedly re-

experienced.

In summary, this superordinate theme, *Ineffective memory processing,*

demonstrates the ways in which participants experience and make sense of

having an incomplete memory for their offence. Although this is attributed to a

variety of causes, participants all highlight their experiences of intrusions and

their sense of current threat and increased arousal, indicating that this is key

to their experience and understanding of offence-related trauma.

3.3 Appraisals of the consequences of offending

This theme highlights participants' understanding of the various

consequences of their offences and addresses the emotional and cognitive

impact of these.

3.3.1 The importance of social relationships

Apparent in this theme are the different attitudes towards, expectations for

and experiences of social relationships following participants' detention in

hospital. Although incongruences are highlighted, it seems that a

commonality between most participants is the understanding that social

relationships play an important role in their future regardless of whether or not they perceive the quality and role of those relationships to have changed as a consequence of their offence.

As has already been mentioned, Liam appears to view social opinion as a reliable reflection and contributor to his self-identity. He places value on the perspectives of both his friends and his clinicians in shaping his own understanding of himself and as a source of support. There is a sense that he interprets the expressed views of others as truth. He also appears to plead with the researcher throughout the interview, as though he is hoping for her to express a particular view that will confirm his own views and positive self-affirmations.

I was worried what people were going to say in the community, Then they sent me to low secure and I got some leave but, but the time I was waiting for the leave I was bricking it because I thought, I thought you know what everyone's going to be starting saying this. Then when I got in, into the community everyone was like, "You alright, Liam?", "Hello Liam". They just treated me the same. Because they know that deep down they know I wouldn't do that. Deep down. […] And even the doctors in here have said to me, "Liam, that, this is not your usual behaviour". […] If you're a paedophile you need to sort your head out. I don't need to worry no more though because I told you when I went back in the community my friends were alright with me. […] But it was my named nurse, when I came in the first time, talking to my named nurse, because I was off my head innit because I stopped taking my

medication. And when I got here she said, 'You're not a paedophile,

Liam", 'n' I was like, that's a good weight off my chest. But the guy who

said I was a paedophile was my own fucking friend. […] *Don't put me*

in that category please. […] *If I was, people would be talking about it*

now. (Liam)

His positive experience with how his friends treated him, although it seems he was initially surprised, appears to have given him reassurance that his social network will support him on his release. This is a view that is expressed by several other participants. For example, Kristopher talks about his girlfriend and the life they will enjoy together as a family in the community. This appears to be a protective factor in his mental health and he thinks about his girlfriend as a way of coping with his distressing symptoms.

Do you imagine your future now at all? *[Nods head]. Family, with my*

family. My girlfriend, she still calls me and she still loves me and we

talked about kids. When I get out of here we'll have kids and no more

drugs. […] When you have the flashback is there anything that's going

through your mind then? *You know, I think about my girlfriend every*

day. It's just… that's her that's positive in my mind. (Kristopher)

Sean and James also highlight the importance of support from their family members. James talks about returning to live with his parents, indicating that he views them as a stable source of support. Sean alludes to the emotional

support his family provides while he is admitted in hospital and gives the impression that this has been of help to him.

> How do you imagine your future? *Getting well. Getting pure stable. And, uh, going back to my Mum and Dad's house. That's it really.* (James)

> *I've got a lot of family support this time. And, er, this time round they offer to visit me and that as well.* (Sean)

Pete appears to have received less support from his family and friends while in hospital. He refers to his experiences of loss and in particular losing his social network as a result of his offence and consequently being detained away from his hometown. Although he is very pragmatic about the reasons for this, there is a sense that he feels abandoned by his family members and he seems to desire a wider support network. He indicates that his previous peer group were unhelpful to his wellbeing and changing the people he was associating with was part of the change he recognised he needed in order to make his life more positive. It is therefore feasible that although this has been a predominantly positive change in his life, he is left with few other friends and therefore a greatly reduced social network. He does, however, highlight the value of social support on his release, particularly given that he feels anxious about what his future holds and the prospect of having to cope with his future alone.

That's the only good things about being here. The rest of it is miss family and friends. Can you tell me a bit more about that? *I haven't seen any of my friends since, since I got in trouble, which is nearly a year ago now. My Mum comes and visits me once every so often. But um since I've been in hospital no, no other family members have visited me, just my Mum and um, …but um.* Uh-huh. And what's that like for you? *I wish I had friends that would come and visit me but because I've moved a long way from where I was living and it's hard for them to be able to come here and visit. I'm in contact with a couple on the phone but to see them, you know, it's not possible really, so.* […] *If my family said that they could help me when I get out to adjust to living somewhere new and getting a new place then that would help. But if I have to do it all on my own and find my way around a new place and a new town, new city, wherever I'd be put then that's going to be hard.* (Pete)

Phil is the only participant who does not talk about his social network in reference to either his current experience or expectations for the future. He only talks about his family in the context of his narrative about his offence, and this is limited to factual information about the events surrounding his offence. He also specifically expresses a desire not to go back to his hometown and does not appear to view his friends and family as an opportunity for social support. This may indicate avoidance of reminders of his offence, embarrassment and shame, or the desire to start a new life somewhere where people don't know about his past. It is unclear which of

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these, if any, Phil is primarily concerned about, but it is apparent that he does not place the same value on the quantity and quality of his social network as the other participants.

> *I wouldn't want to go… home. I would want, I'd go home, I used to go to the house, but I wouldn't want to go to um like stop overnight or anything like that. I wouldn't want that. Er I would feel a bit uncomfortable […] my hometown's not the right place for me because I committed a crime. I want a fresh environment and that, where I feel safe, I can cope well. I think I get on where I am and a fresh start.*
> (Phil)

This theme illustrates the important role of social relationships in helping these individuals cope with the stress of the inevitable changes brought about by committing a crime while also trying to manage symptoms of mental health difficulties. This support seems to be valued both in the present while adjusting to a hospital environment and in the future during the predicted challenges of transitioning back into the community. Some participants appear to have found that their support network has been stable and reliable following their offence, while others refer to changes in their support system as a consequence of their offence, which seems to cause distress in the present and anxiety about the future.

3.3.2 Hospital as a source of cognitive dissonance

This theme demonstrates the conflicting views held by participants regarding their admission in hospital. It appears that some participants simultaneously hold opposing views on whether being in hospital is helpful or not. Pete, for example, expresses a range of negative views about hospital, particularly in comparison to being detained in prison, but also acknowledges that his admission has been beneficial for his physical and mental health. This is a positive view that is shared by several other participants who also express an understanding that being in a hospital environment has been valuable in improving their health and wellbeing.

> *I think they think that I'm getting better and um I'm not hearing things, I'm not hallucinating, you know.* […] *I never used to eat when I was on the outside. Ate very little. In here I'm eating, you know, a lot, quite a lot and I've been gradually putting on weight, which is good here.* […] How does your future look do you think? *…Well at the moment not great. It's looking good in, in the sense I'm not drinking, which has always been a big problem, so I haven't got that part of the problem to deal with anymore. Well not at the moment because I'm in hospital.*
> (Pete)

Similarly to Pete, Liam talks about how his admission has helped him reduce his use of substances.

I don't smoke no weed no more. That was, that was one of the biggest

things. That's what I found the biggest things that I'm happy that I've

done. All this time I've been in at least I've stopped one thing. So,

yeah, that made me happy. (Liam)

Kristopher highlights the benefits of the medication that has been offered to

him in hospital but was not in prison. He also implies that hospital is a more

supportive setting for him, perhaps among other patients as well as staff.

I'm not having nightmare about the manslaughter, no. I used to, I used

to about a year and a half ago. What made that better do you think?

This hospital environment. Because in jail I, I just, um… it was bad and

everybody was hating me because um… I don't know, you know

[visibly upset]. […] I'm happy that I'm in hospital and not in jail,

because in jail they give me quetiapine and that tablet just make me go

to sleep. It doesn't do anything. I wake up and the voices and

hallucinations are still there. […] Now I'm half year or so on clozapine

so I get no hallucinations, no voices. I'm not even moody anymore.

(Kristopher)

Phil also stresses the positive impact of accessing treatment in hospital, but

places more of an emphasis on individual and group therapeutic treatment

rather than medication.

I've done some groups like life skills, some for skills, trust, self-

awareness, anger management. I've got a lot out of anger

management. Um with my viol--, my anger, violence and stuff. (Phil)

Despite these positive views about the impact of being in hospital, the

negative experiences raised by participants are more prominent. Pete talks at

great length about the negative consequences of being in hospital, and points

out that, although his health has improved, this is outweighed by his loss of

freedom, privacy, control and any element of certainty about his future. He

presents himself as healthy but unhappy. It is also noted that his

understanding of what it means to be in hospital is at odds with his

understanding of his current mental health needs. This illustrates his

simultaneous experiences of the positive effects of being in hospital but also

provides an explanation for his frustration and negative feelings towards his

on-going admission. His worries for the future will be discussed in the context

of the next and final theme so this theme focuses on his experiences of

hospital as a 'fishbowl' and a forced surrender of choice and control.

I was ill when I was in prison and it was the right decision to take me

out. […] And being in hospital, what do you think that says about you?

Um I guess it says that I was ill and I am ill, they still think that I need to

be here. I think they said, I think they think that I'm getting better and

um I'm not hearing things, I'm not hallucinating, you know. And what

does being ill mean to you? *To me it means hearing things and*

hallucinating and paranoia, that sort of stuff. Just generally not being

well. […] The future's better because I'm not hearing things, like I say,

I'm not hallucinating, but I'm, other than that, it's not, it's not, I don't feel

happy 'cause I don't know what's going to happen in the future, you

know. (Pete)

The language Pete uses to describe his move from prison to hospital, away from his hometown demonstrates his immediate loss of choice. He appears to have viewed himself as an object that was passed around by others. For example, *I was taken out of prison and put in hospital* (Pete) suggests an involuntary extraction, whereas had he said 'moved' rather than "taken out", it may have implied more of a transition. Now he is in hospital, it seems that Pete feels controlled by staff and that he is unable to exercise choice over his treatment, participation in hobbies, his daily routine and being able to spend time by himself. There is a sense that he feels like a punished child, who has had to surrender his power and live by rules dictated to him and enforced by others, even in his personal bedroom space.

I just found er, my freedom was taken away from me so I found it hard

in that sense and then you have to do groups and you're watched all

the time. And what does that feel like? *It's, it's not nice because you're*

always being assessed, you're always being watched. Are you doing

this and are you doing that, and if you're doing something wrong you

get in trouble and there's no freedom, you know. You can't really relax

in here. You're not allowed to go to your room very often, you're only

allowed to go at set times of the day and if it's a week day you're not in

your room for very long. […] The only thing I like in here is just being

able to play pool sometimes but even then we don't get to play very

often in, um, I used to play a lot of pool when I was on the outside […]

There are times if I feel like I'm going to lose my temper then I want to

take diazepam but I'm not allowed that med, I'm not on that medication

but I think it would help. (Pete)

He portrays a sense that eyes are everywhere and there is nowhere to escape, which caused the researcher to wonder how this environment affects people presenting with paranoia, like Pete. His description of his past hallucinations and paranoid delusions sound very similar to his experiences of hospital. It is as though his paranoia has become a reality, so this may help explain why being in hospital is such a negative experience for him.

A big problem was hearing footsteps, which is what happened with my

neighbour. I though she was watching me and had cameras on me

and following me around and whenever I went in my flat I'd hear

footsteps. (Pete)

There is a great sense of loss regarding choice, freedom, decision-making and control, and rather than encouraging a move to independent living, it seems that Pete experiences being in hospital as synonymous with being stripped of many of the rights typically enjoyed by adults. This is likely to be compounded by the great social and material loss he experienced following his offence, which seems to represent losing a part of himself.

I'm getting a sense that you've lost things by being in here [having talked about social isolation]. *Yeah. I lost my flat, I lost all my possessions. The only possessions that I saved out of my flat was my TV, my stereo and my clothes, everything else I lost.* (Pete)

Pete seems to long to regain his freedom but the sense of desperation he conveys suggests that this may currently feel out of reach. This is part of his reasoning for wanting to be returned to the prison system, where he appears to have experienced a greater sense of freedom and control and perhaps feels it was a more dignified form of punishment.

> *I'm going to get out, you know. …I just want my freedom back. […] When I was in prison I could just lie on my bed, I could watch TV, listen to that radio, I could smoke as much, eat what I want, eat the food that I had, like I could buy with the money I was saving for me and I could eat at any time. There was no times and that sort of stuff so, you know, it's difficult.* (Pete)

Liam also refers to a loss of freedom in hospital, although to a lesser extent than Pete. When asked about the consequences of his offence, Liam first mentions that he has *been locked up for five years now,* implying a sense of forced captivity. He later goes on to say *I've had enough of being inside,* which may be interpreted as an expression of being fed up with being restricted to the 'inside' and his loss of freedom.

James alludes to a sense of discomfort at living in such close proximity to other offenders and patients, indicating a loss of privacy. His expression of *I've got no day whatsoever* also suggests that he would prefer to have more time to himself.

> *Sometimes when other patients in here ask me what section I'm on, that makes me more nervous because I don't want to talk about my past to them, you know. […] There's patients and prisoners; I don't want to tell them my business like that. I don't want to know their business and I don't want them to know mine.* (James)

Liam and Pete convey their experiences of hospital as a punishment, which seems to contradict their perspective of hospital as a tool to improved mental and physical health. For these individuals, hospital is viewed as an unfair and unjust extension to their prison sentence. As has been previously discussed, Liam holds views, based on external validation from friends and clinicians, that he is low down on the hierarchy of sex offenders. This, along with Pete's conviction of affray, a relatively minor offence in which no one got hurt, perhaps suggests that for these individuals, hospital has served its purpose in improving their health and any further admission is an unnecessary punishment and a sentence beyond the expected prison time for the same offence.

I was reading in the paper the other day and this guy got done for indecent assault and he only got two years and in one year he was out. I said to my named nurse "yesterday I looked through the paper and a guy got done for indecent assault". She said, "You know, was he, was he mentally ill?" (Liam)

I didn't want to be in hospital, I just knew I just wanted to be dealt with in prison so I could serve my time and get out there and carry on. You know, do what I've got to do on the outside instead of having to do extra time by being in a hospital. […] I used to look at it as a punishment; I used to think that it would be a punishment to um be in hospital because you can be here for a long time and um….. now I don't see it as much a punishment, I see it as trying to help you. And it is also, I also still think it's punishment 'cause you can be here for a very long time. I believe that you should have a sentence, serve your sentence and then get out, not be kept in, you know, for a long time. […] I think in a way I've been punished too much. I, you know, I mean I was told how long I'd have to do if it was like purely prison time and um I would have been out a long time ago if I was dealt with by prison. (Pete)

Participants also refer to the uncertainties associated with a hospital admission, particularly for the future. Although this could be discussed within the context of this theme, it can also be thought about as long term consequences of offending so will be discussed in the final theme. This

highlights the inter-connecting nature of the themes and emphasises that they should not be read and understood to represent distinct aspects of experience.

This theme highlights the positive attitudes towards being treated in hospital, including a variety of perceived improvements to physical and mental health as a result of the environment and treatments offered. Also captured in this theme is a sense that admission to hospital results in a loss of freedom, choice, control and privacy. For some, this forced access to treatment, despite being beneficial to their health, is viewed as a punishment above and beyond the sentence that would be received in prison, both in terms of length and perceived freedoms. It appears that participants simultaneously hold beliefs about the costs and benefits of being in hospital and that this may create some cognitive dissonance.

3.3.3 Worry about the long-term consequences of offending

This theme incorporates the variety of concerns participants hold about their future as a result of their offence. This includes uncertainties about their length of admission and the process of reintegration into the community, the life-long consequences of offending, and anxiety about the need for offence-related behaviour change.

A number of participants refer to their experience of uncertainty about when they are likely to be discharged and the power that is handed over to clinical staff about this decision. It appears that this is viewed as a

punishment in itself and that hospital is perceived as a barrier to the desired future self.

> *I feel like at the end of the day I'm doing life. How I feel. I've got no day whatsoever and I don't know when I'm getting out. You know, it's for the doctors to decide.* (James)

> *I'm not sure what's going on, I've done my sentence for it, like. […] So, I don't know. I've had enough. I just want to get out man. […] They said I was only supposed to be here for three months. And I've been here a year now, a year and a month now.* (Liam)

> *I just wanted to be dealt with in prison so I could serve my time and get out there and carry on. […] Now I face being in here for I don't know, until I don't know when. So um I could be in here for a short amount of time or be in here for a long amount. […] I've done my time in prison and then I've been in hospital.* (Pete)

Loss of freedom was discussed in the previous theme in the context of current experiences of being in hospital following participants' offence, but for Pete, this appears to extend to his worries about the future so can also be discussed here. He seems to be engaging in constant rumination and excessive worry.

It just plays on my mind all the time, you know, freedom. […] There's a lot of what ifs and buts and what would have happened if I hadn't have done what I've done, what, what the consequences are and things like that. (Pete)

He expresses anxieties about what will happen when he is discharged, exacerbated by his experience of both material loss and the loss of his future choice and control.

Now I haven't got nowhere to live and somewhere will be found for me, but at the moment I haven't got nowhere to live. […] There's worries about, like I said, getting a new place, not knowing where I'm going to live, if I'm going to move, move back to the same town I was living or if I have to be found a place somewhere else to live. …But I don't know what's going to happen in the future. […] I don't feel happy 'cause I don't know what's going to happen in the future, you know, I won't know where I'm going to be. (Pete)

James emphasises the consequence of having to sign the sex offenders' register. It appears that having to acknowledge his unwanted and incongruent label is viewed as a punishment. He goes on to talk about how he is now viewed as a danger as a result, which appears to feel uncomfortable for him, perhaps because he does not consider himself to be a dangerous individual. There is also a sense that he anticipates that he will be permanently pre-judged. This raises questions about the purpose of rehabilitation and

treatment if one is forever going to be considered a risk to society. His view that his life has been ruined suggests that it cannot be repaired and the consequences are life-long. Sean refers to having *wasted two lives*, suggesting that, similarly to James, this consequence is viewed as irreversible and it is too late to change.

> *I feel like I've ruined my life.* Can you expand on that a bit more? *Basically I committed a rape and I'm a convicted rapist now 'n' I've got to sign the register every year. I'm being punished for life for it basically.* What does that say about you as a person? *Basically probably says I'm a danger, some kind of danger. I don't know. I've committed, committed one. They could think I'd commit it again. But I ain't.* (James)

As has been previously discussed, Liam also refers to concerns about other people's perceptions, including those of his family.

> *What about if someone says to my daughter one day this that, this that, and I have to start explaining to her. You know what I mean, it's hard, it's going to be hard man.* (Liam)

He seems anxious about whether or not his behaviour is socially appropriate and seems to be making behavioural changes in an attempt to reduce his risk of allegations in the future. These safety behaviours include only using certain parts of the bus and not sitting next to young women or children. These

experiences were initially viewed as support for the superordinate theme, *Avoidance,* but this theme was discarded as a result of inadequate support from other participants. These experiences are therefore considered here as they also represent Liam's perception of the consequences of his offences. In addition, this clustering seems more appropriate given that Liam suggests he is not currently avoiding bus journeys or speaking to young women and children entirely, but has had a reduction in self-confidence, seems to question whether he can trust either himself or the intensions of others, and is considering the consequences of his actions given his new offence-related label.

> *It's took my confidence away to talk to girls in the community like. I don't know if to talk to them or not to talk to them. I don't know if it will happen again, that's why. […] I'm worried to catch a bus now. Like, when I get out, where do, I think when I catch the bus from in the community, I'll just be standing up near the bus driver because I'm that worried about people saying I done this and I done that. […] Last time just coming off unescorted leave and I was sitting at the back of a bus downstairs and this woman's come on the bus with about four/five kids. So I'm not saying nothing to her. The woman just come and offered me a pretzel so I took it. So what's going on? Are people still tricking me on the bus?* (Liam)

Although Liam appears to be considering the wider consequences of his offences and suggests possible experiences of regret, this is presented as a

selfish emotion given that throughout his interview he does not seem remorseful or empathic towards the victims. He also seems to fail to consider the impact on his daughter but is instead worried about the difficulties for him in having to address and explain his offences to her.

Kristopher refers to an on-going sense of captivity, even following release, as he observes that he will be unable to travel to certain countries.

> *I can't go to America; I want to go. I can't go to Australia, Canada, the biggest countries in the world I just can't enter.* (Kristopher)

Phil, unlike other participants, displays a good understanding of the process and route to discharge, including the prerequisites for moving through the tiered forensic system. For this reason, he does not seem to express anxiety about his future and instead demonstrates a sense of choice and collaboration with clinicians over his living arrangements and career goals. It appears that he has given this some considered thought and understands his treatment as a consequence of his offence, but one that is largely beneficial to him.

> How do you see your future, Phil? *[…] I want to complete the treatment here. […] I'd like to go to low secure from here to a personality disorder place back in the North. I had a good chat with my doctor and the commissioner on the ward, and I have my ward round and mini CPA meeting on Wednesday, and I'd like to go back up there. And there's a place in Lancaster that takes personal—that takes personality disorder*

and MIS [mental illness patients] and all that, there's a place called St. John's. So you'd like to work your way down the system? *Yeah.* And what about when you get into the community? *And when I do get back out in the community I want to work, I want to work for a living and I've always wanted to do landscaping or painting and decorating because I'm really keen on that. And I want, I've always wanted to do that since 'cause I did loads of work experiences when I was doing, when er when I was at school I did a work experience in, at the City Council doing landscaping and did it for two weeks and I really enjoyed it. […] I'm not at the stage at the moment for conditional discharge and that. I know I need to do more treatment but I've got to do my treatment here first, then from here I've got to do some more treatment in the next placement, er in my next place, to continue to get better.* (Phil)

This theme captures the anxious and ruminative experiences of participants regarding the long-term consequences of offending. Concerns and regrets regarding a life-long label are expressed in reference to an inability to travel to certain countries due to a criminal conviction, the requirement to sign the sex offenders' register and therefore be annually reminded of one's offence, and having to explain one's offences to children and loved ones. Sean and James refer to their wasted or ruined life, suggesting an irreversible change that is beyond repair. Several participants appear to be worrying about their discharge, and in particular when this will occur. This uncertainty seems to be viewed as a form of punishment and a demonstration of the power held by

clinicians over their patients. Pete additionally expresses concerns about the uncertainty of his living arrangements post-discharge.

In summary, the superordinate theme, *Appraisals of the consequences of offending,* encapsulates the range of emotional and cognitive appraisals about the importance of social relationships, the role of admission to hospital in experiencing improved health but a simultaneous loss of freedom, control and privacy, and future-based anxiety and uncertainty. Although the focus varies among participants based on what is of most importance to that individual, a part of each of their experiences is a consideration for the consequences of offending, suggesting that this is a key theme in the experience of offence-related post-traumatic stress disorder (PTSD).

CHAPTER FOUR: DISCUSSION

This chapter first discusses the results in relation to each of the research questions. Findings are placed within the context of existing literature and clinical guidelines. Implications for clinical practice and further research are considered. A critical review and the researcher's personal reflections are then offered.

4.1   Addressing the research questions

This research primarily aimed to explore idiographic experiences of offence-related post-traumatic stress disorder (PTSD) among a small sample of mentally disordered offenders (MDOs). It further aimed to consider how similar or different these experiences are to the criteria outlined in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V; American Psychiatric Association (APA), 2013) and the processes described in Ehlers and Clark's (2000) cognitive model of PTSD. The research questions are addressed in turn and discussed in the context of existing literature and theory.

4.1.1 How does a small sample of MDOs experience offence-related post-traumatic symptoms?

The interconnected superordinate themes of '*Responses to an identity shift*', '*Ineffective memory processing*' and '*Appraisals of the consequences of offending*' capture the complexities and variations in the way that these MDOs experience traumatic symptoms in relation to their offence. All participants gave an indication of distress but this was presented in a number of different ways.

All participants also either directly spoke about or insinuated that they were struggling with a sense that their identity had shifted and that their beliefs about themselves had been changed, or had at least been challenged. Two participants suggested that they needed to escape their past lives but that they did not expect change to come about as a result of their index offence. Some of the men placed an emphasis on difficult emotions, which seemed to be central to their understanding of this change. Experiences of disgust, shame, regret and guilt were spontaneously described and may be understood as a response to a changed view of the self. This understanding appears to be reached for some through a process of self-reflection.

The literature on the experience of shame and guilt in victim-related trauma is extensive, but has only been briefly examined in offence-related trauma. Crisford et al. (2008) found that, in their sample of 45 MDOs, higher levels of trauma symptomatology were associated with higher levels of guilt cognitions and that this result remained significant when controlling for offence severity and negative affect. They also found that guilt was not

associated with the severity of the offence and higher levels of guilt were experienced by those who did not know their victim. However, caution is recommended when interpreting this result since the unknown victim group contained more sexual offenders compared to violent offenders than did the known victim group. This relationship therefore needs to be examined further.

Lee, Scragg, and Turner (2001) highlight the role of schemas in the development and maintenance of PTSD, as other social cognitive theories have previously done (Horowitz, 1986; Janoff-Bulman, 1992; McCann, & Pearlman, 1990). They differentiate between shame, guilt and humiliation. Shame refers to an understanding about loss of prestige or value in the eyes of the self or others (Gilbert, 1997). Humiliation is similar to shame but occurs when an individual believes themselves to have been unfairly harmed or ridiculed and that others are to blame for the damage caused to the self. Guilt occurs as a result of feeling responsible for causing harm to others and represents an understanding that one has departed from their usual standards of behaviour. In their models for guilt-based PTSD and shame-based PTSD, Lee et al. (2001) propose two possible pathways based on schema congruence or schema incongruence. Schema incongruence, a mismatch between the meaning attributed to the traumatic event and one's understanding of the self, others and the world, leads to humiliation-based intrusions, rumination intended to assess the extent of damage to the self, and rage and revenge cognitions that aim to regain one's sense of pride. However, humiliation is associated with a robust sense of self that has been challenged but not lost entirely due to external blame. Schema congruence, the confirmation and activation of underlying shame schemas as a result of

the traumatic event, leads to shame-based intrusions and attempts at avoidance and concealment. In their model of guilt-based PTSD, Lee et al. (2001) propose that these same pathways can cause rumination and intrusions that trigger feelings of guilt. Those who experience schema incongruence are likely to want to confess to their wrongdoing and make attempts at reparation, whereas those who experience schema congruence are more likely to experience shame alongside guilt and therefore make attempts at avoidance. In cases where restitution is impossible, however, such as following the death of an individual, it is suggested that greater avoidance is likely. This model draws on the theory of shattered assumptions (Janoff-Bulman, 1992), which proposes that increased symptoms of victim-related PTSD are associated with a perception that a traumatic event has shattered one's beliefs and assumptions. Lee et al.'s (2001) guilt- and shame-based models are supported in the results and the participants' narratives about their negative responses to an identity shift and their worries about the future consequences of their offence demonstrate that these may be useful tools in formulating offence-related PTSD.

Suggestions made by Dunmore, Clark, and Ehlers (2001) and Ehlers, Maercker, and Boos (2000) are also observed in this sample. Trauma-related negative beliefs about oneself, other people and the world, including beliefs that the traumatic event has brought about a negative and permanent change in the self or in the perceived likelihood of achieving personal goals, suggests that similar cognitive structures exist in victim- and offence-related PTSD and the latter may be addressed using current victim-related therapeutic approaches.

A number of participants spoke in detail about offence-related intrusive symptoms, including thoughts, image- and tactile-based recollections and trauma-related nightmares, which were often accompanied by strong emotions and physiological responses. Dissociative responses were also noted, which included flashbacks, diminished or a distinct lack of emotion, a sense of feeling numb, and out of body experiences, as well extreme denial. These symptoms are well documented in victim-related PTSD and it appears from participants' accounts that these experiences of intrusions are mirrored in offence-related PTSD.

As previously outlined, a number of participants disclosed a history of victim-related trauma, which was unsurprising given the documented links between experiences of trauma as a victim and later violence and offending behaviour (Adshead, 1994). While attempts were made to tease apart experiences of victim- and offence-related PTSD, it is acknowledged that further clinical assessment would be needed to determine the cause and triggers of described symptoms. The distinction was further blurred in some cases due to the overlapping context in which the victim-related incident and index offence occurred. This was particularly the case for one participant, who was convicted of manslaughter following the death of a man reported to have sexually assaulted him. He reported intrusive symptoms of PTSD to both events and given the strong connection between the two, it is possible that, despite attempts to clarify the cause of reported experiences, these may not have been fully understood. A higher level of interpretation is required by the researcher during a relatively short research interview compared to an extensive clinical assessment for complex PTSD during which there is more

time to check one's assumptions to make sure information is being understood correctly.

Memory disturbances were common across accounts. Four of the six participants explained that they have extensive gaps in their recall and have largely pieced the details of their offence together from information gathered following the event. They offered possible explanations for their memory difficulty, including substance use and mental illness. This is supported by Eastman, Adshead, Fox, Latham, and Whyte (2012), who suggest that high rates of incomplete recall for offending behaviour may attributed to psychosis, malingering and dissociative amnesia in the context of alcohol consumption, high emotionality and in particular where the victim is known to the offender. One interview was interpreted to demonstrate the function of memory loss in enabling denial and the proclamation of innocence. Eastman et al. (2012) highlight the possibility of claiming amnesia in the hope of escaping conviction, but this research indicates that claims of amnesia may serve a more important function of allowing the preservation of positive self-schemas.

Two participants claimed to have intact memory for their offence but failed to offer any extensive information about the offence itself, despite describing contextual information in detail. This may be interpreted as avoidance and a reluctance to discuss the most upsetting moment of the event, or it is possible that external factors, such as amount of treatment and time since offence, may impact trauma memory processing and recall.

Research on memory processing during trauma suggests that the activation of one of two distinct memory systems during a traumatic event results in fragmented and incomplete recall (Brewin, 2003; Brewin et al.,

1996). Trauma-focused treatment models are based on the suggestion that exposure to a traumatic memory through repetitive discussion, reliving and purposeful recall will enable that memory to be processed and integrated with contextual information previously not present in the trauma memory. It is possible that, although not set up as formal trauma-focused treatment, routine conversations with clinicians over the length of detainment and treatment may serve the same purpose in allowing memories to become contextualised and previously forgotten components of the memory to be remembered. Unfortunately these factors were not assessed in detail so this is a tentative hypothesis, which would need further exploration before drawing conclusions.

One participant described nightmares, which appeared to reflect the distress he felt regarding the consequences of his offence. His view of being detained in hospital indefinitely as an extended and unfair punishment beyond a legal sentence that would be served in prison, was shared with other participants. They also described a common experience of a forced loss of freedom, privacy and control in hospital, where they are constantly watched and judged. However, despite these negative views of the consequences of being in hospital, participants also spoke about how being in hospital had contributed to their improved mental health. The researcher acknowledged and reflected on her prior assumptions that MDOs would be pleased, perhaps grateful for their treatment in hospital as opposed to serving their sentence in prison, where treatment and care was assumed by the researcher to be of a lower standard. These views were changed over the course of the research and it appears from the results that the participants experienced cognitive dissonance about their treatment in hospital. Gilburt,

Rose, and Slade (2008) found similar results in their exploration of patient experiences on acute inpatient wards. They highlight the importance of positive, trusting relationships in hospital involving effective communication, cultural sensitivity and the absence of coercion in creating a sense of safety from other patients and staff, and an overall positive experience. They also address themes of treatment, freedom and the hospital environment, all of which were also raised by participants in this research. This suggests that similar concerns exist among inpatients in forensic and general mental health services.

Participants' views on the impact of their offence on their social relationships were mixed. Half the participants seemed to view their relationships as a reliable and constant source of support that would be available to them upon discharge into the community. One individual placed a particular emphasis on how his relationships influenced and contributed to his sense of identity. Only one participant expressed a sense of social isolation and despair at the social and material loss he has suffered as a result of his offence. Unlike some of the other participants who held positive views of the future, he was consumed by anxieties about his uncertain future. His negative and foreshortened view of his future is in line with existing models and DSM-V criteria based on victim-related PTSD (APA, 2013; Ehlers, & Clark, 2000). A meta-analysis by Brewin, Andrews, and Valentine (2000) found that, of the 14 risk factors for PTSD investigated, social support was shown to have the strongest effect size. This might help explain the high prevalence of PTSD among MDOs. Additionally, the positive views about the stability of social

support expressed by some participants may therefore be understood as a protective mechanism against symptoms of PTSD.

The researcher was surprised, given the contradictory literature in victim-related PTSD (Ehlers, & Clark, 2000), by the positive accounts of their predicted future given by most participants and the certainty with which they spoke about being able to live in the community again. She reflected on her prior assumptions that participants would generally either express negative prospects for the future and acknowledge the slow process of being discharged to the community from a medium secure service, or, in an attempt to control perceived threat, refrain from making plans about the future altogether (Ehlers, & Clark, 2000). Only one participant seemed to have realistic expectations about what would be required in order to progress down the tiered system of services and the type and length of treatment he would need to engage in at each stage. However, he still expressed his hopes, plans and dreams for the future. It is thought that his increased realism in comparison to some of the other participants was perhaps a result of his prior movement between services within the forensic system. Other participants had come to the service straight from prison and possibly therefore had less understanding of what would be involved. Optimism may also serve as a protective factor to anxiety and low mood (Scheier, & Carver, 1992), although this could also leave people vulnerable to disappointment and other negative emotions when they are unable to progress as quickly as they hoped.

4.1.2 How are experiences similar or different to PTSD diagnostic criteria?

As previously outlined, in order to meet DSM-V criteria for a diagnosis of PTSD, one must have been exposed to actual or threatened death, serious injury or sexual violence. One must display persistent symptoms lasting one month or more indicating avoidance, intrusions, negative alterations in cognitions and mood, and changes in arousal and reactivity. These experiences must cause significant distress or functional impairment, and not be better explained by medication, substance use or other illness (APA, 2013). Criterion A, the stressor, was defined by the research question and the chosen sample, so it was specified prior to beginning the interviews that the assumed stressor was the individual's index offence. Although the nature of the index offence varied among participants, in all cases the defined incident met criteria.

Criterions B, C, D, and E refer to the four categories of symptoms. The results indicate that this sample of MDOs meet some but not necessarily all of these criteria. They all spoke about intrusive symptoms, which manifested as at least one of the following DSM-V-defined presentations: recurrent memories, nightmares, flashbacks and dissociation, high levels of distress, and physiological responses to trauma-related stimuli (APA, 2013). It appears, therefore, that experiences of intrusions in the context of offence-related PTSD are similar to existing diagnostic criteria and what is understood about experiences of intrusions among those suffering from victim-related PTSD.

Establishing the similarities and differences in experiences of avoidance and diagnostic criteria is more challenging. DSM-V states that avoidance should be displayed through purposeful and persistent avoidance of either trauma-related thoughts or feelings, or trauma-related external stimuli, such as people, place, conversations, activities, objects and situations (APA, 2013). When giving responses to questionnaires, several people pointed out that they are unable to avoid thinking and talking about their offence while in hospital, as they are expected to engage in detailed conversations with clinicians as well as personal reflection as part of their treatment programme. As such, this was not an area that seemed to resonate with this sample and *Avoidance* was therefore discarded as a possible superordinate theme due to being insufficiently supported across cases. Two participants commented that they prefer to exercise choice and control over whom to share their experiences and details of their offence with. They were explicit in not wishing to discuss these issues with other patients on the ward. Although this could indicate avoidance of talking about reminders of their traumatic event, it may also be better understood as an exercise of control over privacy in an environment where very little choice and privacy exists for patients. It was also interpreted to reflect their sense of shame and disgust. Additionally, it was pointed out during the questionnaires that participants were not exposed to external stimuli, such as places and people that reminded them of their offence. Rather than reflecting effortful avoidance, this was simply viewed as a product of being sectioned on an inpatient ward, which for many was located a considerable distance from the site of their offence. Even those who were able to take leave outside the hospital grounds

were therefore not likely to come into contact with reminders. The results therefore suggest that avoidance symptoms in relation to offence-related PTSD are either not relevant to this sample or are not a key feature of their experience.

DSM-V requires two examples of negative alterations in cognitions and mood from a possible list of seven that either began or worsened since the traumatic event in order to meet criteria for a diagnosis (APA, 2013). The first, dissociative amnesia or the inability to recall key elements of the traumatic event, is evident in all accounts. However, the DSM-V specifies that memory loss due to head injury, alcohol or drugs should not be included. Since half of the participants either stated or alluded to the possibility that they were intoxicated at the time of their offence, the cause of incomplete recall, and therefore whether or not they would meet this criterion, is unclear. Additionally, there is no mention in the DSM-V of excluding memory loss caused by other illness. One participant attributed his memory dysfunction to his diagnosis of paranoid schizophrenia but it is unclear whether or not this should be excluded.

The second example outlined in the DSM-V (APA, 2013), persistent and often distorted negative beliefs about oneself or the world, does not seem to apply to these individuals. The researcher was struck by their predominantly positive outlooks on their future, which included statements of certainty about being discharged back into the community and hopes for work, family and relationships, and positive goals for mental health and substance use outcomes. Despite acknowledging the severity of their offences and holding negative beliefs about this new self, it was also notable

that participants had managed to hold on to a sense of their old self, the type of person they believed themselves to be, and with that came positive beliefs about themselves.

The third example for this DSM-V criterion is the persistent distorted blame of the self or others for causing the traumatic event or resulting consequences (APA, 2013). The proposed superordinate theme, *External blame,* was discarded during analysis due to not being fully supported across cases and its peripheral nature to the research. Having received convictions, their expressed views of personal blame are not considered to be distorted and do not reflect an experience of offence-related trauma. The majority of participants spoke about the impact of mental health difficulties and substance misuse on behaviour, one's ability to manage strong emotions and one's sense of control. Only one participant, however, alluded to the view of himself as the victim and he spoke about the injustice of subjective opinion. He blamed the victim for the consequences of his offences and argued that in one case, a teenage girl was unreasonable to report his behaviour, and in another case he maintained his innocence. In this case, this individual's views may be taken in support of this criterion.

All the participants raised the next DSM-V example, persistent negative trauma-related emotions (APA, 2013). Fear, horror, anger, guilt, shame and disgust are a prominent feature of accounts, and with this comes a constricted affect. The DSM-V refers to a persistent inability to experience positive emotions. None of the participants raised positive emotions during their interviews so this may be true. However, it is not possible to make the assumption that they do not experience positive emotions based on this

because they were not directly asked about it. A diminished interest in pre-traumatic significant activities, the fifth example, was not raised by any participants. This may be irrelevant to this sample as they are currently in hospital where opportunity to pursue interests and hobbies is limited.

The final example in this criterion is feeling alienated, detached or estranged from others (APA, 2013). One participant talked about having lost his family and friends as a result of his offence, but the wording of the DSM-V makes it difficult to assess whether this would qualify as a symptom of this category. Does the DSM-V intend to refer only to an emotional detachment from others who are physically present in one's life, or does distress regarding physical separation as a result of the traumatic event still meet this criterion? Feeling separated from significant others is perhaps a natural consequence of being an inpatient but this in itself is a consequence of the traumatic event so should still be viewed as part of a trauma presentation. Conversely, the reluctance to engage with other patients described by two participants was not interpreted as a sense of trauma-related alienation but instead as struggle for lost control and a desire to minimise negative trauma-related emotions. This would not fit in this example but may be viewed as a negative consequence of the traumatic event and may therefore be considered as an indicator of this criterion.

Criterion E, the final of the four symptom categories, requires two examples of alterations in arousal and reactivity from a possible six that either began or worsened since the traumatic event. This criterion is difficult to evaluate among MDOs during only a short interview, particularly given that the criterion does not take comorbidity into account. Their primary diagnosis,

which for all but one participant was a psychotic disorder, and medication means that any experiences of irritability, aggression, recklessness and disturbances in concentration or sleep may be attributed to factors other than trauma and need further enquiry to determine whether or not they are trauma-related. One participant described feeling jumpy, which could indicate an exaggerated startle response, and several participants spoke about feeling on-guard or as though they were constantly looking over their shoulder. These experiences could potentially indicate hypervigilance, but again, further assessment is needed to determine whether these experiences are trauma-related or better explained by comorbid mental health diagnoses and symptoms, such as experiences of paranoia.

The impact of being on an inpatient ward with other MDOs and a high staff presence should also be considered as a possible cause of heightened anxiety on the wards, and was illustrated by several participants. One participant emphasised that his experiences of being in hospital are similar to 'being in a fishbowl', where patients are constantly observed and given very little privacy. Others highlighted the dynamic between patients rather than staff and patients, all of whom have either been convicted of or are on remand and awaiting trial for violent and/or sexual offences. There was a sense that hospital is not an entirely safe place, that patients should not be trusted and that personal information should remain private from other patients in order to safeguard oneself. These understandable experiences may help explain some of the elevated anxiety among the participants.

Criterion F, the persistence of symptoms for more than one month, was met by all participants. Criterion G requires that symptoms indicated in

Criterions B-E cause significant distress or functional impairment. As already discussed, all participants indicated a level of distress related to their trauma, which was presented in different ways, but some also indicated distress regarding their symptoms. For example, one participant expressed concern over the meaning of his intrusive thoughts, and another described feeling scared when he wakes from nightmares. However, during the questionnaires it became apparent that the question of functional impairment was largely irrelevant for this population. Participants were asked on the *Post-traumatic Diagnostic Scale* (PDS; Foa et al., 1997) whether their reported symptoms had interfered with any of the following areas of their life in the past month: work, household chores and duties, relationships with friends, fun and leisure activities, schoolwork, relationships with family members, sex life, life satisfaction and overall level of functioning. Responses indicated that these factors are largely irrelevant to inpatients on a single-sex forensic mental health ward because they are not currently working, they do not currently have a house to upkeep, relationships were strained because of their offence and their admission to hospital rather than as a result of trauma symptoms, and in hospital there is minimal access to previously-enjoyed leisure activities and no sex life. This indicates that this criterion may need to be re-thought when considering a diagnosis of offence-related PTSD for individuals who are currently incarcerated, whether that is in prison or in hospital. More of an emphasis on distress about symptoms and the ways in which this might present may be more beneficial.

Finally, Criterion H excludes those whose disturbance can be better explained by medication, substance use or mental illness. One may

hypothesise that it is this criterion that makes clinicians reluctant to consider a diagnosis of offence-related PTSD among MDOs as their primary diagnosis, medication and a history of substance use can sometimes cause similar symptoms and lead to a possible misinterpretation of the causes of distress. With the time and space to conduct a full assessment, unlike the short single session interviews that were possible here, it is hoped that this research along with future evidence will provide clinicians with a framework for identifying, formulating and treating offence-related PTSD.

4.1.3 How are experiences similar or different from the processes described in Ehlers and Clark's (2000) cognitive model of PTSD?

As previously described, Ehlers and Clark's (2000) cognitive model highlights the role of negative appraisals and the nature of the trauma memory in contributing to a sense of current threat, either external or internal. Maladaptive strategies intended to control this threat and the associated symptoms, most notably avoidance, are viewed as the main factor that prevents change in negative appraisals and the trauma memory, thus maintaining the traumatic symptoms. This model is widely used to formulate and inform a cognitive behavioural approach to the treatment of victim-related PTSD. However, this research suggests challenges in using this model as a framework for the formulation and treatment of offence-related PTSD.

The constructs of negative appraisals and a fragmented and disorganised memory for the event are well documented and supported within

this research. However, it appears that attempts to control threat were not central to the experience of these participants. It therefore appears that the cognitive model may offer an inadequate explanation of the maintenance of offence-related PTSD. Avoidance of trauma stimuli, thought suppression and the adoption of safety behaviours were not raised by participants. Further to this, participants pointed out not only their inability to avoid conversations about their offence while engaging in therapeutic work, but that this was largely viewed as a helpful tool to engagement in reflection meaning trauma discussion was therefore voluntarily pursued. One participant also mentioned that he watched television programmes that would be expected to act as reminders. Instead of being a trigger for intrusions, it appeared that he enjoyed these and he used them as confirmation of his self-schemas. The focus of the cognitive model on dropping maladaptive behavioural and cognitive strategies that prevent memory elaboration, maintain symptoms and prevent updates to negative appraisals, therefore seems largely redundant in this population. The techniques used to achieve this, such as graded exposure, may also be limited to imaginal exposure in an inpatient setting, thereby reducing options for treatment strategies. It is also a concern that these participants have presumably been repeatedly exposed to talking about their offence with law enforcement professionals as well as their clinical teams, but that this does not seem to have had a positive impact on their symptoms. This may indicate that a treatment model based on the principle of exposure may be inappropriate for this sample as there are perhaps other unaccounted for maintaining factors at play. Alternatively, one may infer that contextual information is not being added during these conversations and

traumatic memories are therefore not being transformed and integrated into the autobiographical memory.

Memory elaboration could potentially provide a helpful focus for treatment. However, given extensive reports of gaps in memory, this research indicates that the identification of a hotspot for targeted reprocessing may be challenging with this population. Offence-related PTSD may therefore be more suited to an alternative treatment approach with less emphasis on the reprocessing of distinct memory fragments.

Given the extensive negative appraisals raised by participants, it appears that the cognitive model is helpful in explaining the role of these cognitions in developing and maintaining offence-related PTSD. The modification of problematic appraisals, guided by this model, may be a beneficial focus for treatment.

4.2   Strengths and limitations

4.2.1   Sample

In order to gain an insight into the specific phenomena of offence-related PTSD, as is the aim of Interpretative Phenomenological Analysis (IPA), only participants for whom this topic is directly relevant and meaningful were selected. As discussed previously, the use of purposeful selective sampling to create a homogenous sample is theoretically consistent with IPA. This sample was homogenous in that all participants were adult males convicted of a violent or sexual offence, and currently being detained and treated under the

Mental Health Act (2007) at a medium secure forensic hospital. All participants were aged between 23 and 36, four of the six participants identified as white British, with the other two identifying as mixed white and black Caribbean, and white European. However, the lack of diversity with regards to demographic variables such as age, gender, race and ethnicity could also be seen as a limitation, particularly when using this research to inform assessment, diagnosis and treatment across the MDO population. The extent to which, if at all, these variables increased participants' willingness and ability to engage in the research compared to other MDO demographic groups is also unclear.

Concerns may also be raised about areas of heterogeneity within the sample, particularly where data was not collected for some variables. For example, data on past and current treatment and physical health were not collected. It was confirmed by the responsible clinicians that none of the participants had previously received trauma-focused treatment, but had otherwise undergone varying treatment programmes specific to their primary diagnosis, which also varied among the participants, and their offence. This may have consisted of both individual and group sessions, both at the recruitment site and in some cases at previous hospitals and prisons as adults and young offenders. As this data is not available, it is not possible to determine the impact of previous treatment on current experiences of offence-related PTSD. Some authors have hypothesised that, in MDOs, previous treatment for non-PTSD mental illness may be positively correlated with PTSD symptoms due to an increased awareness of one's offence and the impact of one's mental health difficulties (Crisford et al., 2008). Similarly,

Clark et al. (2014) suggest that trauma-related discussion has the potential to re-traumatise individuals. Since much of the previous treatment received by the participants is likely to have involved conversations about both their offence and their mental health, these points emphasise that previous treatment may play a crucial role in current experience. Questions may also be raised about whether some of the experiences captured in this research can be better understood as part of a PTSD presentation or as responses to previous treatment that has encouraged reflection and may therefore be expected to produce experiences of shame, guilt, regret and remorse. Similarly, consideration of the impact of variations in physical and mental health on current experience is beyond the scope of this study.

4.2.2 The use of screening measures

The design used for this research raised several limitations that have to be considered. Although the primary research question was interested in clinically significant offence-related PTSD symptoms so the use of standardised measures was thought to be appropriate, by using questionnaires that screen for PTSD based on diagnostic criteria, it is acknowledged that differential experiences of offence-related traumatic distress may have been excluded. It could be argued that this is a significant flaw since participants were recruited based on self-reported symptoms key to DSM-V diagnosis but the secondary research question was interested in how experiences of offence-related trauma were similar or different to DSM-V (APA, 2013) criteria.

The researcher met with participants to go through the two screening questionnaires, the *PDS* (Foa et al., 1997) and the *Impact of Events Scale - Revised* (IES-R; Weiss, & Marmar, 1995) together. These were chosen for use in this research due to their strengths in identifying past victim-related trauma and allowing participants to identify their most personally distressing offence and respond to questions in reference to only that incident. The researcher read the questions aloud, most of which required a numerical answer on a Likert scale, and then made a note of the participants' responses. It was found that participants tended to offer a sometimes lengthy and detailed verbal explanation for their response and had to be directed back to the questionnaires. Following each meeting, notes were made in a reflective journal but it was felt that valuable, rich data was still lost as the questionnaire sessions were neither recorded nor analysed. The reflective notes served to remind the researcher of what was important to the participant and which topics they wanted to discuss further, as well as facilitating reflection and acknowledgement of the thoughts, feelings and assumptions raised by each meeting. This enabled the researcher to make thoughtful prompts during the interviews, although in most cases these topics of importance were brought up again spontaneously but not always in as much detail. Some participants seemed reluctant to repeat themselves as they were aware that they had previously told the researcher about aspects of their experience while completing the questionnaires. It is recognised that the use of questionnaires, particularly when completed face to face, is likely to have impacted on the assumptions made by the participant in relation to the topic areas they were expected to talk about and those they need not raise a

second time, and by the researcher regarding expected topics of importance. The researcher attempted to guard against this by acknowledging this possibility through reflection, remaining open to possibilities and by encouraging later participants to keep responses brief during the questionnaires so as to minimise the possibility of lost data, and instead to tell their story in full during the interview.

It is also acknowledged that these measures are based on the diagnostic criteria of 4th edition of the DSM (DSM-IV; APA, 1994). To the knowledge of the researcher, there are not currently any validated PTSD questionnaires based on DSM-V criteria. While this could be viewed as a limitation given the changes to criteria, the questions remain largely relevant and they continue to be used both in research and clinically so it was decided that their use as a research screening tool remained appropriate.

4.2.3 Interviews

It is important to note that some authors have criticised the use of interviews in generating qualitative data, despite the vast popularity of this method. Potter and Hepburn (2005) raise four main concerns about the use of interviews and the way that authors present the data generated from interviews to their audience, including a failure to consider interviews as interactions, omission of the interviewer's questions, unavailability of the interview set up and context, and the specificity of analytic observations. The researcher attempted to address these criticisms by including interviewer questions in some extracts and differentiating between interviewer and

participant speech on transcripts by starting a new line and using italic bold font to highlight participant responses. The researcher also provided contextual information including how the interview was set up and presented to participants. Furthermore, the perspective that interviews should be viewed as an interaction involving a dual sense-making process and a level of interpretation is central to IPA and has been discussed in detail.

One interview had to be repeated due to a recording device malfunction and it was the second interview that was used for analysis. Detailed notes were kept in a reflective journal following the initial interview, which revealed that the content of the second interview was largely the same as the first and the participant raised the same concerns and offered the same details of his experience. This enabled the researcher to view this as a positive opportunity to check out the initial interpretations from the first interview. Stiles (1993) recommends adopting a method of checking interpretations with participants in order to assess reliability. The researcher noted, however, that the participant seemed less animated. In the first interview, he proclaimed that he was definitely suffering from PTSD, and the researcher was left to question the purpose of this self-diagnosis. As the content remained stable, it is not thought that the analysis of a repeated interview poses a significant threat to the integrity of the results, but it is acknowledged that the way in which the participant expressed himself and portrayed those experiences may have varied between the two interviews. Moreover, the researcher inevitably held some assumptions about the topics that would be raised based on the first interview, and her interpretations may therefore have been affected. Attempts were made to guard against this by

using a reflective journal and openly acknowledging pre-conceived ideas so that they might be bracketed more effectively.

4.2.4 Researcher-participant interaction

In order to assist readers in evaluating the quality of this research, personal orientation, expectations, theoretical perspectives and the social and cultural context of the participants and the researcher have been disclosed. Peer reflective groups and a group for multi-disciplinary IPA researchers were also utilised to discuss the assumptions and expectations held by the researcher regarding the participant group, their experiences and the data generated from the interviews, with the aim that this would help in 'bracketing' preconceptions.

The researcher was mindful of her position as a female trainee clinical psychologist and how her gender, lack of experience and age might affect participants' perceptions and willingness to discuss a potentially distressing topic. Generally, prospective participants seemed keen to engage and those who agreed to participate seemed to view it as an opportunity to access support. Those who did not consent to participate often explained that they felt the research was inappropriate for them as they were not feeling distressed by their offence. Positive engagement was demonstrated during the interviews of several participants but it was noted that some tried to push professional boundaries, while others were unsure of the differentiation in role between the service's clinicians and the researcher so this had to be explained and reinforced.

The needs of the participants were at the forefront of every interview and in one case in particular this meant that the boundaries between researcher and clinician became blurred due the need for symptom management intervention during the interview. Although it is acknowledged that it is not ideal for a researcher to adopt an unexpected clinical role outside the context of the research, it was felt that the researcher held a duty of care that meant that quickly and effectively reducing high levels of distress caused by the interview took priority over maintaining the strict distinction between researcher and clinician.

One participant appeared to view the researcher as a potential ally and the transcript of his interview demonstrates his tendency to plead with and make attempts to convince the researcher of his innocence. He also tested the boundaries at one stage during the interview, making a comment about the researcher's age in the context of discussing how his conviction has increased the age of women he now pursues for relationships. Although the researcher felt it important to redirect the conversation away from herself, this comment was understood to reflect his mental state and possible difficulty in managing social interaction appropriately rather than his attitude towards and perceptions of the researcher in the context of their researcher-participant relationship.

Participants were positioned as experts in their experience and it was explained that the researcher was interested in hearing their personal accounts of those experiences. The researcher periodically stated what was being understood during the interviews, giving participants an opportunity to confirm, correct or alter the meaning of observations. The researcher's

interpretations were also checked against supervisor and peer-researcher analysis in order to assess for the reliability and validity of the researcher's exploratory coding and emergent themes.

Following reflection on the process and start of the first two interviews, the researcher changed how the purpose of the interview was explained as well as the wording of the first question. During the questionnaire stage, participants were told that the interview would be an opportunity to give more information and tell their story in their own words. Immediately prior to starting the recording, participants were reminded to talk about their experiences like a story, and it was explained that the researcher would not talk very much or ask many questions, unlike the initial questionnaire meeting. The original wording of the first question was prompting confused responses where participants expressed uncertainty about what they were expected to talk about. They therefore asked the researcher what she wanted to know, indicating a possible desire to please and the potential that participants were entering the interview with assumptions about what was expected of them. After the question was rephrased to ask participants to tell the researcher more about their experiences and the points they raised during the questionnaires in their own words, it was found that more detailed responses were spontaneously given. The interviews were neither rushed nor drawn out. Participants were given space and time to discuss difficult topics and they were enabled to bring up issues of particular importance to them. However, it was also accepted that some participants needed more encouragement and prompts in order to divulge detailed information about their experience, and some could only tolerate a shorter interview.

4.3 Implications and Recommendations

4.3.1 Implications for clinical practice

As previously outlined, the present study highlights that symptoms of avoidance, currently necessary for a diagnosis of PTSD, were not raised by participants either spontaneously or following prompts from the researcher. The insinuation is therefore that these individuals would not currently meet criteria for a diagnosis according to the DSM-V (APA, 2013), despite reporting high levels of distress and a range of other symptoms commonly associated with PTSD. This has extensive implications for clinical practice as, without a diagnosis, MDOs experiencing high levels of offence-related trauma will not be offered trauma-focused treatment. The concern is that without accessing trauma-focused treatment, individuals are at a greater risk of failing to make significant improvements in the areas of mental health, offending behaviour and functionality (Kubiak, 2004; Rogers et al., 2000). Furthermore, some authors suggest that the treatments routinely offered to MDOs may serve to re-traumatise them (Clark et al., 2014). They therefore highlight the importance of identifying and treating trauma prior to engaging in other interventions for comorbid diagnoses and offending behaviour, and endorse the use of routine trauma screening at admission for all MDOs.

In terms of appropriate treatment for offence-related PTSD, this research raises concerns about using imaginal exposure; a key technique used in trauma-focused cognitive behavioural therapy (TF-CBT) to access, contextualise and process trauma memory hotspots. The re-living approach

relies on being able to identify one or multiple hotspots and remember

sufficient information in order to start processing. Given that fewer than half of

the participants identified repeated re-experiencing of the same hotspot, it is

questionable whether this method would be most beneficial to this population.

Eye movement desensitisation and reprocessing (EMDR) or narrative

exposure therapy (NET) may be more helpful.

Pollock (2000) describes the successful use of EMDR to treat offence-

related PTSD in Patient R, who reported no prior mental health concerns but

was experiencing recurrent flashbacks and intrusive images after committing

a homicide. Clark et al. (2014) reported that clinical improvements made by

Mark, a 26 year old male detained in a medium secure service under the

Mental Health Act (2007), during EMDR treatment were maintained at one-,

three- and 12-month follow-up. They propose the possible need, however, for

an adapted EMDR protocol for use with MDOs experiencing offence-related

PTSD. They point out that, unlike traumatised victims, offenders may perceive

themselves as a threat rather than vulnerable to threat, emotions that seem

illogical for victims, such as guilt and shame, may be considered appropriate

among offenders, and that trauma resolution may involve reaching an

understanding of the context of the offence, acceptance of a change in

identity and inability to change history, and self-forgiveness. These ideas are

supported by the themes raised in the current research.

Hecker, Hermenau, Crombach, and Elbert (2015) propose the use of

Narrative Exposure Therapy for Forensic Offender Rehabilitation (FORNET),

which aims to reduce symptoms of traumatic stress and reduce aggressive

behaviour. The approach follows the protocol of NET, with the therapist

guiding the client through a chronological exposure to their traumatic experiences, with the aim of integrating these experiences and the associated negative and positive emotions, cognitions and sensory information with contextual information in autobiographical memory. Although they propose a focus on past and future violent and aggressive behaviours, it is also possible that this technique could also be used to address multiple traumas, both victim- and offence-related. A randomised controlled trial of 32 male youths provides evidence for the efficacy of this approach (Crombach, & Elbert, 2015). The authors report that at 4-7-month follow-up, the group who received treatment reported committing significantly fewer offences and presented with fewer physical health difficulties.

Lee et al. (2001) point out that imaginal exposure aims to treat fear as the primary emotional response to trauma. They suggest that this treatment may be disrupted by other emotional responses, particularly shame, guilt, humiliation, anger and sadness, and that neglecting to address these may lead to a worsening of symptoms (Pitman et al., 1991; Resick, & Schnicke, 1992). Given the strength of guilt- and shame-based reactions among these participants, Lee et al.'s (2001) approach to formulation may be helpful in guiding treatment using psycho-education and cognitive restructuring to address these emotions among MDOs. They point out that this can be done alongside imaginal exposure. It is also possible that using techniques from compassionate therapy would have positive outcomes for these participants given their expressed negative emotions and their experiences of an identity shift that creates shame. This shame can be understood as external threat in

the form of other people's negative perceptions and internal threat in the form of negative self-evaluation (Lee, 2009).

The researcher was struck by the focus of some participants on the consequences of offending behaviour and attitudes to being in hospital. The research highlights the importance of effectively managing and containing the uncertainty these participants expressed regarding their admission. Additionally, service providers may wish to consider the possibilities for delivering inpatient care in a way that allows patients to have more choice and maintain social relationships, hobbies and a sense of personal space, while also continuing to effectively manage risk issues. Involving service-users in decisions about their care and daily routine may help alleviate some of the hostile feelings about being in hospital that this research has exposed. For example, giving service-users the option of several appropriate hospitals with current bed availability immediately prior to transfer and admission may still result in people being moved away from their social support network, but would at least give patients a degree of choice and an ability to minimise this distance should they wish to, within the practical limits of available bed space. Once admitted and provided that funding allows, discussions with the hospital staff may involve allocating free time on the wards so that service-users can pursue hobbies, interests and have time to themselves in their room away from both staff and other patients. There is currently a busy schedule of important and beneficial treatment, as pointed out by participants, but it appears that an ideal balance is yet to be met and that striving to strike this balance may have a favourable impact on patient mental health by allowing time for personal reflection and a sense of maintaining some aspects of prior

identity, as is suggested by the shattered assumptions theory of trauma response (Janoff-Bulman, 1992).

Current research suggests that treating PTSD has favourable mental health and risk outcomes (Clark et al., 2014; Kubiak, 2004; Mueser et al., 2002). This suggests that improved trauma treatment may help service-users move more rapidly through the system so they can be treated safely and effectively in the community. This research can be used by clinicians to help identity, assess and treat offence-related PTSD, which may have the effect of increasing the positive appraisals about hospital raised by participants, given the potential improvements to mental health and perceived likelihood of discharge, and decreasing negative appraisals, which for these participants centred around the view of hospital as an on-going punishment.

There was also a sense that the current hospital environment is far from ideal for service-users with a history of paranoia and perhaps, in the case of PTSD, for those with symptoms of hypervigilance. In some cases, experiences of being in hospital appeared very similar to what is known about experiences of paranoia (Freeman, 2007). A sense of being constantly watched, scrutinised, and judged were raised by participants, as well as the inability to escape this. Service providers may also wish to consider whether the way secure inpatient services are delivered for paranoid individuals can be modified in a way that maintains the safety of staff and patients but creates a compassionate environment that promotes a collaborative relationship between staff and service-users rather than one of observation and direction.

4.3.2 Implications for further research

This research offers insight into the idiosyncratic experiences of offence-related PTSD. The themes discussed are specific to the six participating MDOs, all of whom have been convicted of violent and sexual offences and are currently being detained and treated in a medium secure service. It was noted that none of the participants were identified by their referring clinician as having symptoms of PTSD. It was reported on referral forms and during conversations between the researcher and referring clinician that some were distressed by their offence but this was not considered to be at a level requiring intervention. This was not a referral criteria due to the inclusion of a screening stage prior to interview selection and invitation, but raised questions about this recruitment strategy given the high levels of self-reported clinically significant symptoms of both offence-related PTSD and, for some, victim-related PTSD. If these individuals were missed by their clinicians for consideration of a PTSD diagnosis and treatment, there may be others who were overlooked for referral to the researcher and did not have the opportunity to share their stories and experiences. This has implications for future research into trauma symptoms among MDOs and future researchers may wish to consider other strategies, such as recruiting via a routinely used outcome measure that is used across the recruitment site and therefore does not exclude anyone from being invited to participate. This would enable the identification of individuals reporting high levels of PTSD symptoms who may have otherwise been overlooked by clinicians.

The results raise questions about whether the DSM-V (APA, 2013) is the most helpful tool for identifying offence-related trauma and whether a distinct diagnosis is needed to differentiate between victim-related and offence-related PTSD. To the researcher's knowledge, this is the first explorative study in to the experiences of offence-related PTSD that does not use a single case study design and therefore expands on previous literature. However, further research is needed to explore whether the experiences portrayed here generalise to a wider population of MDOs prior to making an argument for an alternative set of diagnostic criteria specific to offence-related PTSD. Comparisons between different groups may also help to shed light on the complexities of the diagnosis and any differences between distinct populations. For example, comparisons between sexual offenders and violent, non-sexual offenders, those who have experienced victim-related trauma and those who have not, and individuals with different primary diagnoses may highlight some interesting and potentially important considerations, which would impact the way in which assessment and treatment is approached. Additionally, further research will need to address the demographic homogeneity of the current study's sample by considering variations in gender, age, race and ethnicity.

It is recommended that as more is learnt about the phenomenon of offence-related PTSD, research in this area be further expanded to include quantitative designs that aim to further understanding rather than simply demonstrating existence, as has been a primary focus of previous quantitative research in this area (Crisford et al., 2008; Gray et al., 2003). For example, although detailed analysis was beyond the scope of this study, the

researcher thinks it likely that several participants were excluded from the interview stage of the present study due to reduced scores in standardised measures which do not account for the apparent lack of avoidance symptoms. Further research may wish to use standardised measures to compare a group of individuals with suspected offence-related PTSD and a group of victim-related PTSD sufferers on scores of DSM-V criterions B, C, D and E (APA, 2013). This would help quantify a difference in experience between the two groups. Additionally, pre- and post- non-trauma treatment comparisons along with longitudinal studies over a length of admission may offer insights in to how symptoms change over the course of routine mental health and offending behaviour treatments. It is possible that attempts at avoidance and intrusive symptoms decrease over time as a result of being required to talk about one's offence in order to engage in treatment and therefore having an opportunity to contextualise and process one's memory of the offence. Conversely, it is possible that negative cognitions and mood increase as a result of coming to an understanding of one's changed identity and the consequences of one's offence.

The research has also raised questions about the appropriateness of different treatment approaches to offence-related PTSD. Quantitative research comparing outcome data of different approaches, such as TF-CBT, NET and EMDR, would be a valuable step in assisting clinicians to choose the most suitable approach for their clients.

4.4 Conclusion

This research explored the experiences of offence-related PTSD among six MDOs identified as showing clinically significant symptoms in relation to their index offence on the *PDS* (Foa et al., 1997) and the *IES-R* (Weiss, & Marmar, 1995). Analysis of semi-structured interviews identified three superordinate themes: *Responses to an identity shift, Ineffective memory processing,* and *Appraisals of the consequences of offending*. These have been discussed in relation to each of the participants. Discussion aimed to consider how similar or different these experiences are from both the DSM-V (APA, 2013) diagnostic criteria for PTSD and the processes identified in Ehlers and Clark's (2000) cognitive model of PTSD. It appears that these participants display many of the same intrusion symptoms that have previously been identified in sufferers of victim-related PTSD, but considerations for treatment are needed given the possible difficulty in identifying a hotspot. Avoidance symptoms appear to be less relevant and less prominent than might have been expected given the existing diagnostic criteria, and it is apparent that these participants would not meet criteria for a PTSD diagnosis. This suggests the possible need for alternative criteria for offence-related PTSD. Alterations to cognitions, mood, reactivity and arousal were identified, with a particular emphasis on a sense of incongruence between a previous and new identity brought about as a consequence of one's offence and the negative emotional responses to this. This was discussed in relation to literature on shame and guilt, and the implications for treatment were considered. Additionally, participants stressed the importance of the consequences of their offence.

The implications of these experiences were discussed in relation to appropriate and optimal service delivery and treatment. Finally, recommendations for further research have been highlighted.

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APPENDICES

Appendix A: Literature search strategy

For the purposes of a literature review, a search was conducted to identify literature relevant to this study. The Royal Holloway, University of London E-Resources search website and EBSCOHost were used to search the following electronic databases: JSTOR, PsycArticles, PsycInfo, PubMed and Science Direct. Google Scholar was used to identify key words and additional relevant books and articles. Reference lists of identified resources were searched for other relevant literature.

The search terms "post-traumatic stress", "trauma", "offence-related" and "mentally disordered offenders" were used in initial searches. Synonyms, such as "perpetrator", and alternative spellings and acronyms, such as 'posttraumatic stress', 'PTSD' and 'MDOs' were then used. All these terms were then coupled with each other in various combinations in order to narrow the search. The use of an asterisk (*) in searches allowed for varying word endings to be identified. For example, searching for 'offender*' also searched for 'offenders' and 'offending'.

Appendix B: Recruitment and data collection procedure flowchart

Clinician information sheet and referral form distributed to the clinical teams along with a request for responsible clinicians and psychologists to consider possible referrals.

Consent Obtained

Consent Not Obtained → End of Contact

Consent to approach obtained from the service user's responsible clinician and clinical team (including nursing staff on the day).

Service user approached to discuss the information sheet and answer any questions about participation in the study. Service user given a copy of the information provided to consider for a minimum of 24 hours before being approached for a decision.

Service user approached to ask whether they would like to participate.

Consent Obtained from Service User

Consent Not Obtained → End of Contact

Convenient time to complete screening measures arranged with the service user and clinical team.

Service user and researcher verbally completed the Post-traumatic Diagnostic Scale and Impact of Events Scale – Revised. Service user thanked for their time and paid £5.

Inclusion Criteria Met

Inclusion Criteria Not Met → End of Contact

Convenient time to conduct the interview arranged with the service user and clinical team.

Service user approached to ask whether they would still like to participate in the interview.

Consent Obtained from Service User

Consent Not Obtained → End of Contact

Interview completed. Service user thanked for their time and paid an additional £5.

Demographic information collected from participants' medical notes and their referring clinician. → End of Contact

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Clinician Information Sheet

Title of Project: Mentally disordered violent offenders' experience of offence-related post-traumatic stress disorder (PTSD): Considerations for diagnosis and treatment.

I would like to ask you to consider whether any of the service-users under your care may be suitable for the above research study. Please consider the following information carefully and please do ask me if you have any questions or would like more information.

I am Jocelyn Fleming and I am conducting this research as part of my Doctorate in Clinical Psychology at Royal Holloway, University of London. I am supervised by a member of the Royal Holloway academic staff, Simone Fox, and by Lucy McCarthy and Patrick Sims.

Aims of the study

The research is aimed at addressing the following questions:

- How do mentally disordered violent offenders experience symptoms of post-traumatic stress disorder (PTSD) related to an offence? How are these experiences similar or different from the typical diagnostic criteria for PTSD?

- How are these experiences similar or different from the key components of Ehlers and Clark's (2000) cognitive model, which is used to guide treatment?

The study has been approved by the Stanmore NRES Research Ethics Committee and Royal Holloway.

Who is able to participate?

I am looking for men, aged 18-65 who have committed a violent offence for which they have already been convicted. They need not have had an assessment of PTSD as this will be addressed as part of the research. Participants must also have a good understanding of English and be able to comprehend and communicate in verbal and written forms.

What will participants be asked to do?

Once I have received your consent, I will contact all individuals identified as potentially suitable. They will be asked to meet with me to complete two questionnaires that assess the frequency of and distress related to symptoms of PTSD (the Posttraumatic Diagnostic Scale, and the Impact of Events Scale – Revised). The second of these (the IES-R) will ask participants to consider only symptoms related to the offence that bothers them most. Those who indicate clinically significant symptoms to a violent offence on these scales will be asked to meet with me again for an interview. During this interview, which will last approximately 45-60 minutes, I will ask them in more detail about their offence and the symptoms they identified in the questionnaires.

Will you be required to have any input in the research?

Aside from assisting me in identifying potential participants, you will not be required to have any input in the research. The responsible clinician, psychologist and any other relevant professionals will be informed of potential risk or distress identified during the research so that participants are able to access appropriate support should it be required.

How should referrals be made?

Please now consider the service-users under your care and inform me, Lucy McCarthy or Patrick Sims of potentially suitable referrals by returning the attached form. Given the confidential nature of this information, I ask that you only speak to us in person.

Will you see the results?

Following data analysis, I will be presenting the results at the recruitment site. A written summary can be provided on request. It is hoped that the results of the study will help improve the identification and treatment of offence-related PTSD.

Thank you for taking the time to read the above information. Please contact me if you have any questions and I look forward to hearing from you about potential participants.

Clinician Research Referral Form

Title of Project: Mentally disordered violent offenders' experience of offence-related post-traumatic stress disorder (PTSD): Considerations for diagnosis and treatment.

I have identified that the following service-user may be suitable for the above research study:

Name:

Date of Birth:

Diagnoses:

Can understand and communicate in verbal and written English:
Yes   No

Brief history of offending behaviour (past offences as well as index offence):

Do you suspect symptoms of PTSD? (N.B. need not have had an assessment):

Risk information:

Any other information that may be of help:

I give my consent for Jocelyn Fleming to approach the above service-user regarding participation in this research study: Yes   No

Name of referring clinician:

Appendix D: Participant information sheet

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Participant Information Sheet

Title of Project: Violent offenders' experience of offence-related
post-traumatic stress disorder (PTSD):
Considerations for diagnosis and treatment.

I would like to invite you to take part in the above research study. Before you
decide, it is important that you understand why the research is being done
and what it will involve. Please take your time to consider the following
information carefully and please ask me if you have any questions or would
like more information. Thank you.

The Study
I am Jocelyn Fleming and I am conducting the research as part of my
Doctorate in Clinical Psychology at Royal Holloway, University of London.
The research is aimed at addressing the following questions:

- How do people who have committed violent crimes experience
  symptoms of post-traumatic stress disorder (PTSD) related to their
  offence?

- How are these experiences similar and different from those of other
  people who experience PTSD? Can they be treated in the same way?

All research conducted in the NHS is looked at by a Research Ethics
Committee, that aims to protect your safety, rights, wellbeing and dignity. The
study has been reviewed and given favourable opinion by the Stanmore
NRES Research Ethics Committee and Royal Holloway, University of
London.

Why have you been asked?
A selection of service-users from this hospital have been invited to take part. I
am interested in talking to people who have committed a violent offence in the

past. You will be given at least 24 hours after reading this and speaking with me to decide if you wish to take part in the study.

What will you be asked to do?
If you decide to take part, you will be asked to meet with me and complete two questionnaires. I will begin by asking you some background questions and then we will go through the questionnaires. One of these will ask you about trauma you may have experienced over your lifetime and your emotions about this. The second will ask you to think only about the offence which bothers you most (this may or may not be the offence for which you are currently incarcerated). You will be asked similar questions about your emotions regarding your offence. It is estimated that this meeting will take approximately 30 minutes. Should you wish to take breaks or complete these questionnaires over two sessions, please ask as this can easily be arranged. Anyone who agrees to take part will receive payment to the value of £5, which will be given at the end of the session.

A selection of those who complete the questionnaires will then be asked to meet with me again for an interview, which will be audio recorded. I will ask you in more detail about the emotions and experiences you identified having in the questionnaires. I will also ask you about your emotions at the time of your offence and your memory of the event. It is expected that the interview will last approximately 45-60 minutes. Anyone who agrees to take part will receive payment to the value of £5, which will be given at the end of the interview. This is in addition to the £5 received at the questionnaire stage.

Will taking part in the study affect your treatment or legal rights?
If you choose to participate in the study, it will have no effect on your treatment in hospital or your legal rights. I hope that the results of the study will help improve the identification and treatment of people who have committed violent offences and are experiencing distressing emotions and experiences as a result.

Confidentiality will be maintained except in circumstances of risk of harm to self or others, in cases where a crime has been disclosed and the perpetrator has not been convicted, and in instances of extreme distress. Please note that talking about your experiences may cause you to have some distressing emotions. In such cases it will be necessary to inform your responsible clinician and/or psychologist. If you become distressed during the research I may also inform the nursing staff or other professionals who are involved in your care in order to ensure that you receive appropriate support. I will always discuss this with you first. If you disclose a crime, committed by either yourself or others, for which the perpetrator has not been tried and convicted, the police will be informed. Again, I will discuss this with you first. Your GP will not be informed of your participation unless you request for us to contact them.

What will happen next?
You will have at least 24 hours to decide if you want to take part. If you choose to participate, you will be asked to sign a consent form to show that you have agreed to take part and have understood the information given here. It will also ask your permission to gather background information from your hospital files. You are free to withdraw at any time, without giving a reason, and all data will be destroyed, including both anonymised and identifiable data. It is entirely up to you if you wish to take part. If you choose not to take part or you withdraw from the study, this will in no way impact your current or future treatment in hospital.

Who will see the results?
Any information obtained from your file, questionnaires and interview will have your name and details removed in order to maintain anonymity. All research data will be treated as strictly confidential. Audio recordings of the interview may be heard by a professional transcriber, who is also bound by strict confidentiality guidelines, provided they contain no identifiable information, such as your name and the name of the hospital. These anonymous transcripts may be seen by other research psychologists to ensure high quality analysis. The results may be published in a journal or presented at a conference but no publication will be made with any participant's personal details or the name of the hospitals.

Where can you get more information?
If you have any questions or concerns, please ask me. Alternatively you can speak to your psychologist or responsible clinician.

Where can you make a complaint?
The Patient Advice and Liaison Service (PALS) offers confidential advice, support and information on health- and NHS-related issues. They can support you if you have any concerns or complaints about your care. You can call them free of charge Monday-Friday between 9am and 4pm on
0800 064 3330.

Thank you for reading this information and for considering taking part in this research.

Jocelyn Fleming
Trainee Clinical Psychologist

Appendix E: Consent form for participation in the screening stage

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Participant Consent Form – Questionnaire participation

Title of Project: Violent offenders' experience of offence-related
                          post-traumatic stress disorder (PTSD):
                          Considerations for diagnosis and treatment.

Name of researcher: Jocelyn Fleming

Patient Identification Number:

N.B. The following statements refer to the questionnaire stage of the study

Please tick box

I confirm that I have read and understood the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected. If I choose to withdraw, I will still be paid for my time.

I understand that any data I provide during the interview is confidential and will be anonymised. I also understand that if the researcher is concerned about my wellbeing or that of others, she will discuss this with both me and my responsible clinician and/or psychologist. If I disclose an unresolved crime, I understand that the police will be informed.

I permit the researcher to have access to my medical notes for the purpose of recording my participation and collecting information relevant to the study.

I agree to take part in the study

_____   _____   _____
Participant name   Participant signature   Date

_____   _____   _____
Researcher name   Researcher signature   Date

Appendix F: The Post-traumatic Diagnostic Scale

Please note, the Post-traumatic Diagnostic Scale has been omitted due to copyright restrictions.

Appendix G: The Impact of Events Scale – Revised

Revised - Impact of Events Scale

	Below is a list of difficulties people sometimes have after stressful life events. please read each item and then indicate how distressing each difficulty has been for you during the past 7 days or other agreed time:	**0** = Not at all **1** = A little **2 =** Moderately A lot **= 3** Extremely = **4**				
a	any reminder brought back feelings about it	0	1	2	3	4
b	I had trouble staying asleep	0	1	2	3	4
c	other things kept making me think about it	0	1	2	3	4
d	I felt irritable and angry	0	1	2	3	4
e	I avoided letting myself get upset when I thought about it or was reminded of it	0	1	2	3	4
f	I thought about it when I didn't mean to	0	1	2	3	4
g	I felt as if it hadn't happened or it wasn't real	0	1	2	3	4
h	I stayed away from reminders about it	0	1	2	3	4
i	pictures about it popped into my mind	0	1	2	3	4
j	I was jumpy and easily startled	0	1	2	3	4
k	I tried not to think about it	0	1	2	3	4
l	I was aware that I still had a lot of feelings about it, but I didn't deal with them	0	1	2	3	4
m	My feelings about it were kind of numb	0	1	2	3	4
n	I found myself acting or feeling like I was back at that time	0	1	2	3	4
o	I had trouble falling asleep	0	1	2	3	4
p	I had waves of strong feelings about it	0	1	2	3	4
q	I tried to remove it from my memory	0	1	2	3	4
r	I had trouble concentrating	0	1	2	3	4
s	reminders of it caused me to have physical reactions	0	1	2	3	4
t	I had dreams about it	0	1	2	3	4
u	I felt watchful and on-guard	0	1	2	3	4
v	I tried not to talk about it	0	1	2	3	4
	Totals					

avoidance subscale (total of e, g, h, k, l, m, q, v divided by 8) =
intrusion subscale (total of a, b, c, f, i, n, p, t divided by 8) =
hyperarousal subscale (total of d, j, o, r, s, u divided by 6) =

Weiss,D.S. & Marmar,C.R. *The impact of event scale-revised.* in Wilson,J.P. & Kean,T.M. (eds.) *Assessing psychcological trauma and PTSD: a practitioner's handbook (ch 15).* N.Y: Guildford, 1995.

Appendix H: Consent form for participation in the interview

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Participant Consent Form – Interview participation

Title of Project:	Violent offenders' experience of offence-related post-traumatic stress disorder (PTSD): Considerations for diagnosis and treatment.

Name of researcher: Jocelyn Fleming

Patient Identification Number:

N.B. The following statements refer to the interview stage of the study

Please tick box

I confirm that I have read and understood the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected. If I choose to withdraw, I will still be paid for my time.

I understand that any data I provide during the interview is confidential and will be anonymised. I also understand that if the researcher is concerned about my wellbeing or that of others, she will discuss this with both me and my responsible clinician and/or psychologist. If I disclose an unresolved crime, I understand that the police will be informed.

I permit the researcher to have access to my medical notes for the purpose of recording my participation and collecting information relevant to the study.

I agree to take part in the study

Participant name	Participant signature	Date
Researcher name	Researcher signature	Date

Appendix I: Table of demographic details and questionnaire data

Participant	Age	Ethnicity	Mental health and substance misuse details	Index offence	Time since offence (year of offence)	Trauma history (self-reported on Post-traumatic Diagnostic Scale)	Post-traumatic Diagnostic Scale score and severity	Impact of Events Scale - Revised score	Met inclusion criteria?
James	31	White British	Schizophrenia History of self-harm and attempted suicide	Rape (threatening with a knife)	9 years (2006)	Childhood physical and sexual abuse, Prison	19, moderate	41	Yes
Kristopher	23	White European	Paranoid schizophrenia Poly-substance misuse	Manslaughter	2 years (2013)	Physical assault, Rape, Prison, Torture	34, moderate-severe	57	Yes
Pete	33	White British	Paranoid schizophrenia Alcohol dependency	Affray (threatening with a knife)	1 year (2014)	Mugged during an epileptic seizure, Prison, Experiences of having epilepsy	41, severe	52	Yes
Phil	36	White British	Antisocial and Borderline Personality disorders Meets criteria for PCL-R Psychopathy Alcohol and cannabis misuse	Grievous Bodily Harm (GBH) against a child	20 years (1995)	Childhood sexual and physical abuse, History of bullying and running away from home during childhood	34, moderate-severe	47	Yes

Sean	36	White British	Schizoaffective disorder Antisocial Personality disorder Poly-substance misuse	Manslaughter	9 years (2006)	Childhood physical abuse, Experiences in care system, Prison	34, moderate-severe	62	Yes
Liam	35	White and Black Caribbean	Schizoaffective disorder Cannabis dependence syndrome	Four counts of sexual assault, sexual activity with a child under 16 and sexual assault of a child under 13	5 years (2010)	Road traffic accident when a teenager (run over) – resulted in coma and lengthy hospital treatment, Childhood physical abuse, Stabbed multiple times, Prison	21, moderate-severe	38	Yes
Jack	22	White British	Paranoid schizophrenia Poly-substance misuse	Sexual assault by penetration	3 years (2012)	Fence fell on his head as a child, Physically assaulted, Prison	27, moderate-severe	16	No
Matthew	30	White British	Paranoid schizophrenia Poly-substance misuse	Theft and two counts of attempted robbery	3 years (2012)	Caught in a fire as a child, Childhood sexual abuse, Military combat, Prison	11, moderate	9	No
Adrian	39	White British	Amphetamine induced psychosis Poly-substance misuse	Rape and Actual Bodily Harm (ABH)	3 years (2012)	Physical assault, Military combat, Prison	2, mild	4	No
Mike	39	White British	Paranoid schizophrenia Poly-substance misuse	Attempted robbery (with a pretend gun)	9 years (2006)	Childhood physical and sexual abuse, Prison, Witnessed domestic violence	6, mild	29	No

Appendix J: Interview schedule

PTSD symptoms
1) You may remember answering some questionnaires, which asked you about the offence that bothers you the most and your mood since then – can you tell me more about this?

The following to be used as prompt questions if needed.

2) Have you noticed any other changes, such as … [*use PDS and IES-R to identify symptoms not mentioned during response to q1*]?

3) When did this start?

Strategies to control threat
4) When you experience … [*specify symptoms*], what, if anything, makes it better?

5) What, if anything, makes it worse?

Memory of the offence
6) Can you tell me about your offence [*specify for individual*]?
What do you remember most clearly?
What is most difficult to remember?

Negative appraisals of offence and sequelae
7) When you remember your offence, what are your thoughts about it / what's going through your mind?

8) When you remember your offence, how does it make you feel?

9) What have the consequences of your offence been?

10) How do you feel about these consequences?

11) How do you imagine your future?

12) What does this [*the offence, the consequences of the offence, PTSD symptoms*] say about you / other people / the world?

All participants to be asked if there's anything else they feel is of importance that I haven't asked them about.
Participants to be thanked for their time and asked whether they would like to discuss the issues raised further with their psychologist. Agree whether I will pass information on to responsible clinician and/or psychologist.

NHS
Health Research Authority

NRES Committee London - Stanmore

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SE1 6LH
Telephone: 020 7972 2552

15 April 2014

Dear Miss Fleming

Study Title: Mentally disordered violent offenders' experience of offence-related post-traumatic stress disorder (PTSD): Considerations for diagnosis and treatment.

REC reference: 14/LO/0537

IRAS project ID: 149154

The Research Ethics Committee reviewed the above application at the meeting held on 03 April 2014. Thank you for attending to discuss the application.

Documents reviewed

The documents reviewed at the meeting were:

Document	Version	Date
Investigator CV	Jocelyn Fleming V1	17 March 2014
Other: Appendix A - Research Referral Form	1	17 March 2014
Other: Memorandum - Provisional approval granted, plus feedback	1	17 March 2014
Other: RHUL Proposal Feedback Comments	1	17 March 2014
Other: Memorandum - Approval granted, plus comment	1	17 March 2014
Other: Academic Supervisor CV: Simone	1	17 March

Fox		2014
Participant Consent Form: Appendix C - Questionnaire Participation	1	17 March 2014
Participant Consent Form: Appendix D - Interview Participation	1	17 March 2014
Participant Information Sheet: Appendix A - Clinician Information Sheet	1	17 March 2014
Participant Information Sheet: Appendix B	1	17 February 2014
Protocol	1	17 March 2014
Questionnaire: Appendix E - Draft Interview Schedule	1	17 March 2014
REC application	149154/5795 06/1/305	13 March 2014

a. The Chair clarified with you that the participants were not prisoners but had a mental disorder. You said that the participants had already been convicted and were now in a secure unit but are not prisoners.

b. The Chair Confirmed with you that measures were in place for her own safety. You added that procedures were in place and you were fully trained as part of your induction. Also that the room you would interview in would have an alarm.

c. The Chair asked what the process is if a participant became distressed. You assured members that their clinician would be available and the applicant would be offered professional support.

d. The Chair advised you that the application form was difficult to read, and acronyms ought to put in full in the first instance and then use the abbreviations throughout the study documentation. In addition, to use lay language throughout; the Chair pointed out the word sequlae in section A6 and informed you that you could have used the word consequences. You noted the Chair's comments.

e. The Chair pointed out that the information sheet and consent forms were not correctly formatted, they must be separate documents. Also Royal Holloway headed paper needs to be used on all documents. You agreed to make amendments to the documents.

f. The Chair asked you if the process would take longer than 30 minutes. You clarified that the questionnaire should only take 30 minutes but the interview would take 45 – 60 minutes. This should be stated in the revised information sheet. It came to light that the documentation sent to the Committee was inaccurate, and that the updated documents had not been sent. You agreed to re-send with information sheets with corrections.

g. The Chair pointed out that there was an inconsistency between the IRAS form and the information sheet in regard to allowing participants to consent; 24 hours are mentioned in the information sheet but the IRAS form A.13 states 48 hours. You confirmed that participants could have 48 hours but 24 minimum.

h. You were also asked to add the following:- put that NRES Committee Stanmore reviewed the study, add a space for the researcher and participants' signature on the consent form, to correct the formatting of the information sheet and consent form and to add PALS or something similar should participants wish to complain which you agreed to do.

i. The Committee questioned whether it was appropriate for the service users to be asked for their feedback on the Post Diagnosis Scale (PDS), Impact of Events Scale-Revised (IES-R) and interview schedule, as it might affect the study results. You said that you are merely asking for their opinion on the forms in use.

j. The Chair asked if using the word violent in the heading of the questionnaire would have a detrimental effect on the participants. You said that participants are aware of what they have done and by using the term 'violent offenders' would enable the participants to think about how they answer the questions.

k. You were asked if you would inform police if a participant revealed information about an additional crime. You said you would break confidentiality and inform the police. It was agreed that this would be added to the information sheet.

l. The Chair asked you to state that participants can withdraw from the study and that any identifiable data would be destroyed but anonymised date would be kept, which you agreed to.

m. The Chair asked you to make a space for both names and signatures in the consent form; Also to add whether or not you intend to inform the participants' GP of their taking part in the study, which you agreed to.

The Committee would be content to give a favourable ethical opinion of the research, subject to receiving a complete response to the request for further information set out below.

Authority to consider your response and to confirm the Committee's final opinion has been delegated to the Chair.

Further information or clarification required

1. Add to the information sheet what procedure is in place should any additional information come to light particularly any other criminal acts. Also add to the information sheet that in such cases you would have to break confidentiality.

2. Add to the information sheet that you intend to record the interview.

3. Make additional space in the consent form signatures as well as names for both researcher and participant.

4. Use lay language in the information sheet and put the correct schedule times in for the questionnaire to be completed and how long the interview is likely to last; with the correct version numbers and dates.

5. Correct the last paragraph of the consent form starting with the sentence 'I give permission of the researcher'.

6. State in the information sheet that data would be destroyed if a participant withdraws from the study but anonymised data is kept.

7. State that NRES Committee London Stanmore reviewed the study.

8. Add Patient Advisory Liaison Service (PALS) are available for complaints or something similar.

9. Provide the Committee with a confidentiality agreement should a professional transcriber be used.

If you would find it helpful to discuss any of the matters raised above or seek further clarification from a member of the Committee, you are welcome to contact Julie Kidd 020 7972 2552.

When submitting your response to the Committee, please send revised documentation where appropriate underlining or otherwise highlighting the changes you have made and giving revised version numbers and dates.

If the committee has asked for clarification or changes to any answers given in the application form, please do not submit a revised copy of the application form; these can be addressed in a covering letter to the REC.

The Committee will confirm the final ethical opinion within a maximum of 60 days from the date of initial receipt of the application, excluding the time taken by you to respond fully to the above points. A response should be submitted by no later than 15 May 2014.

Membership of the Committee

The members of the Committee who were present at the meeting are listed on the attached sheet.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

Yours sincerely
Mrs Rosemary Hill
Chair

NHS
Health Research Authority

NRES Committee London - Stanmore

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Telephone: 020 7972 2552

09 June 2014

Dear Jocelyn

Study Title: Mentally disordered violent offenders' experience of offence-related post-traumatic stress disorder (PTSD): Considerations for diagnosis and treatment.

REC reference: 14/LO/0537

IRAS project ID: 149154

Thank you for your letter of 14 May 2014, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair. We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to make a request to postpone publication, please contact the REC Manager, Hayley Fraser, nrescommittee.london-stanmore@nhs.net

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

You should notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. The REC will acknowledge receipt and provide a final list of the approved documentation for the study, which can be made available to host organisations to facilitate their permission for the study. Failure to provide the final versions to the REC may cause delay in obtaining permissions.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non clinical trials this is not currently mandatory.

If a sponsor wishes to contest the need for registration they should contact Catherine Blewett (catherineblewett@nhs.net), the HRA does not, however, expect exceptions to be made. Guidance on where to register is provided within IRAS.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS sites

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Non-validated questionnaire [Appendix E - Draft Interview Schedule]	1	17 March 2014
Other [Memorandum - Provisional approval granted, plus feedback]	1	17 March 2014

Other [RHUL Proposal Feedback Comments]	1	17 March 2014
Other [Academic Supervisor CV: Simone Fox]	1	17 March 2014
Other [Appendix A - Research Referral Form]	1	17 March 2014
Other [Memorandum - Approval granted, plus comment]	1	17 March 2014
Participant consent form [Interview Participation]	2	09 May 2014
Participant consent form [Questionnaire participation]	2	09 May 2014
Participant information sheet (PIS)	2	09 May 2014
Participant information sheet (PIS) [Appendix B]	1	17 February 2014
REC Application Form	149154/579506/1/305	13 March 2014
Research protocol or project proposal	1	17 March 2014
Response to Request for Further Information	Email from Jocelyn Fleming	14 May 2014
Summary CV for Chief Investigator (CI)	Jocelyn Fleming V1	17 March 2014

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a

favourable opinion, including:
- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in requirements or procedures.

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at http://www.hra.nhs.uk/hra-training/

With the Committee's best wishes for the success of this project.

Yours sincerely
Mrs Rosemary Hill
Chair

Appendix L: Research and Development Ethics Committee approval letter

Dear Miss Fleming

Title: Mentally Disordered Violent Offenders' Experience of Offence-Related Post-Traumatic Stress Disorder (PTSD): Considerations for Diagnosis and Treatment

Sponsor: University of London

Local Collaborator: Lucy McCarthy

Chief Investigator: Jocelyn Fleming

Thank you for submitting your project to the ███████████████████ NHS Trust's R&D Department. The project has now been given NHS permission by:
Dr Gopi Krishnan: R & D Director, on behalf of ███████████████ NHS Trust

NHS permission for the above research has been granted on the basis described in the application form, study protocol and supporting documentation. The following documents were reviewed:

Document	Version
IRAS REC Form	
Clinician Information Sheet	V3 03/07/2014
Clinician Research Referral Form	V3 03/07/2014
Interview Schedule	V1 17/03/2014
Participant Consent Form – Interview	V2 09/05/2014
Participant Consent Form – Questionnaire	V2 09/05/2014
Participant Information Sheet	V4 07/07/2014
Ethics Approval	09/06/2014

Permission is granted on the understanding that the study is conducted in accordance with the Research Governance Framework, ICH GCP [ONLY if applicable], and NHS Trust policies and procedures available http://www.███████████████.nhs.uk/contact-us/freedom-of-information/policies-and-procedures/

The research sponsor or the Chief Investigator, or the local Principal Investigator at a research site, may take appropriate urgent safety measures in order to protect research participants against any immediate hazard to their health or safety. The R&D office should be notified that such measures have been taken. The notification should also include the reasons why the measures were taken and the plan for further action. The R&D Office should be notified within the same time frame of notifying the REC and any other

regulatory bodies. All amendments (including changes to the local research team) need to be submitted in accordance with guidance in IRAS.

Please note that the NHS organisation is required to monitor research to ensure compliance with the Research Governance Framework and other legal and regulatory requirements. This is achieved by random audit of research.

Yours Sincerely
Shirley Mitchell
Head of Research Management and Governance

Appendix M: Royal Holloway, University of London Ethics Committee approval documentation

Memorandum

To:	Jocelyn Fleming
From:	Gary Brown (on behalf of the Research Sub-Committee and Course Executive)
Date:	16th January 2014
Copy To:	Simone Fox
Re:	Main Research Project Proposal

The Research Sub-Committee has considered your Main Research Project Proposal response and has decided to give you **Provisional approval**.

In order to receive full approval you need to respond in writing to the following points by **13th February**. You should meet with your supervisor(s) to discuss your response to the Committee in the light of these comments. **Please ensure that your feedback to each item is not more than 200 words with an overall limit of 1500 words for the whole reply.**

1. It is unclear how your proposed methodology will address your 2nd and 3rd research questions.
2. How are you going to determine the quality of your analysis? You do not refer to quality guidelines for conducting qualitative research in your proposal.
3. It is problematic that the PDS and IES-R do not currently map on to DSM-V criteria. How are you going to manage this issue, beyond discussion of it as a limitation of your study? Will this impact on your ability to answer your 2nd research question?
4. If PTSD is under-diagnosed in MDO's, as stated in your background section, how likely is it that responsible clinicians will be able to identify suitable patients that meet your inclusion criteria? Perhaps you are expecting referrals for all MDO's and then you will screen out based on PDS scores, but this isn't clear in your proposal.
5. You have probably underestimated the time required to complete the interview. 30 minutes does not seem like enough time to complete the assessment, given the number of questions you have and the fact that participants may require some prompting for certain questions, and some time at the end for debriefing.
6. Distress upon exposure to reminders of trauma (e.g., bringing to mind and discussing it) is a cardinal feature of PTSD. It may be advisable to add a sentence in your information sheets that explicitly informs

participants about this so that they can make an informed decision about whether or not they take part.

7. Although your proposed study is qualitative, and therefore generalizability of findings is not as much of a concern as it is in quantitative designs, have you considered the potential that your sample may be 'self-selecting'? i.e., most people with PTSD don't want to think or talk about their trauma experiences (indeed, avoidance is one of the key diagnostic criteria for PTSD in DSM5). The very fact that participants in your study will have volunteered to think and talk about their trauma experiences may already make them somewhat 'atypical' of people with PTSD in the wider population.

8. The language used in the information sheets could do with some revision to make it more easily understandable for lay people.

Royal Holloway University of London
DClinPsy
Proposal Feedback Comments

Trainee name: Jocelyn Fleming

Project title: Mentally disordered violent offenders' experience of offence-related post-traumatic stress disorder (PTSD): Considerations for diagnosis and treatment.

Academic supervisor: Simone Fox

_____

1. **It is unclear how your proposed methodology will address your 2nd and 3rd research questions.**

   A qualitative method has been proposed as I'm interested in the personal experience of mentally disordered offenders and whether, based on these reports of personal experience, the diagnostic criteria and Cognitive model of victim-related PTSD are appropriate for application in cases of offence-related PTSD. The draft interview schedule addresses my second and third research questions by asking questions that correspond to diagnostic criteria and the key components of the Cognitive model. The following topics will be covered either by the participant in response to open questions, or as additional prompts and questions:

   PSTD diagnostic criteria:
   - re-experiencing
   - avoidance

- arousal and reactivity
- cognitions and mood
- duration and functional significance

Cognitive model:
- negative appraisals of trauma and its sequelae
- internal and external current threat (self and world),
- nature of memory for offence
- strategies to control threat

Impact of treatment

Once themes have been drawn out of data, the interpretative element of IPA will be key in analysing whether these themes of personal experience are similar or different from those highlighted in diagnostic criteria and the Cognitive model above. I may find that these do or do not apply, and additional themes of importance may become apparent.

2. **How are you going to determine the quality of your analysis? You do not refer to quality guidelines for conducting qualitative research in your proposal.**

I will take a number of steps to ensure good quality, publishable research, which is reliable and valid. Smith (2011) outlines four criteria for 'acceptable' quality IPA, and a further two for 'good' quality. I will ensure that these standards are met by:
- Demonstrating that my work is phenomenological, hermeneutic, and idiographic.
- Providing an annotated transcript and all analysis tables to guarantee transparency and allow readers to determine the depth and plausibility of my analysis.
- Providing sufficient evidence for each theme. Extracts from at least 3 participants per theme is recommended for sample sizes of 4-8.
- Offering an in-depth analysis of a specific topic and remaining focused on this.
- Attending IPA training and engaging in peer review at data analysis clinics and within the cohort to ensure strong data and interpretation, which goes beyond a descriptive level.
- Remaining engaged and immersed in my research throughout.

Elliot, Fischer, and Rennie (1999) and Yardley (2000) also propose guidelines for qualitative research. To ensure these are followed, in addition to the points above, I shall:
- Demonstrate reflexivity and acknowledge how my perspectives impact the data.
- Situate the sample.
- Situate the research within the wider context of relevant literature, theory and clinical importance.

3. **It is problematic that the PDS and IES-R do not currently map on to DSM-V criteria. How are you going to manage this issue, beyond discussion of it as a limitation of your study? Will this impact on your ability to answer your 2nd research question?**

   There are currently no validated measures of PTSD that correspond to DSM-V criteria. A summary of changes to criteria from DSM-IV-TR are as follows:
   - More explicit criteria regarding what constitutes a traumatic event.
   - A response of 'intense fear, helplessness or horror' has been removed as a criterion.
   - Instead of three symptom clusters, there are now four: re-experiencing, heightened arousal, avoidance, and negative changes in cognitions and mood.

   These changes do not make any additions to criteria that are not already covered the PDS and IES-R.

   Additionally, as I am attempting to establish whether a PTSD diagnosis is appropriate in cases of offence-related PTSD, measures are being used to screen for post-traumatic symptoms in relation to the offence rather than as a diagnostic tool. It was therefore decided that the PDS and IES-R would be suitable for use in this project.

4. **If PTSD is under-diagnosed in MDO's, as stated in your background section, how likely is it that responsible clinicians will be able to identify suitable patients that meet your inclusion criteria? Perhaps you are expecting referrals for all MDO's and then you will screen out based on PDS scores, but this isn't clear in your proposal.**

   Clinicians will be asked to identify potential participants who meet the first four inclusion criteria:

   - Male
   - Aged 18-65
   - Good comprehension and expression in English, both written and verbal
   - Committed a violent offence for which they have already been convicted

   All those identified, regardless of perceived PTSD symptoms, diagnosed or undiagnosed, will then be assessed using the PDS and IES-R.

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5. **You have probably underestimated the time required to complete the interview. 30 minutes does not seem like enough time to complete the assessment, given the number of questions you have and the fact that participants may require some prompting for certain questions, and some time at the end for debriefing.**

The estimated time to complete the interview has been revised to 45-60 minutes.

6. **Distress upon exposure to reminders of trauma (e.g., bringing to mind and discussing it) is a cardinal feature of PTSD. It may be advisable to add a sentence in your information sheets that explicitly informs participants about this so that they can make an informed decision about whether or not they take part.**

Please see appended information sheet, which contains an additional sentence regarding distress in response to exposure.

7. **Although your proposed study is qualitative, and therefore generalizability of findings is not as much of a concern as it is in quantitative designs, have you considered the potential that your sample may be 'self-selecting'? i.e., most people with PTSD don't want to think or talk about their trauma experiences (indeed, avoidance is one of the key diagnostic criteria for PTSD in DSM5). The very fact that participants in your study will have volunteered to think and talk about their trauma experiences may already make them somewhat 'atypical' of people with PTSD in the wider population.**

All psychological models are based on individuals that consent to research and/or treatment. Very little is known about individuals that do not seek treatment as they are also unlikely to participate in research. This is particularly the case for PTSD, as potential difficulties with exposure remain constant in research and treatment. Given their consent to participate in research, it is probable that my sample will also be those likely to seek treatment, so yes, they may differ from others in the general population who do not seek treatment, but this sample will have greater clinical relevance given that the model has been based on, and is used with, other treatment-seeking individuals.

Additionally, research indicates that avoidance does not necessarily prevent treatment-seeking behaviour, and therefore participation in research. Demographic variables, such as age, minority race and marital status, and perceived need, based on interference of symptoms

on daily life and co-morbid diagnoses, also influence treatment-seeking behaviour (Koenen, Goodwin, Struening, Hellman, & Guardino, 2003). While I agree that treatment-seeking behaviour is reduced among individuals with PTSD compared to other disorders, it is not possible to say whether my sample is atypical of those with PTSD without considering these other variables.

8. **The language used in the information sheets could do with some revision to make it more easily understandable for lay people.**

   Please see appended information sheet (Appendix A). Language has been revised to make it more accessible to lay people. All details will also be expressed verbally when potential participants are approached.

Memorandum

To: Jocelyn Fleming
From: Gary Brown (on behalf of the Research Sub-
             Committee and Course Executive)
Date: 13th February 2014
Copy To: Simone Fox
Re: Main Research Project Proposal
_____

The Research Sub-Committee has considered your Main Research Project Proposal response and has decided to give you **Approval** with a comment. Your research costs have also been approved. Please note that if these costs change and you do not re-submit an amended form for approval prior to incurring any additional costs, these additional costs will not be reimbursed**.**

- It is important to distinguish between guidelines for sufficiency of application of a methodology provided by those with an allegiance to the methodology (e.g., Smith, 2011) and general quality standards. You quote selectively from Elliott et al and Yardley, but examiners will be more convinced if you apply the whole set of criteria from either source, Elliott et al. being particularly suited to phenomenological approaches such as IPA. Please refer also to the following sources from books in the resource area for an up-to-date discussion of these issues: Willig (2013) Ch. 14; Braun & Clarke (2013) Ch. 12; Harper et al (2013) Ch. 16

"In addition, as your proposed study is qualitative, please keep the following points in mind throughout your major project:

1. Justification for choosing a qualitative approach instead of a quantitative approach for the research questions you wish to address.

2.	Providing a rationale for the particular method you chose as opposed to other methods, including the stated philosophy behind the method.

3.	Reflecting on your own contribution to the research process.

4.	Stating and adhering to published quality standards.

5.	Stating what potential contribution to knowledge your study can make. Whereas many qualitative approaches discourage predicting specific outcomes, this does not preclude anticipating in general terms how outcomes you foresee will be useful to future steps in research and practice. These should be stated in specific enough terms that the reader of your eventual thesis can judge whether or not you achieved the goals you set out to achieve."

Appendix N: Stanmore NRES Research Ethics Committee amendments approval letter

NHS
Health Research Authority

NRES Committee London - Stanmore

Skipton House Ground Floor
NRES/HRA 80
London Road
London
SE1 6LH
Telephone: 020 7972 2552

31 October 2014

Dear Miss Fleming

Study Title: Mentally disordered violent offenders' experience of offence-related post-traumatic stress disorder (PTSD): Considerations for diagnosis and treatment.

REC reference: 14/LO/0537

Amendment number: Minor amendment: new NHS sites

Amendment date: 29 October 2014

IRAS project ID: 149154

Thank you for your email of 29 October 2014 notifying the Committee of the above amendment.

The Committee does not consider this to be a "substantial amendment" as defined in the Standard Operating Procedures for Research Ethics Committees. The amendment does not therefore require an ethical opinion from the Committee and may be implemented immediately, provided that it does not affect the approval for the research given by the R&D office for the relevant NHS care organisation.

Documents received

The documents received were as follows:

Document	Version	Date
Interview schedules or topic guides for participants	2	06 October 2014
Other [Clinician Information Sheet]	2	06 October 2014
Other [Clinician research referral form]	2	06 October 2014
Participant information sheet (PIS) [Participant Information Sheet]	3	06 October 2014

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

Yours sincerely
Amy Spruce
REC Assistant

Emergent Themes	Transcript (Kristopher)	Exploratory Coding
	1. You may remember that last time we met, you answered	
	2. some questionnaires about your offence and how you've	
	3. been feeling since then. I was wondering whether you could	
	4. tell me a little bit more about that?	
	5. **What do you want to know?**	Do I need to re-phrase this first question in future interviews to make it clearer? Is he asking for clarification because he has assumptions about what I want to know and the repercussions of what he tells me?
	6. Anything that you think is important.	
	7. **…[Sighs] I, I don't know.**	
	8. So, maybe things about your mood or your thoughts; the	Prompt needed.
	9. way you've been feeling.	
	10. **I've been having voices. Saying that they rape me and**	This could be a symptom of his schizophrenia diagnosis or victim-related trauma.
	11. **now I have to do something about it. They're saying that**	

Emergent Themes	Transcript (Kristopher)	Exploratory Coding
	12. *they raped my sister as well. And my girlfriend. And just*	
	13. *it, it was not good.*	
	14. That sounds awful. Has that been since your offence or has	
	15. that been more recently?	
	16. *That's, that's happened before the offence.*	Confirmation that this isn't an offence-related trauma symptom.
	17. That was before the offence. Has anything changed with	
	18. your mood or thoughts since your offence?	
Thinking about the offence	19. *…I keep thinking about that day, you know, of it.*	Is he describing intrusive thoughts (re-experiencing) or purposeful rumination? 'That day' isn't very descriptive – is he avoiding talking about it?
	20. Uh huh. What kind of things do you think about?	
Incomplete memory	21. *About how I've done it. I can't remember everything, but*	Lack of memory – why? Dissociation, mental state, drugs/alcohol etc?
Feelings of disgust	22. *the bits I remember it's just disgusting.*	'Disgusting' – does disgust also imply regret and/or shame? This is a strong word and was said forcefully. He uses it 3 times during the interview – this seems to be important for him.
	23. Are you able to tell me a little bit about your offence?	

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Emergent Themes	Transcript (Kristopher)	Exploratory Coding
	24. **It's manslaughter.**	
	25. Uh huh.	
	26. **I strike him with hatchet about twenty times.**	He's using the present tense – is this because he's reliving it?
	27. …Okay. And which bits are most clear to you?	
	28. **…..I don't know.**	
	29. Is there anything that stands out in your memory?	
	30. **No.**	A hazy memory indicates possible dissociation.
	31. Okay. So, which bits are most difficult to remember?	
Memory as an incoherent list of details provided by others	32. **…..You see, I can't remember. The police said that I**	Lack of memory. The police have filled in contextual details.
	33. **barricaded the doors from both sides, from every side, and**	
	34. **I went through the window. I can't remember that either.**	Says 'I can't remember' four times during the interview – is this particularly important to him?
	35. **I can't remember, but I read it in the papers about the**	
	36. **barricade… Then the person I murdered is, um, they**	

Emergent Themes	Transcript (Kristopher)	Exploratory Coding
	37. *found like 20 different drugs in his system, and they said*	This memory is confusing and is reported with inadequate detail to produce a clear narrative of what happened. This may indicate that his traumatic memories have been insufficiently processed.
	38. *he's a dead walking man. The, uh, prison officers said the*	
	39. *man was dead anyway because he had so much drugs in*	He uses words like 'manslaughter' and 'murdered' but then appears to minimise his role in the death.
	40. *his body that it could kill him any second.*	
	41. …So, there are bits that you remember and bits that have	
	42. been filled in for you by the newspaper and the police?	
	43. *Yeah.*	
	44. The bits that you remember, you said that you think about	
	45. those. Can you tell me some more about that?	
Improving health	46. *I don't have any more voices. But sometimes, like, was it*	
	47. *eight months ago, I was really unwell I used to hear*	What does 'unwell' mean to him – is hearing voices key?

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Emergent Themes	Transcript (Kristopher)	Exploratory Coding
	48. *voices telling me that he's not dead and he's going to do*	
	49. *bad things in my sleep and stuff. So, I couldn't eat for a*	This content possibly relates to victim-related trauma.
	50. *week because I thought he'd be poisoning my food. And*	Is he paranoid and/or scared following traumatic experiences in which he's been the victim?
	51. *it's just [sighs] horrible.*	
	52. When you remember your offence, when you think	
	53. about it and talk about it, how does that make you feel?	
Time as an aid to stabilising strong emotions	54. *Now, after so long time, it doesn't make me feel anything.*	This implies he used to feel something. No feeling now? Numb? Emotionless? Or just improved coping and mental state?
	55. *The first year was hard….. The first year if I*	Experience used to be worse and has improved.
The emotionless new self	56. *had to speak this stuff I would cry. But now it's not*	Crying – did he experience grief? Regret? Shame? 'Had to speak' implies only when forced – does this mean it was otherwise avoided?
	57. *worrying me anymore.*	Used to worry him.
	58. And what, if anything, goes through your mind when you	
	59. think about it or talk about it?	
	60. *Nothing.*	

Emergent Themes	Transcript (Kristopher)	Exploratory Coding
	61. Okay. …When you say you don't feel anything when you	
	62. talk about it, how would you describe that?	
The numb and disconnected self	63. **Just numbness.**	Difficulty experiencing strong emotions and a sense of feeling numb suggests possible dissociation. What does numb feel like? Has he disconnected because he doesn't associate his old self with the version of him that has murdered someone?
	64. Numb. Okay. …And what have the consequences of your	
	65. offence been?	
Loosing freedoms and hopes for the future	66. **Consequences? I've been locked up for years.**	'Locked up' suggests without freedoms.
	67. Anything else or is that the main thing?	
	68. **Yeah. I can't go to America; I want to go. I can't go to**	'I wanted to go' suggests a change in the hopes he has for his future.
	69. **Australia, Canada, the biggest countries in the world I**	
	70. **just can't enter.**	He's captive. He's 'locked up' literally and even after release.
	71. When you think about those consequences, what does that	

Emergent Themes	Transcript (Kristopher)	Exploratory Coding
	72. say about you?	
	73. **I don't know.**	
	74. How did you imagine your future before your offence?	
	75. **I, I didn't think about the future.**	
	76. Do you imagine your future now at all?	
Social relationships as stable and unfaltering	77. **[Nods head]. Family, with my family. My girlfriend, she**	He sees more of a future that he did previously.
	78. **still calls me and she still loves me and we talked about**	
Hospital as a trigger for positive healthy change	79. **Kids. When I get out of here we'll have kids and no more**	This is very positive. 'When I get out' suggests a certainty that he will live in the community again.
	80. **drugs.**	
	81. You mentioned that you think about your offence. Are there	
	82. any other things that have started since your offence?	
	83. **Uh, nightmares.**	Possible re-experiencing.
	84. Are you able to tell me more about those?	
	85. **Um, a, a dream that I've taken so much cocaine and I**	
	86. **can't even move. And they start doing bad things to me,**	

Emergent Themes	Transcript (Kristopher)	Exploratory Coding
	87. *raping me and stuff. Um, that's it, you know, that's all.*	This is about victim-related trauma.
	88. Okay. I'm wondering whether you have nightmares about	
	89. the rape or about your offence, about the manslaughter?	
	90. *I'm not having nightmares about the manslaughter, no.*	
Improving health	91. *I used to, I used to about a year and a half ago.*	Past re-experiencing in the form of nightmares but not present.
	92. What, what made that better do you think?	
Hospital as a non-judgemental environment in which people can get better	93. *This hospital environment. Because in jail I, I just, um…*	Being in hospital is a positive experience.
Prison as a destructive environment	94. *it was bad and everybody was hating me because um…*	Difference in attitudes and treatment in jail vs hospital.
	95. *I don't know, you know [visibly upset].*	He was tearful and the memories of jail seemed to upset him.
	96. That's okay, it's all right, we don't have to talk about it…	
	97. Is there anything else that you've noticed about the	
	98. manslaughter rather than about the rape? Maybe feelings or	

Emergent Themes	Transcript (Kristopher)	Exploratory Coding
	99. sensations in your body or thoughts that you might have?	Prompts needed.
	100 **No.**	
	101 Okay. And do you feel distressed by it still?	
	102 **I do, yeah.**	
	103 Okay. So, tell me a bit more about that.	
Feelings of disbelief	104 **It's just what I've done. I can't believe it. I can't believe**	Disbelief in self and actions. Possible regret and shame?
Mourning the loss of the previous self	105 **that he's dead, you know. I didn't mean to kill anyone.**	'Didn't mean to' – does this imply accidental or a lack of control? Are they synonymous to Kristopher?
Inability to take control over revenge	106 **Just it was revenge and I could not control myself.**	Revenge takes control.
	107 Not being able to control yourself, what does that say	
	108 about you?	
The self as mentally ill	109 **I'm schizophrenic since I'm seven years old, you know.**	Impact of mental health diagnosis. 'I'm schizophrenic' – owning the diagnosis and use of a label. Is it part of his identity? Do we have control over our identity? Does this explain a lack of control to him?

Emergent Themes	Transcript (Kristopher)	Exploratory Coding
Mental illness as an uncontrollable and unconscious force	110 **So, I've done some things that I can't remember.**	Lack of memory and lack of control is attributed to mental health. If you can't remember something and it's out of your control, does that make it unconscious?
	111 So, it says something about your mental health perhaps?	
	112 **[Nods head]**	Why does he not use speech here? Is he ashamed? Unsure?
	113 What are your thoughts about having a mental health	
	114 condition, having schizophrenia?	
	115 **I'm happy that I'm in hospital and not in jail, because in**	Positive approaches in hospital compared to jail.
Lack of choice over treatment in prison	116 **jail they give me quetiapine and that tablet just make me**	
	117 **go to sleep. It doesn't do anything. I wake up and the**	
	118 **voices and hallucinations are still there.**	
	119 So, here you're being helped more?	
Hospital as a treatment-focused service	120 **Yeah.**	
	121 Okay, going back to the images you mentioned, do you	Images were mentioned during the screening, not during the interview – data has been lost due to research design.

Emergent Themes	Transcript (Kristopher)	Exploratory Coding
	122 still get those?	
	123 **Yeah.**	
	124 Can I clarify, are they about the manslaughter or the rape?	
	125 **Both.**	
	126 Okay, so thinking just about the ones, um, about the	
	127 manslaughter, um, what if anything makes those better?	
	128 **How? Who? What?**	
	129 Is there anything that you can do or other people can do?	
	130 What, what makes, when you get those images, is there	
	131 anything that makes it better?	
	132 **No.**	
	133 Is there anything that makes it worse?	
	134 **…Used to but not anymore.**	
	135 Okay. So, what used to make it worse?	
	136 **Mood. Well, if I didn't have breakfast in the morning I'd**	
	137 **be moody and I'd think about it more.**	Chicken and the egg – is he moody because he's thinking about it, or does his negative mood come first?

Emergent Themes	Transcript (Kristopher)	Exploratory Coding
	138 Uh uh. Okay. So, thinking about it was, was a trigger for	
	139 the images, is that right?	
	140 **Yeah.**	
	141 Okay. So, how did you manage that?	
Improving mental health and coping	142 ***Just, just had to get on with it. Now I'm half year or so on***	Coping strategies are to just carry on.
	143 ***clozapine so I get no hallucinations, no voices. I'm not***	Hospital approach has improved mental state.
	144 ***even moody anymore.***	
	145 …Is there anything that's still residual? So, it sounds like	
	146 there's some things that have, have stopped bothering you	
	147 now.	
	148 **Yeah.**	
	149 So, like nightmares. Is there anything that still bothers you	
	150 now?	
	151 ***These nightmares and that's about it.***	
	152 ***… I don't remember my dreams anymore. I remember***	Use of word 'dreams' rather than nightmares'

Emergent Themes	Transcript (Kristopher)	Exploratory Coding
Re-experiencing symptoms	153 ***them during the day. It just comes any time. It's like***	There's a sense that his memories are intrusive.
	154 ***déjà vu, like it's happened before, you know.***	Déjà vu suggests re-experiencing.
	155 Okay. So, it feels like it's happening again?	
	156 ***Yeah.***	A sense of 'nowness' suggests flashbacks.
	157 Feels like déjà vu. And is that, that experience, is that just	
	158 about the rape or manslaughter or both?	
	159 ***Both, both.***	
	160 Both, okay. And you… can you tell me more about those?	
	161 We call them flashbacks.	
	162 ***Flashbacks, that's it.***	
	163 Um, are you able to tell me more about those flashbacks?	
	164 How… what that experience is like for you?	
Feeling anxious	165 ***It's stressful, you know, it's stressful. It disgusts me. I***	The repetition of 'stressful' indicates how anxiety-provoking this experience is. Disgust, shame and regret.
Disconnection and loss of the previous self	166 ***can't believe myself that I've done something***	Disbelief. Disconnected from who he thought he was. Loss of that person.

Emergent Themes	Transcript (Kristopher)	Exploratory Coding
Feeling of disgust, shame and regret	167 ***disgusting like this.***	Disgust – shame, regret.
	168 How, how does it feel in, in your body when you have a	Prompt needed
	169 flashback?	
	170 ***Scary.***	Fear is primary emotion during flashbacks.
	171 …Yeah. Do you notice any changes in your body?	
	172 ***…..Not really, no.***	Emotions are more prominent than the physiological changes associated with them.
	173 …And what is it, what are you, which aspects of the, the	
	174 manslaughter are you going back to? You said it's like déjà	
	175 vu; what is it that you go back to when you have a	
	176 flashback?	
	177 ***I don't understand your question.***	
	178 Um, so you said it's like déjà vu…	
	179 ***Yeah.***	
	180 Um, do you go right back to the, to the beginning where	
	181 the bits that you can't remember, like barricading the door?	
	182 Or do you go back to just a very specific moment?	

Emergent Themes	Transcript (Kristopher)	Exploratory Coding
The identification of a hotspot	183 ***A specific moment.***	Repeated re-experiencing of a hotspot.
	184 Which, which moment is that, if you want to tell me?	
	185 ***Um, when he drew a knife on me and cut my hand, and I***	A switch in to the present tense – is he reliving it now?
	186 ***strike him and I didn't stop striking him.***	Hotspot is the offence.
	187 Okay. And so when you have the flashback is there	
	188 anything that's going through your mind then?	
Social support as a protective factor	189 ***You know, I think about my girlfriend every day. It's***	Social support network acts as a protective factor. Used as a coping strategy.
	190 ***just… that's her that's positive in my mind.***	If there's a need for constant support, does this mean there's constant distress?
	191 So, does that make it better thinking about your girlfriend?	
	192 ***Yes, it does.***	
	193 Okay.	
	194 ***I only had two girlfriends and, uh, I don't want no other***	
	195 ***girlfriends. [Laughs].***	
	196 [Laughs]. So, when you're… I'm really interested to hear	This is a poor question – too complex and includes multiple questions.
	197 about these flashbacks. Um… and I'm wondering when,	

Emergent Themes	Transcript (Kristopher)	Exploratory Coding
	198 when you're in the flashback, when you're in the déjà vu,	
	199 does it… what's going through your mind? What emotions	
	200 are you feeling?	
	201 ***Can't explain; I don't know.***	
	202 What is it that feels most strong, what's most noticeable	
	203 about having that déjà vu?	
Feelings of disbelief. Mourning the loss of the previous self.	204 ***The fact that it really happened. I still don't believe myself***	Disbelief and denial. Mourning a loss of himself?
	205 ***that I done something nasty like this.***	He's different from the person he thought he was.
	206 Had you committed any offences in the past?	
	207 ***Yes, but not… nothing serious like this.***	A new level of crime he didn't think he was capable of.
	208 Is there anything else that you think is important for me to	
	209 know about your experience? What you're experiencing	
	210 now?	
	211 ***Not really.***	
	212 Do you, um…, do you avoid, try to avoid talking about it or	

206

Emergent Themes	Transcript (Kristopher)	Exploratory Coding
	213 thinking about it?	
Choosing who to talk to	214 **Yeah, yeah. To certain people I do feel sympathetic**	Some avoidance with some people but not others.
	215 **enough I speak to about it. Certain people I don't trust.**	Doesn't trust everyone – paranoia, tactical (wants to be released to the community), or avoidance when not forced (he will have to talk to some people about his offence)?
	216 Hm. What do you do when you don't want to think about it,	
	217 is there anything you do to try and stop thinking about it?	
	218 **Just have to wait till it disappears.**	
	219 Okay. …..Do you, do you feel – so you said you feel scared	
	220 – um, do you feel anxious at all? Do you feel…?	
	221 **Anxious as well, yeah.**	
	222 Okay. So, how does that anxiety feel for you?	
Experiences of panic	223 **Short of breath. Panic attacks.**	Some physical sensations of anxiety.
	224 Okay. And what happens when you have a panic attack?	
	225 **Feel like everybody's against me.**	Is this paranoia or part of his offence-related anxiety?
	226 Uh huh. …Okay. So, that's kind of the paranoia that you	

Emergent Themes	Transcript (Kristopher)	Exploratory Coding
	227 were talking about.	
	228 **Yeah.**	
	229 Paranoia and short of breath. …..When you feel, when you	
	230 get those panic attacks is there, is there anything you can do	
	231 to make those better?	
	232 **They don't last that long, but… a couple of seconds.**	
	233 Anything that makes them worse?	
	234 **Small rooms.**	
	235 Do you have any idea why small rooms make it worse?	
	236 **No. I'm not claustrophobic; but it's just in my own head**	
Re-experiencing triggered by conversation	237 **it's longer. [Sighs] I'm feeling one now as well.**	
Dissociation requiring intervention	238 Okay. So, what can I do to help make it better for you?	
	239 **No, nothing.**	
	240 Does it feel like you're having a flashback?	

208

Emergent Themes	Transcript (Kristopher)	Exploratory Coding
	241 *Yeah.*	Flashback during the interview. He seemed to be dissociating so was brought back to the room with grounding techniques.
	242 Yeah? Okay. Stamp your feet for me and move your hands	
	243 [demonstrates].	
	244 *No, no.*	
	245 [Demonstrates again]…	
	246 *Like this? [Stamping and clenching/relaxing hands]*	
	247 Yeah, just like that.	
	248 *It helps really. [Laughs]*	
	249 [Laughs]. The idea with the flashback is that, like you said,	
	250 you're going back to, to that moment, and we need to bring	
	251 you back here now. You're here. You're safe here. You're	
	252 in hospital. It's 2014. And if you can do things that help	
	253 bring you back to now, like stamping your feet and moving	
	254 your hands [demonstrates], you're here; you're not there.	

Emergent Themes	Transcript (Kristopher)	Exploratory Coding
	255 *Okay.*	
	256 Yeah?	
	257 *Yeah.*	
	258 Is it, is it better? Has it passed?	
	259 *Yeah it is, yeah.*	
	260 Okay. Well, shall we…? Is there anything else that you'd	
	261 like to tell me? To…	
	262 *No.*	
	263 No?	
	264 *No.*	
	265 Okay. Well, Kristopher, you've been really helpful and	
	266 thank you so much for talking to me about this.	
	267 *Okay.*	
	268 Do you feel able to manage for the rest of the day if you	
	269 have flashbacks?	
	270 *Yeah.*	
	271 Will you remember to do that?	
	272 *Yeah, it helps; it really [laughs]…*	
	273 [Laughs]. Yes, and you can say things to yourself as well,	

Emergent Themes	Transcript (Kristopher)	Exploratory Coding
	274 just like I did like: you're here; you're in hospital and	
	275 you're safe. Yeah? Just remind yourself of those things and	
	276 stamp your feet, walk around, do whatever's going to help	
	277 to make you come back to now.	
	278 **Yeah, okay.**	
	279 Okay. Well, I'll stop recording then.	

Appendix P: Table of Kristopher's initial 'emergent' themes

Kristopher		
	Emergent Theme	**Quote Line Number**
1	Thinking about the offence	19
2	Incomplete memory	21, 32
3	Feelings of disgust	22
4	Memory as an incoherent list of details provided by others	32-40
5	Improving health	46-47, 90-91
6	Time as an aid to stabilising strong emotions	54-57
7	The emotionless new self	56-57
8	The numb and disconnected self	63
9	Loosing freedoms and hopes for the future	66-70
10	Social relationships as stable and unfaltering	77-78
11	Hospital as a trigger for positive healthy change	79-80
12	Hospital as a non-judgemental environment in which people can get better	93-94
13	Prison as a destructive environment	93-95
14	Feelings of disbelief	104-105, 204-205
15	Mourning the loss of the previous self	104-106, 204-205
16	Inability to take control over revenge	106
17	The self as mentally ill	109
18	Mental illness as an uncontrollable and unconscious force	110
19	Lack of choice over treatment in prison	115-118
20	Hospital as a treatment-focused service	115, 119-120
21	Improving mental health and coping	136-144
22	Re-experiencing symptoms	151-154
23	Feeling anxious	165
24	Disconnection and loss of the previous self	165-166
25	Feelings of disgust, shame and regret	165-167
26	The identification of a hotspot	183-186
27	Social support as a protective factor	189-190
28	Choosing who to talk to	214-215
29	Experiences of panic	223-225
30	Re-experiencing triggered by conversation	237
31	Dissociation requiring intervention	240-259

Appendix Q: Table of Kristopher's cluster themes

Kristopher		
Cluster Theme	**Emergent Themes**	**Quote Line Number**
Disgusted by the new self following the loss of a previous self	3) Feelings of disgust	22
	9) Loosing freedoms and hopes for the future	66-70
	14) Feelings of disbelief	104-105, 204-205
	15) Mourning the loss of the previous self	104-106, 204-205
	24) Disconnection and loss of the previous self	165-166
	25) Feelings of disgust, shame and regret	165-167
Dissociation as an explanation for emotionless and incomplete recall	2) Incomplete memory	21, 32
	4) Memory as an incoherent list of details provided by others	32-40
	7) The emotionless new self	56-57
	8) The numb and disconnected self	63
	31) Dissociation requiring intervention	240-259
Re-experiencing and heightened anxiety as a response to reminders	1) Thinking about the offence	19
	22) Re-experiencing symptoms	151-154
	23) Feeling anxious	165
	26) The identification of a hotspot	183-186
	29) Experiences of panic	223-225
	30) Re-experiencing triggered by conversation	237
The self as out of control	16) Inability to take control over revenge	106
	17) The self as mentally ill	109
	18) Mental illness as an uncontrollable and unconscious force	110
Hospital as a tool to improved physical and mental health	5) Improving health	46-47, 90-91
	6) Time as an aid to stabilising strong emotions	54-57

	11) Hospital as a trigger for positive healthy change	79-80
	12) Hospital as a non-judgemental environment in which people can get better	93-94
	20) Hospital as a treatment-focused service	115, 119-120
	21) Improving mental health and coping	136-144
Prison as an unhelpful service, particularly for those who are unwell	13) Prison as a destructive environment	93-95
	19) Lack of choice over treatment in prison	115-118
Social relationships as a reliable source of support	10) Social relationships as stable and unfaltering	77-78
	27) Social support as a protective factor	189-190
Exercising choice over who to share experiences with	28) Choosing who to talk to	214-215

Appendix R: Table of superordinate, subordinate and cluster themes

Superordinate Themes	Subordinate Themes	Cluster Themes
Responses to an identity shift	A changed self	Worries about the future (Pete)
		Incongruent understandings of the self (Phil)
		A search for understanding (Sean)
		The new self as shameful and confusing (James)
		Disgusted by the self following the loss of a previous self (Kristopher)
		Escaping a past life (Pete)
		The appearance of multiple selves (Liam)
		Reflection as an important process in transforming the self (Liam)
	Appraisals about the self	Disgusted by the self following the loss of a previous self (Kristopher)
		The appearance of multiple selves (Liam)
		Denial and dissociation as protective functions (Liam)
		The new self as shameful and confusing (James)
		The self as upstanding (Sean)
		The world is unsafe (Sean)
		Escaping a past life (Pete)
		An understanding of the damage caused (Phil)
Ineffective memory processing	Memory disturbances	Memory difficulties (Sean)

		Re-experiencing in the face of denial (Liam)
		Memory strengths and weaknesses (Phil)
		Simplified recall (James)
		Memory difficulties (Pete)
		Dissociation as an explanation for emotionless and incomplete recall (Kristopher)
		Denial and dissociation as protective functions (Liam)
	Current threat	Nightmares (Pete)
		Re-experiencing and heightened anxiety as a response to reminders (Kristopher)
		Re-experiencing in the face of denial (Liam)
		Hyperarousal and physical sensations of anxiety (James)
		Intrusive experiences (Sean)
		Intrusive flashbacks (Phil)
Appraisals of the consequences of offending	The importance of social relationships	Valued social support (Sean)
		Social relationships remaining constant (James)
		Social isolation (Pete)
		Social relationships as a reliable source of support (Kristopher)
		Social relationships as a reliable contributor to self-identity (Liam)
	Hospital as a source of cognitive dissonance	Hospital as a route to improved physical and mental health (Pete)
		Hospital as an uncertain punishment (Pete)
		Hospital as a forced

		surrender of choice and control (Pete)
		Hospital as a fishbowl (Pete)
		Prison as a more appropriate service (Pete)
		Hospital as a tool to improved physical and mental health (Kristopher)
		Prison as an unhelpful service, particularly for those who are unwell (Kristopher)
		Hospital as a punishment (Liam)
		A path towards positive change (Liam)
		Hospital as a helpful service (Phil)
		Loss of privacy (James)
	Worry about the long-term consequences of offending	Consequences as irreversible (Sean)
		Life-long consequences (James)
		Future restrictions (Kristopher)
		Worries about the future (Pete)
		Loss of material self (Pete)
		Anxious considerations of behaviour change (Liam)

Appendix S: Table of discarded themes

Discarded themes			
Superordinate Themes	**Subordinate Themes**	**Cluster Themes**	**Reason for discarding**
External blame	The nature of one's life	The impact of victimisation (Phil)	Peripheral to the research and, particularly in the case of 'I'm the victim', not fully supported
		The world is unsafe (Sean)	
		Escaping a past life (Pete)	
	The role of mental health	Inability to manage emotions (Pete)	
		The self as out of control (Kristopher)	
		Mental health as a key influence on control and behaviour (Liam)	
	I'm the victim	The injustice of subjective opinion (Liam)	
Avoidance	Strategies to control threat	Loss of privacy (James)	Not fully supported and better thought of as representations of shame, a lack of privacy on the ward and anxiety about the future
		Anxious considerations of behaviour change (Liam)	
		Exercising choice over who to share experiences with (Kristopher)	

Appendix T: Transcription key and extract from Liam's transcript illustrating how quotes were refined

- Three dots in square brackets […] indicates omitted text
- A double dash -- indicates stuttering or halting speech half way through a word
- Three dots … indicates a shorter pause of three to five seconds
- Five dots ….. indicates a longer pause greater than five seconds
- Text in square brackets [text] indicates non-verbal communication or an unsaid explanation of an abbreviation or topic area
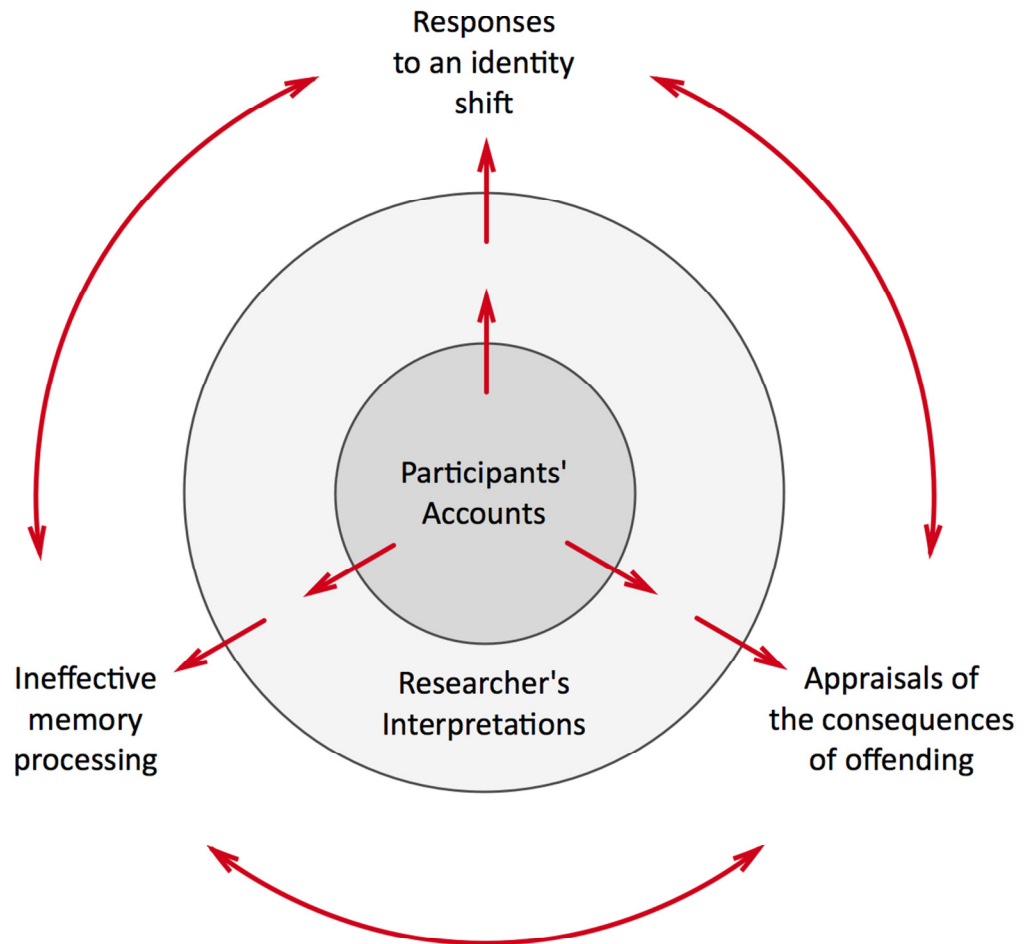
Liam
What happen was, did I tell you, last time just coming off unescorted leave and I was sitting at the back of a bus downstairs, and so a woman's come on the bus. You know the bus at the back, the back of a bus? Yeah. *And like you walk down the aisle and you've got a chair like opposite the aisle?* Yeah. *So I'm sitting there and this woman's come on the bus with about four, four/five kids. Obviously then you know the seats where, you know the seats where they're facing like the other way like you're facing, you'd be facing that way and the bus is going that way [demonstrating using gestures]?* Yeah. *She sat there, a little boy sat there, another little kid sat there, and another little kid sat there and another one along the seat [demonstrating with his hands]. So I'm not saying nothing to her. The woman just come and offered me a pretzel so I took it. So what's going on? Are people still tricking me on the bus?*

The above extract, taken from Liam's transcript, was refined into the quote below to be used in the narrative.

Last time just coming off unescorted leave and I was sitting at the back of a bus downstairs […] and this woman's come on the bus with about four/five kids. […] So I'm not saying nothing to her. The woman just come and offered me a pretzel so I took it. So what's going on? Are people still tricking me on the bus?

Appendix U: Inter-connection of themes

Appendix V: Table of participant representation across themes

Superordinate theme	Subordinate theme	James	Kristopher	Pete	Phil	Sean	Liam	Present in > half the sample?
Responses to an identity shift	A changed self	YES	YES	YES	YES	YES	YES	YES
	Appraisals about the self	YES	YES	YES	YES	YES	YES	YES
Ineffective memory processing	Memory disturbances	YES	YES	YES	YES	YES	YES	YES
	Current threat	YES	YES	YES	YES	YES	YES	YES
Appraisals of the consequences of offending	The importance of social relationships	YES	YES	YES	NO	YES	YES	YES
	Hospital as a source of cognitive dissonance	YES	YES	YES	YES	NO	YES	YES
	Worry about the long-term consequences of offending	YES	YES	YES	NO	YES	YES	YES