“It’s Not Just the Victim Who Suffers” Offence Related Trauma; Does It Exist and What Are the Experiences of Professionals?

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CANDIDATE DECLARATION

Title of degree programme	**Doctorate in Clinical Psychology**
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Initial date of registration	**September 2011**

Declaration and signature of candidate

I confirm that the thesis submitted is the outcome of work that I have undertaken during my programme of study, and except where explicitly stated, it is all my own work.

I confirm that the decision to submit this thesis is my own.

I confirm that except where explicitly stated, the work has not been submitted for another academic award.

I confirm that the work has been conducted ethically and that I have maintained the anonymity of research participants at all times within the thesis.

Signed: H.Cowan Date: 17th September 2014

Acknowledgments;

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Abstract;

This research thesis evaluates existing literature which considers whether offenders who commit violent crime experience psychological trauma as a direct result of their behaviour (‘offence related trauma’). It further explores the experiences of professionals working with such offenders who experience ‘offence related trauma’.

Chapter one is a literature review examining ten empirical studies which investigated whether offenders who commit violent crime were traumatised by their actions. The findings revealed that a significant number of offenders experienced ‘offence related trauma’. However, due to methodological limitations these findings need to be considered. The results do pose significant clinical implications for the assessment and treatment of ‘offence related trauma’.

Chapter two is an empirical study conducted in a low and medium secure unit which explored the experience of professionals, including those undertaking professional training, working with violent offenders traumatised by their actions. Six professionals participated in the study and the data were analysed using Interpretative Phenomenological Analysis (IPA). Three super-ordinate themes emerged from the data; ‘psychological resilience of professionals’, ‘barriers to engagement’ and ‘managing offence related trauma’. These findings are integral to the application of clinical supervision, staff training and the recovery of offenders. The findings are discussed in detail as well as the clinical implications, limitations and areas for future research.

Chapter three offers a reflective account of a novice researcher conducting empirical research and explores the parallel process between participant and researcher. Methodological limitations and ethical dilemmas are also discussed together with the professional and personal impact of this research.

Chapter One: Literature Review

A Review of the literature exploring Post Traumatic Stress Disorder after Committing Violent Crimes.

This paper has broadly been prepared in accordance with the requirements of the Journal of Forensic Psychology. Author Guidelines are listed in Appendix One.

Supplementary information is presented within the thesis chapter to aid overall cohesion; this will be removed prior to journal submission in order to reduce the word count.

Word Count: 6513 (Exclusive of figures, tables and references)

1.1 Abstract

Objectives;

The aim of this traditional literature review is to systematically search and evaluate the existing literature on the psychological trauma experienced after committing a violent crime for the offender.

Methods;

The following databases were searched for relevant literature; PsychINFO, PsychARTICLES, AMED, Cinahl, MEDLINE, PsychBOOKS and Academic Search Complete. Further studies were also hand searched from references from related reviews and articles. The search terms used were; (“post-traumatic stress disorder” OR trauma OR “offence related trauma”) AND (“violent crim*” OR murder* OR homocid*) AND (perpetrat* OR offend* OR “mentally disordered offend”*).

Results;

Ten papers met the inclusion criteria and were therefore reviewed. The findings from all ten papers were that a significant amount of offenders who commit violent crimes do experience post-traumatic stress disorder (PTSD). However, there were methodological limitations that needed to be considered before firm conclusions were made.

Conclusions;

The findings suggest that a significant number of participants experienced PTSD after committing a violent crime. However, these findings need to be considered due to the methodological limitations of the studies. Further research is needed that includes larger sample sizes, equal gender and ethnic minority groups and an exploration of how staff understand this type of trauma. It is integral that ‘offence related PTSD’ is assessed for due to the potential re-traumatisation for the service user if this trauma is left untreated.

1.2 Introduction;

This traditional literature review has systematically searched and evaluated the current literature with regard to the psychological effects, resulting from the commission of violent crimes or homicide on the individual who perpetrates the crime. This systematic approach has therefore enabled the review process and the results to be clear and reproducible. There is a wealth of research that considers the impact and effects on victims of violent behaviour, however, little is known about effects on perpetrators. There does however, seem to be an increasing awareness of an interest in the emotional well-being and mental health of individuals who commit violent offences or manifest behaviours that pose high risk to others. This review will consider the minimal research that is currently available in forensic and offender populations, examine its quality, synthesise and report its findings.

1.2.1 Post Traumatic Stress Disorder (PTSD);

In 1980, the Diagnostic and Statistical Manual of Psychiatric Disorders (DSM-III) first published the disorder ‘Post Traumatic Stress Disorder’. The appearance of this disorder in the DSM-III was related to research into Vietnam combat veterans, the effects of war and the psychological consequences of natural disasters (MacNair, 2002). PTSD has now appeared in all further editions of the DSM. Over the past decade, there has been a considerable amount of research and subsequent publication exploring the nature of psychological trauma and Post-Traumatic Stress Disorder (PTSD) in both general and psychiatric populations (Miller, 2007). Trauma can be defined in many ways, but Pearlman and Saakvitne (1995) state that psychological trauma results from an event or experience that cannot be fully understood by an individual and this causes an inability to process cognitions and emotional responses that result from the traumatic event or experience. The direct experience of or exposure to a traumatic event can cause an individual to feel overwhelmed by thoughts, emotional responses, bodily sensations and feelings of threat and uncertainty (Welfare & Hollin, 2010). The Diagnostic and Statistical Manual of Mental Disorders (DSM-V, APA, 2013) states that for an individual to receive a diagnosis of PSTD they must

have witnessed or experienced an actual or life threatening event and felt intensely fearful and helpless. The DSM-V (APA, 2013) further states that an individual experiencing PTSD will have intrusive recollections of the event, an avoidance of cognitions, emotions and triggers of the trauma and will experience increasing levels of arousal.

In the general population the approximate lifetime prevalence for PTSD is between 5-15% (Norris, 2012) depending upon age, gender, ethnicity and socio-economic factors. However, within a psychiatric population this figure is higher. Mueser et al. (1998) found that in 1998, the lifetime prevalence of PTSD in a psychiatric population was as much as 48% higher than in a non-psychiatric population. There are numerous reasons why the lifetime prevalence in a general population might be lower; these include underreporting, non-recognition of symptoms, gender differences and misdiagnosis. However, the figures of PTSD in psychiatric populations are still considerably higher than in general non clinical samples.

Further studies have indicated that psychological trauma and PTSD are also more common in populations with additional mental health difficulties. Sarkar, Mezey, Cohen, Singh and Olumoroti (2007) found that this figure also increases in individuals who not only have mental health difficulties, but also forensic histories. Sarkar et al. (2007) found that in a forensic population, 52% of individuals had symptoms of PTSD along with other mental health difficulties. In comparison, in a sample of individuals with no forensic histories, but who had mental health difficulties, only 29% had PTSD. This research demonstrates the prevalence of PTSD in the general population, and the increasing figures within combined psychiatric and forensic populations.

The identification and reporting of the prevalence of trauma and PTSD in individuals with mental health difficulties and/or forensic histories appears to be increasing. There are several studies that advocate early recognition of PTSD in inpatient settings and promote the importance of treatment (Papanastassiou, Waldron, Boyle & Chesterman, 2004; Morrison, Read & Turkington, 2005; & Gray et al. 2011). However, Morrison et al. (2005) highlight the immediate need for staff working with inpatients not only to consider and believe the concept of service

user trauma, but to also enquire about this. Roy and Janal (2005) further describe that mental health workers who hold a purely biological view of mental health may be less likely to enquire about trauma and this could have detrimental consequences for service user recovery.

1.2.2 Offence related PTSD;

The mental health of soldiers and military veterans is currently an area of increasing research. The experience of veterans and in particular the effects of combat was first researched, during the First World War. Terms such as 'shell shock' and 'soldier's heart' became popular ways of describing the impact of killing another human being during war. It was, however, in World War II that the psychological impact of combat was finally recognised (MacNair, 2002). Research focusing on Vietnam veterans and Israeli soldiers found that both groups had high prevalence rates of PTSD and the symptom profile proved to be consistent regardless of varying factors (MacNair, 2002). It was also found that veterans who had actively killed, as opposed, to witnessing death, had higher rates and severity of PTSD (MacNair, 2002). More recently there has been further research examining the effects on police officers who have taken the lives of others in the course of their duties. Manolias and Hyatt Williams (1993) reported that half of the police officers that participated in their study felt sadness and intense guilt as a result of wounding or killing an individual. It was further revealed that several police officers went onto to meet the DSM criteria for severe PTSD as a result of their actions (Manolias & Hyatt Williams, 1993). It is important to remember however, that it could be argued that the actions of soldiers and police officers are a necessary and often requisite part of their duty and thus more socially acceptable.

This then poses the question that if soldiers and police officers can experience traumatic symptoms following violent actions, albeit in the course of their 'duties' might violent offenders experience similar reactions as a result of their actions, even though the element of 'duty' is clearly not a component? There is a small body of emerging evidence concerning the concept of trauma experienced by individuals who have committed violent offences-'Offence related trauma'.

MacNair (2002) states that this concept relates to the individual’s experience of trauma symptoms as a direct result of their involvement in violent crime. Papanastassiou et al. (2004) further believe that extreme crimes such as homicide can lead to the individual or perpetrator, in this case, experiencing intense traumatic symptoms. In their study they concluded that more than half of the individuals who had committed homicide experienced symptoms of trauma. Friel, White and Hull (2008) also state that there are high rates of ‘perpetrator induced trauma’ in adult prison populations and forensic mental health units and that further research is needed due to the clinical implications of recovery.

1.3 Rationale of the review;

This literature review will therefore consider the body of research that is focused on the potential traumatic psychological effects experienced by individuals who are perpetrating violent crimes against others. The aim of the review is to provide a clearer evaluation of the psychological effects that can be experienced by being violent towards another human being. It is hoped that this review will identify further areas of research.

1.3.1 Research Question;

The research question that will be explored within this literature review is:

Do offenders of violent crimes experience PTSD due to their actions?

1.4 Method;

1.4.1 Inclusion criteria;

To be included in this review studies and participants had to meet the following inclusion criteria;

1) Published in English, due to a lack of translation resources

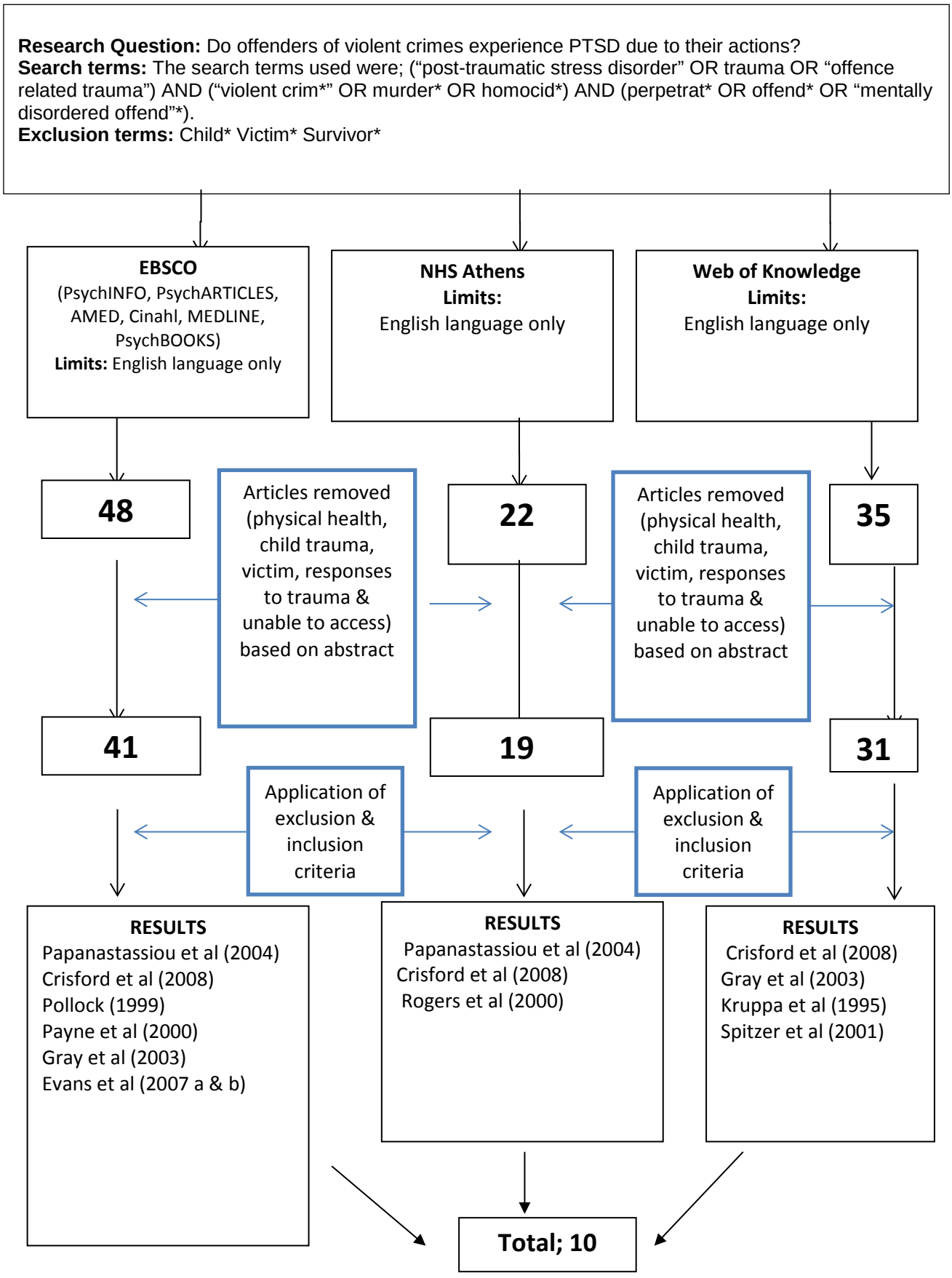
2) Participants to be perpetrators, not the victims
3) The offence or behaviour was violent in nature

1.4.2 Search strategies;

In order to complete a broad search from psychology, social sciences and health literature, a number of databases were selected and searched through EBSCOhost, Web of Knowledge and NHS Athens. The databases searched included; PsychINFO, PsychARTICLES, AMED, Cinahl, MEDLINE, PsychBOOKS and Academic Search Complete. Further studies were also hand searched from references, related reviews and articles.

The literature search was completed in October 2013. The search terms used were; (“post-traumatic stress disorder” OR trauma OR “offence related trauma”) AND (“violent crim*” OR murder* OR homocid*) AND (perpetrat* OR offend* OR “mentally disordered offend”*).The search terms produced 105 results after the removal of duplicates. A further 95 articles were removed due to the following exclusion criteria; participants were victims (N=40), participants were survivors (N=37), under the age of 18 (N=3), focus on physical health trauma (N=4), focus upon nurses’ responses to trauma (N=6) and unable to access paper from all available sources (N=5). Therefore, the total number of studies reviewed which met the inclusion criteria and were accessible was 10. Figure 1.1 details this search strategy further.

Figure 1.1: Literature Review Systematic Search Strategy



1.4.3 Types of studies included;

The majority of the studies included in the review were quantitative in their methodology (N=8; Gray et al. 2003: Crisford, Dare & Evangeli, 2008; Papanastassiou et al. 2004; Pollock, 1999; Evans, Ehlers, Mezey & Clark, 2007a; Kruppa, Hickey & Hubbard, 1995; Spitzer et al. 2001; Payne, Watt, Rogers, & McMurran, 2008). One study was of qualitative methodology (N=1, Evans, Ehlers, Mezey & Clark, 2007b) and one study was a case study utilising quantitative methods (N=1; Rogers, Gray, Williams & Kitchiner, 2000).

1.4.4 Analysis;

Nine out of the ten papers were analysed using the Downs and Black checklist for non-randomised studies (Downs & Black, 1998). This was due to the methodology being quantitative, but not being randomised controlled trials (RCTs). The qualitative methods paper was analysed using the CASP (Critical Appraisal Skills Programme, 2006).

1.4.5 Aims and objectives;

The aims of the paper by Crisford et al. (2008) were very clear. They built upon existing literature that supports the theory that offenders of a crime/offence can become traumatised by their behaviour and develop PTSD symptoms. Crisford et al. (2008) also wanted to explore the relationship between guilt and ‘offence related PTSD’. They developed two hypotheses, based on previous literature;

1) “There will be a relationship between levels of offence-related guilt cognitions and levels of offence related PTSD symptoms”
2) “The level of violence exhibited during the offence and closeness of the relationship to the victim, will be associated with levels of offence related guilt”.

Gray et al. (2003) aims and objectives were also clearly defined. The purpose of their study was to explore the frequency of PTSD in a group of violent offenders,

all of whom had a primary mental health diagnosis. They further wanted to investigate what variables contributed to and maintained the PTSD. These factors included; remorse, nature of offence and relationship to the victim.

The aims of the research carried out by Papanastassiou et al. (2004) were equally clear and highlighted the need to establish the current and lifetime prevalence of PTSD that was directly related to homicide. The participants were further diagnosed with a primary mental health problem and were inpatients in a medium secure unit. They hypothesised that a high number of participants experienced PTSD as a result of their offending behaviour.

Pollock’s, (1999) aims were similar to those of Papanastassiou et al. (2004). Pollock (1999) set out to explore the possibility that offenders who committed homicide would experience symptoms of PTSD. Pollock (1999) hypothesised that the type of violence (instrumental or reactive) would be related to PTSD symptoms.

Spitzer et al. (2001) reported their aims and objectives in a clear and detailed manner. Due to the high prevalence of PTSD in the general, psychiatric and offender population, Spitzer et al. (2001) set out to establish the prevalence of PTSD, traumatic events and psychological distress in an inpatient forensic population. They hypothesised that there would be high prevalence rates of PTSD in forensic populations that could be related to index offences and further explored what variables were related to the development of PTSD.

The aims and objectives of four of the following studies were not stated or were unclear. Evans et al. (2007a) aims were listed, but lacked clarity. Evans et al. (2007a) reported that there was a lack of evidence that explored the nature of traumatic memories related to PTSD and therefore attempted to investigate traumatic memories associated with the commission of violent crime. Whilst their research did not explore PTSD in its full spectrum, intrusive memories are a subcategory of PTSD. Evans et al. (2007b) subsequently built upon their previous study findings (Evans et al. 2007a) and the aims had greater clarity. They explored the relationship between cognitive and emotional factors and intrusive memories in offenders who had committed violent crimes. They hypothesised that PTSD symptom severity would be associated with variables such as; threat perception,

prior anti-social beliefs, negative emotions during the offence, organisation of offence, negative appraisals and cognitive processing during the offence.

The study conducted by Payne et al. (2008) was a partial replication of Pollock’s (1999) study. However, it failed to state its aims or objectives. It appears that Payne (2008) wanted to explore the relationship between historical trauma exposure and current PTSD severity. Their study stated that prior exposure to trauma might sensitise or habituate offenders to the development of trauma symptoms related to their offence. Finally, the aims of Rogers et al. (2000) were not included in their study at all. This was a single case study which focused on PTSD directly related to homicide in a female participant. They did however, conclude that the participant experienced PTSD due to her offending behaviour and detailed a behavioural approach to treatment. Kruppa et al. (1995) study also lacked aims. They explored the prevalence of offence related PTSD in sample of ‘legal psychopaths’ held in a maximum security hospital.

1.5 Results

1.5.1 Participants and settings;

Table 1.1details a summary of each study involved in the review. The number of participants in each study ranged from 1- 105. Out of the 10 studies, only five used both male and female participants (Spitzer et al. 2001; Kruppa et al.1995; Papanastassiou et al. 2004; Crisford et al. 2008; and Gray et al. 2003). Five studies used only male participants (Pollock, 1999; Evans et al. 2007a; Payne et al.2008; and Evans et al. 2007b) and one study used a female participant only (Rogers et al.2000).

Participants were recruited from inpatient medium secure units (Rogers, et al. 2000; Papanastassiou et al. 2004; Gray et al. 2003; Crisford et al. 2008; and Pollock, 1999), inpatient high secure units (Spitzer et al. 2001; Kruppa et al. 1995) and prisons (Evans et al. 2007a; Evans et al. 2007b and Payne et al. 2008). The majority of the studies were conducted in the United Kingdom (Kruppa et al.1995; Gray et al. 2003; Crisford et al. 2008; Papanastassiou et al. 2004; Evans et al. 2007a; Evans et al. 2007b; Payne et al. 2008 and Rogers et al. 2000), one study

was conducted in Northern Ireland (Pollock, 1999) and the final study was carried out in Germany (Spitzer et al. 2001).

Participants in the studies were recruited in several ways. Five studies recruited participants who the researchers had existing knowledge of and met the inclusion criteria (Kruppa et al. 1995; Rogers et al. 2000; Spitzer et al. 2001; Evans et al. 2007a and Evans et al. 2007b). Two studies used a clinical psychologist working in the research setting to identify suitable participants that met inclusion criteria and gave consent (Gray et al. 2003; Pollock, 1999) One study selected participants at random and if they met inclusion criteria and consented to take part in the study (Payne et al. 2008). A further study identified participants by examining clinical records that indicated the individual met the inclusion criteria (Papanastassiou et al. 2004). The final study used a consultant psychiatrist working in the research setting to provide the names of individuals who met the inclusion criteria and who were under the psychiatrist’s care (Crisford et al. 2008; Papanastassiou et al. 2004)

1.5.2 Inclusion and exclusion criteria;

Inclusion and exclusion criteria for involvement varied between the ten studies. Pollock (1999) excluded participants if they did not fully acknowledge their behaviour in their offending history, in this case, murder. He did not however, specifically describe inclusion criteria detail.

Crisford et al. (2008) specified their inclusion criteria as; being over 18 years of age, having an IQ equivalent to or greater than 75, having committed a violent or sexual act and possessing sufficient resilience to take part in the study, ascertained by a psychiatrist. Participants were excluded if they were on remand or awaiting trial or sentence. The exclusion of participants awaiting a trail is problematic due to the legality of not influencing or undermining court evidence. However, the data that could be obtained from individuals awaiting trial could have been influential in the results. The exclusion of individuals with an IQ less than 75 is an interesting concept. It could imply that the experience of individuals with a potential learning disability, is either not as valid or not as important.

Grey et al. (2003) did not state exclusion criteria, but inclusion involved: the commission of a serious offence, detention in a secure unit, a serious mental health problem and capacity to consent to the study.

Papanastassiou et al. (2004) included participants in their study if they were aged between 18-65 years and had a primary diagnosis of 'mental illness'. The diagnoses were identified from clinical records and confirmed by clinical teams working with those participants. These diagnoses were further confirmed against criteria from the International Classification of Diseases, 10th Revision (ICD 10). Participants were excluded if they had a learning disability, organic disorder or were severely distressed. This was due to their inability to provide informed consent and the unreliability of interviews. Consent was further sought from the client and Responsible Medical Officer (RMO).

Evans et al. (2007a and b) included participants who had been convicted of grievous bodily harm (GBH), attempted murder, manslaughter or murder. They excluded participants who could not speak fluent English, had a severe learning disability, assessed by the administration of The Quick Test (Ammons & Ammons, 1962) and were actively psychotic and/ or suicidal, denied being involved in the offence and who posed a high security risk e.g. history of hostage taking.

Spitzer et al. (2001) inclusion criteria involved participants who were aged between 18 and 65 years, were inpatients in a high security unit and who were diagnosed with mental health problems. Participants were excluded if they had a learning disability or an organic disorder due to the implications around capacity to give informed consent to meaningfully take part in the study.

The inclusion and exclusion criteria of the following three studies were unclear or not stated. This therefore has implications for the reliability of the findings and does not allow for potential biases to be considered in light of the results. Payne et al. (2008) included participants who had been convicted of murder and were serving life sentences in a Category B prison. No exclusion criterion was given. Rogers et al. (2000) did not detail inclusion or exclusion criteria. However, they completed a case study with one participant who had been convicted of manslaughter and was detained in a medium secure unit under section 37/41 of the Mental Health Act (1983). Kruppa et al. (1995) equally did not

describe inclusion or exclusion criteria. This study included male and female participants who were detained in a high secure unit under the Mental Health Act (1983), had committed a violent offence and had a mental health diagnosis.

1.5.3 Measures;

All the studies used well established standardised measures to assess for PTSD and the level of its severity. Papanastassiou et al. (2004) assessed PTSD using the Clinician-Administered PTSD sale (CAPS, Blake 1994). This structured interview is used to assess adults for PTSD symptoms according to the DSM IV (APA, 1994). This also incorporates assessment for guilt, dissociation, depersonalisation, derealisation and reduction in awareness. Papanastassiou et al. (2004) state that this was chosen for its psychometric properties, such as, high reliability, sensitivity and specificity. Its use is further advocated in forensic populations. Interviewers received training in the administration of CAPS and inter-rater reliability was tested in a non-clinical group.

Grey et al. (2003) used several standardised and non-standardised measures to assess for PTSD. These included The Impact of Events Scales (IES; Horowitz, Wilner & Alvarez, 1987), Beck’s Depression Inventory (BDI; Beck & Steer, 1987) and The State Trait Anxiety Inventory (STAI; Speilberger, Gorscuh & Lushene, 1970). The IES (Horowitz et al. 1987) measures emotional distress following a specific life event, in this case, the offence and focuses upon three of the main cluster symptoms of PTSD; intrusions, avoidance and hyper –arousal. The BDI (Beck & Steer, 1987) measures depression and its severity and the STAI (Speilberger et al. 1970) assesses anxiety. Grey et al. (2003) reported that these additional measures were used due to primary mental health disorders being a strong indicator for the onset of PTSD in offenders. Grey et al. (2003) used clinical interviews and semi structured interviews to ascertain PTSD symptoms related to offending behaviour. No information was provided in relation to the psychometric properties of each measure used. However, all measures listed are internationally used and are well known, therefore, it is assumed that the psychometric properties are good.

Payne et al. (2008) used the Posttraumatic Stress Diagnostic Scale (PDS; Foa, 1995). The PDS measures PTSD according to the DSM-IV (APA, 1994) criteria. Furthermore it provides qualitative information about symptom severity. Payne et al (2008) did not amend the PDS as such, they did however, offer verbal cues and prompts to questions which are problematic within a prison environment. This could pose difficulties in the replication of this study and reduce the reliability and validity of the findings.

Payne et al (2008) also used the IES (Horowitz et al.1987) and The Trauma History Questionnaire (THQ; Green, 1995). The THQ (Green, 1995) explores a range of traumatic events in relation to; being a victim, general trauma and physical and sexual trauma. Again, no information was provided in relation to the psychometric properties of the measures. However, due to their established nature, it is thought that reliability and validity were high.

Spitzer et al. (2001) used the CAPS (Blake 1994), The Modified PTSD Symptom Scale (MPSS; Falsetti et al. 1993), The Dissociative Experiences Scale (DES; Bernstein & Putnam, 1986) and the Symptom Checklist-90 Revised (SCL-90-R; Derogatis, 1983). The MPSS (Falsetti et al. 1993) is a self-report scale used to assess the core symptoms of PTSD. The psychometric properties are described as ‘good’. The DES (Bernstein & Putnam, 1986) assesses PTSD symptoms such as dissociation against the DSM-IV (APA, 1994). Spitzer et al. (2001) changed the language to German and reported that the psychometric properties were very similar to the English results. These produced good reliability and validity. The SCL-90-R (Derogatis, 1983) measures current psychopathology. The psychometric properties are listed as ‘good’.

Rogers et al. (2000) used the PTSD Symptom Scale Self Report (PSS-SR, Foa et al; 1997), the IES (Horowitz et al. 1987) and the BDI (Beck & Steer, 1987) to assess for PTSD in relation to manslaughter. The PSS-SR (Foa et al; 1993) similar to other measures is used to assess for PTSD against the DSM-IV (APA, 1994) criteria. Rogers et al. (2000) describe the psychometric properties for all measures. The PSS-SR (Foa et al; 1993) is described as having high test reliability, good concurrent validity and sensitivity to treatment effects. The IES

(Horowitz et al.1987) is reported to have good test-retest reliability and the BDI (Beck & Steer, 1987) is considered to have satisfactory reliability and validity.

Evans et al. (2007a and b) used the initial part of the PDS (Foa, 1995) to assess for previous traumatic experiences and used the PTSD Symptom Scale-Interview Version (PSS-I, Foa, 1993) to asses for PTSD against the DSM-IV criteria (APA, 1994). Evans et al. (2007a and b) described the psychometric properties of the measures as; high internal consistency (α=.85), high test retest reliability (r=.80) and high inter-rater reliability (k=.91). Other measures were used to assess for intrusive memories, offence characteristics and levels of rumination.

Two of the studies (Pollock, 1999; Kruppa et al. 1995) assessed for PTSD using the PTSD interview (PTSD-I; Watson et al. 1991) which compares PTSD symptoms to the DSM-IV (APA, 1994) definition. This measure is described as valid, reliable and sensitive. Other measures were used to assess the typology of offenders (Pollock, 1999).

Crisford et al. (2008) investigated the prevalence of PTSD in their study using the Detailed Assessment of Posttraumatic Stress (DAPS; Briere, 2001) which again compares symptoms with the DSM-IV (APA, 1994). Crisford et al. (2008) reported that the measure was reliable when compared to other measures. Further measures were used for the assessment of guilt and for offender explanation of offence involvement.

1.6 Main Findings;

All the studies reported significant findings of PTSD related to participants' index offences or violent behaviour. However, of the nine quantitative studies, one paper did not include the statistical analysis data in their results section (Kruppa et al. 1995) and it is therefore difficult to draw any firm conclusions from this study.

1.6.1 'Offence related PTSD';

In considering the remaining eight quantitative studies Papanastassiou et al. (2004) reported the highest prevalence (58%) of PTSD as a direct result of

index offences or violent behaviour and further added that 21% of the sample also met the criteria for partial PTSD. Pollock (1999) found that 52% (n=44) of the sample met the criteria for PTSD and out of these, 82% (n=33) reported the trauma to be as a direct result of the offence. Payne et al. (2008) found that 27% of their sample experienced PTSD as a result of murder or manslaughter perpetrated by them. Spitzer et al. (2001) reported the lowest levels of PTSD with only 15% of their sample experiencing PTSD due to their offence.

1.6.2 Trauma and guilt;

Papanastassiou et al. (2004) further found that 84% of the sample expressed significant guilt in relation to their index offence and concluded that there was a significant relationship (Fisher’s exact=9.11, $p< 0.01$) between guilt and the development of ‘perpetrator induced trauma’. Crisford et al (2008) found similar results and reported that 40% of the sample experienced ‘offence related trauma’ and that higher levels of guilt were associated with higher levels of ‘offence related trauma’.

1.6.3 Trauma, Co-morbidity and Offence;

Grey et al. (2003) reported that 33% of their sample experienced PTSD due to their offence. They further concluded that there was a significant relationship between higher levels of trauma and existing mental health diagnoses. They also reported that offences related to murder and manslaughter had higher significance levels ($p=.065$) for PTSD than other violent acts.

1.6.4 Trauma and Intrusive Memories;

Evans, et al. (2007a and b) reported that six participants met the criteria for PTSD related to their offence. However, the main finding indicated that 45.7% of the sample experienced intrusive memories and that the severity of these was significantly related to the severity of PTSD. The qualitative findings (2007a)

revealed that the most distressing aspect of PTSD and intrusive memories was the realisation that the offence had escalated to murder.

1.7 Discussion;

This review has examined the limited research which has attempted to establish if the perpetrators of violent crime can experience psychological trauma as a direct result of their offending behaviour. A total of ten papers have been reviewed which have assessed the prevalence of PTSD in perpetrators of violent crimes within mental health and prison contexts.

The main finding from all reviewed papers is that PTSD was reported to be experienced by perpetrators of violent crime. The prevalence of PTSD is however, varied and requires further discussion before firm conclusions can be drawn regarding the relationship between violent crime and ‘offence related trauma’.

1.7.1 Considerations;

Whilst the majority of studies were methodologically sound, there are a number of issues that need to be highlighted before conclusions can be made. The first consideration concerns samples. Eight out of the ten studies used small sample sizes, with the exception of Evans et al. (2007a and b) (n=105) and Pollock (1999) (n=80). The sample sizes ranged from 1-53 participants. Four of the studies (Payne et al. 2008; Evans et al 2007 a and b; & Pollock, 1999) used only males in the sample and Rogers et al. (2000) used one female in their sample. The remaining five studies (Papanastassiou et al. 2004; Crisford et al. 2008; Grey et al. 2003; Kruppa et al. 1995 and Spitzer et al. 2001) did use male and female participants. However, the number of females was still low in comparison to male participants. Small sample sizes and an over representation of males may be problematic in terms of generalisability. However, this gender bias is to be expected due to the larger numbers of males in secure units and prisons. Several studies (Papanastassiou et al. 2004; Grey et al. 2003) were also unable to show significant associations between PTSD and other variables (age, gender,

relationship to victim) due to small sample sizes. These associations may have strengthened the results. There is also an under-representation of ethnic minority groups within the ten papers and this may also have implications for generalisability. The recruitment of participants is also an area for consideration as only Payne et al. (2008) used random sampling to select participants. The remaining studies recruited participants that were already known to them or that a psychologist or psychiatrist selected. This may have caused a sampling bias as the samples are strongly biased towards participants who are experiencing difficulties.

A further consideration involves the comparison of studies. This is problematic due to several utilising prison populations (Pollock, 1999 and Payne et al. 2008) and the remainder using mental health populations. Therefore, the samples have been drawn from related but different populations. Further considerations are required when comparing studies, as some used only murder as an offence (Pollock 1999 and Papanastassiou et al. 2004) whereas other studies used a wide range of offences. Therefore direct comparison of studies is problematic.

Whilst the majority of the studies involved included inclusion and exclusion criteria and aims and objectives, there were four studies that did not (Rogers et al 2000; Kruppa et al. 1995; and Payne et al. 2008). This may again have implications for generalisability, but more so for the reliability and validity of the results. The measures used in the assessment of PTSD are also factors which may compromise validity and reliability. Several studies (Grey et al 2003; Payne et al. 2008 & Rogers et al. 2000) utilised the IES (Horowitz, et al. 1987) to assess for PTSD symptoms relating to a specific event. The IES (Horowitz, et al. 1987) is reported to have good reliability and has proved to be specific and sensitive. However, a major limitation of this measure is that participants are asked to only consider their emotional distress over the previous seven days. This could have implications for the under-estimation and reporting of PTSD symptoms. A further implication regarding the measures used is that of the reporting of the psychometric properties. Studies such as Grey et al. (2003), Payne et al. (2008) and Spitzer et al. (2001) either did not include the psychometric properties of the

measures or described them as 'good'. This therefore could have implications for the reliability and validity of the prevalence of PTSD in violent offenders.

All the studies relied upon self-report questionnaires and interviews to assess for 'offence related PTSD'. Whilst this has many advantages, a concerning factor is associated with the accuracy of self-reporting. Studies such as Pollock (1999) reported that over half of the sample were classified as psychopathic and a feature of this is 'pathological lying' (Hare, 2003). Therefore, the reliably of the data needs to be considered. Studies that used self-report measures could have used alternative sources to corroborate information to increase the reliability of data. Another possible concern involves perceived incentives. It is possible that participants may believe that the admission or exaggeration of their trauma symptoms arising from their behaviour, may result in a reduction in their prison sentence or the recommendation of a mental health review.

A wider consideration pertaining to all the studies is that of confounding variables and their potential impact. A large proportion of the samples had been exposed to prior trauma and could have experienced PTSD symptoms as a result of this. If this is the case then it might prove extremely difficult for participants to separate pre-existing PTSD symptoms with PTSD symptoms directly related to their offence. This could therefore mean that the presence of PTSD was not related to their offence. Furthermore, a large number of participants were diagnosed with major mental illnesses and therefore, this could make it problematic to separate these symptoms from PTSD.

However, studies such as Crisford et al. (2008) reported that they controlled for confounding variables but did not specify what these were. Papanastassiou et al. (2004) also discussed that PTSD profiles can be very similar to those of depression. They therefore attempted to control for confounding variables by assessing for depression. The remaining eight studies did not attempt to control for confounding variables resulting in difficulties drawing firm conclusions.

1.7.2 Clinical Implications and Future Research;

The identification and reporting of the prevalence of PTSD in forensic and mental health settings is increasing (Sarka et al. 2007). It seems that prior traumatic experiences and violent offences provide the main reasons for the increase in rates of PTSD within a forensic population (Spitzer et al. 2001). In consideration of the methodological rigour, the findings of the review, all reported an association between violent offending and the development of PTSD to a greater or lesser extent. The notion that perpetrators can experience PTSD as a direct result of their behaviour does pose implications for clinical practice.

There is a considerable body of research that explores the stress vulnerability model (Zubin & Spring 1977). This is an individual's vulnerability to stress and the potential onset of other mental health disorders associated with this vulnerability. The symptoms of PTSD can serve to be a severe stressor and can exacerbate other disorders such as psychosis (Nuechterlein & Dawson, 1984). Therefore if individuals who have committed violent crimes can experience PTSD and this results in an increase in other mental health disorders, then the assessment and treatment of PTSD is integral to an individual's mental health, care package and recovery. The timely identification of 'offence related PTSD', is paramount for long term recovery and outcomes, not only in prisons, but also in mental health units (Grey et al. 2003). Further research is therefore required into the outcomes of PTSD in relation to co-morbidity, mental health and further criminal convictions.

Offending behaviour work also needs modification if an individual experiences 'offence related PTSD'. This clinical work often requires the offender to take responsibility for their actions and to consider their impact on the victim (Grey et al. 2003). However, if an individual is experiencing 'offence related PTSD' then the very nature of offending behaviour work could increase re-traumatisation if this is not assessed and managed in the first instance (Rogers et al. 2000). There is a further body of research that has suggested that the presence of PTSD) can increase suicidal ideation in a forensic population (Blaauw, Kraaij & Bout, 2002). This, therefore, has clinical implications for the assessment and management of risk in forensic settings.

Kruppa (1991) highlights the overarching clinical implication for 'offence related PTSD' as being the integral need for staff to be aware of it, to assess for it and to consider its implications with regards to engagement, mental health, well-being, treatment and recovery/rehabilitation. It is further thought that the assessment and treatment of 'offence related PTSD' should occur before any other clinical work (Papanastassiou et al. 2004).

In view of the fact that a large proportion of the research (Kruppa, 1991, Grey et al. 2003, & Morrison et al. 2005) advocates that clinical staff need to assess, understand and treat 'offence-related PTSD' it would be integral to consider the emotional and physical impact that working with this type of trauma could have upon professionals. There is a large body of research exploring the concept of 'vicarious trauma' that is increasingly being reported by professionals working in forensic settings (Devilly, Wright &Varker, 2009; Way, VanDeusen & Cottrell, T, 2007 & Sabin-Farrell & Turpin, 2003). Vicarious trauma is believed to be a psychological reaction that could be experienced by professionals who have empathic relationships with clients who are experiencing PTSD or have been involved in traumatic events (Conrad, 2011). It is believed that engaging in an empathic relationship with an individual who has experienced a traumatic event could lead to the professional 'taking on' some of the emotional, psychological and physiological consequences of trauma (Tehrani, 2011). Conrad (2011) further describes vicarious trauma as the personal damage and stress caused by helping an individual who is traumatised. Vicarious trauma can manifest itself in psychological distress, strong physical reactions and a significant change in a professional's views of themselves, the world and others (Dillenburger, 2004). It would therefore be integral for professionals working with offenders experiencing PTSD and 'offence related trauma' to be aware of the concept of vicarious trauma and to take necessary steps such as: self-care, supervision, an equal work-life balance and caseload management, to reduce the likelihood of experiencing this trauma (Braithwaite, 2007).

Firm conclusions from this review and the application to wider settings are generally difficult to make due to methodological concerns. However, several studies that controlled for confounding variables and were methodologically sound (Crisford et al. 2008; Grey et al. 2003 & Papanastassiou et al. 2004) reported that

perpetrators of violent crimes can and do experience PTSD, shame and guilt in relation to their offence. Future research may attempt to overcome issues such as small sample sizes, sampling bias and confounding variables by recruiting larger samples, balancing gender and ethnicity bias, using random sampling and attempting to control for confounding variables. Future research, if it were to confirm the current view that perpetrators of violent crime can experience PTSD, could instigate the investigation of further treatment pathways and specific interventions. Additional research is also required in order to assist clinical staff in their understanding, awareness and recognition of this type of trauma, which will provide the basis for comprehensive assessment.

1.7.3 Critique of Review;

There are several considerations to this review. Firstly, the number of studies that have been involved is limited and this makes conclusions difficult to draw. However, the small number simply reflects the lack of research into this area. A further consideration relates to limited translation resources and an inability to therefore obtain four specific studies resulting in their exclusion from this review. These studies could have proved beneficial in improving the generalisability and application of the findings. This only increases the need for future research in this area.

The appraisal tools used within this literature review to evaluate the ten studies and the researcher’s inexperience is also an area that needs to be considered. It is thought that the researcher may have been too critical at times and this may have given an unbalanced review in places. Whilst the use of peer reviewed, published journal articles was necessary in this review, it is also considered that only reviewing published papers may have resulted in an over reporting of results. It is further possible that some papers addressing this topic of may have been discarded as a result of the choice of search terms employed.

Further limitations include the narrow focus of this review. Whilst this narrow focus was required, it is thought that there could be other studies exploring

a similar topic, such as, sexual crimes, which might prove beneficial to the findings from this literature search. Therefore, due to the narrow focus and the topic chosen, the conclusions are limited and this may therefore have implications for the generalisability of this review.

1.8 Conclusions;

The ten studies, reviewed, all reported a significant level of PTSD in relation to individuals who had committed violent crimes. These findings pose significant clinical implications for and challenges to the staff and services who work within a forensic population. However, given the methodological considerations, these findings must be treated cautiously. Further research is required to strengthen the basis of this review and this could be achieved by increasing sample sizes to include more females and ethnic groups and by the use of random sampling and controlling for confounding variables. Future areas of research would involve the need to increase and enhance levels of understanding and awareness that clinical staff possess in relation to ‘offence related trauma’ as they are integral in its assessment.

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Table 1; Study design, characteristic, main finding and limitations.

Author and Date	Sample	Measure used	Findings	Strengths	Limitations
1) Papanastassiou, Waldron, Boyle & Chesterman (2004) UK	N=29 3 Female 26 Male Medium Secure Unit Clinical records examined and if met inclusion criteria, invited to take part.	CAPS (1994) Quantitative methods	58% of sample met criteria for PTSD that was directly related to their offence. 21% met criteria for 'partial PTSD'. Significance between guilt and PTSD.	Controlled for some confounding variables Measure had high validity Training on conducting the research and using measure	Small sample size Gender bias; female (n=3) Statistical data not displayed

2) Crisford, Dare & Evangeli (2008) UK	N=45 45 Male 2 Female Medium Secure Unit Consultant psychiatrist selected participants that met inclusion criteria.	The DAPS (2001) Quantitative methods	40% of sample met criteria for PTSD. Higher levels of guilt; more severe PTSD Unknown victims; higher guilt	Clear aims Controlled for confounding variables. Measure had good psychometric properties. Allowed participants to choose most traumatic offence.	Sampling bias; Female (n=2). Sampling method Perceived incentives
3). Payne, Watt, Rogers & McMurran(2000) UK	N=26 Male Prison Random Sampling if met criteria	PDS (1995) IES (1997) THQ (1995) Quantitative methods	31% of sample met full criteria for PTSD. No difference between murder and 'non murder group'	Sampling strategy Clinical implications	Gender bias Small sample No clear aims No control for confounding variables.
4.) Grey, Carmen, Rogers, MacCulloch, Hayward & Snowden (2003)	N = 37 32=Males 5= Females Medium Secure	IES (1987) BDI (1987) STAI (1970) Quantitative	33% met criteria for PTSD 54% showed partial symptoms Relationship	Included written consent form Valid measures Clear aims	Gender bias (N=5 females) Small sample No discussion of

UK	Unit Recruitment by a Clinical Psychologist	methods	between primary mental health diagnosis and increased PTSD after offence. Higher PTSD if offence was murder	Controlled for perceived incentives	limitations No control for confounding variables
5& 6) Evans, Ehlers, Clark & Mezey(2007a and b) UK	N=105 Male Prison Participants recruited as known to researchers and met with inclusion criteria.	PDS (1995) PSS-I 2007a; quantitative methods 2007b; qualitative methods	48% of sample experienced intrusive memories 95% experienced intrusions about trauma 67% described the most distressing element of the trauma when they realised they event had changed for the worse.	Large sample Detailed statistical analysis Verbatim extracts Rigour described	Gender bias Sample bias e.g. only prisoners No quality checks Reflexivity vague Sampling strategy
7) Pollock (1999) Northern Ireland	N=80 Male Prison Recruitment by a	PTSD-I (1991) Quantitative methods	52% of sample met criteria for PTSD related to offence. 82% of sample that met PTSD criteria reported offence to	Clear aims Included hypothesis	Gender bias Sampling strategy Previous DSM measure used

	Clinical Psychologist		be the reason		
8) Spitzer, Dudeck, Liss, Orlob, Gillner & Freyberger (2001) Germany	N=53 Male= 51 Female = 2 High secure unit Participant recruited as known to researchers and met with inclusion criteria	CAPS (1994) MPSS (1993) DES (1986) SCL-90-R (1983) Quantitative methods	15% of sample met criteria for PTSD	Clear aims Inclusion criteria detailed Clinical implications considered	Gender bias (N=2 females) Sampling strategy
9) Kruppa, Hickey & Hubbard (1995) UK	N= 44 Female= 11 Male= 33 High secure unit Participant recruited as known to researchers and met with inclusion criteria	PTSD-I (1991) Quantitative methods	'Offence related PTSD' was highest type of trauma 'Offence related PTD' differs from non-offence related PTSD.	Good discussion about clinical implications Future research considered	Aims and inclusion criteria unclear. Small sample No control for confounding variables No statistical analysis results included Sampling strategy

10) Rogers, Gray, Williams & Kitchiner(2000) UK	N=1 Female Participants recruited as known to researchers	PSS- SR (1997) BDI (1987) Quantitative methods	Participant met full PTSD criteria. Behavioural approach used to treat PTSD related to homicide. Reduction on PTSD measures after intervention	Very replicable Interventions were gold standard High inter-rater reliability Follow up a 30 month	Aims unclear Method unjustified No control for confounding variables Limited ethical consideration Small sample size Gender bias Sampling strategy

N= Sample size. CAPS= Clinician Administered PTSD Scale (Blake, 1994). DAPS= Detailed Assessment of Posttraumatic Stress (Briere, 2001). PDS= Posttraumatic Stress Diagnostic Scale (Foa, 1995). IES= Impact of Events Scale (Horowitz *et al*. 1987). THQ= The Trauma History Questionnaire (Green, 1995). BDI= Beck's Depression Inventory (Beck & Steer, 1987). STAI= State Trait Anxiety Inventory (Speilberger *et al.* 1970). PSS-I= PTSD Symptom Scale Interview Version (*Foa et al*. 1993). PTSD-I= PTSD Interview (Watson *et al*. 1991). MPSS= The Modified PTSD Symptom Scale (Falsetti *et al.* 1993). DES= The Dissociative Experience Scale (Bernstein & Putnam, 1986). SCL-90-R= Symptom Checklist-90 Revised (Derogatis, 1983). PSS-SR= PTSD Symptom Scale – Self-Report Version (Foa *et al,* 1997).

Chapter Two: Empirical Study

Experiences of Working with Violent Offenders.

This paper has broadly been prepared in accordance with the requirements of the Journal of Forensic Practice. Author Guidelines are listed in Appendix Two.

Supplementary information is presented within the thesis chapter to aid overall cohesion; this will be removed prior to journal submission in order to reduce the word count. References will be completed in APA style to add fluidity the whole document. This style will be changed according to the journal before submission.

Word Count: 7991 (Exclusive of figures, tables and references)

2.1 Abstract

There is emerging research exploring the links between offenders of violent crimes and the development of Post-Traumatic Stress Disorder (PTSD). This trauma is known as ‘Offence Related Trauma’ and is thought to pose challenges and implications for professionals working within forensic services. This is the first known study, to date, that explores the experiences of professionals, including those undertaking professional training, working with violent offenders experiencing offence related trauma. Four qualified professionals and two undertaking professional training working in low and medium forensic units participated in a semi-structured interview exploring their working experiences. The data were analysed using Interpretive Phenomenological Analysis (IPA) and three super-ordinate themes emerged from the data; ‘Professionals Psychological Resilience’, ‘Barriers to Engagement’ and ‘Managing Offence Related Trauma’. The findings revealed the emotional impact that professionals working with violent offenders experience and what strategies are used to manage these emotional responses. Identification with the victim, a disparity between the offender’s personality and nature of offence and severity of offence were all variables that impacted negatively upon engagement with service users. Over time participants felt an increased level of empathy towards violent offenders and in particularly towards offence related trauma. Further research is needed into experiences of violent offenders in the community or high secure environments.

2.2 Introduction

2.2.1 Violence; The context;

Krug, Dahlberg, Mercy, Zwi & Lozano (2002) define violence as;

“The intentional use of physical force or power, threatened or actual, against oneself, another person or group or community, that either results in, or has a high likelihood of resulting injury, death, psychological harm, mal-development or deprivation” p5

The Crime Survey for England and Wales (2013) reported that during 2012-2013 there were 1.7 million reported victim based crimes, a 4% reduction since 2011-2012. During this period there were 553 crimes that fall into the ‘homicide’ category, 410 attempted murders and 312,083 violent crimes that caused injury. These figures represent a reduction from previous years. The National Health Service (NHS) 2012-2013 statistics for violent crimes in healthcare settings was reported as 1,166,859.

2.2.2 Types of Violence;

The Violence Prevention Alliance (VPA, 2014) defines the typology of violence in three categories; self-directed violence, collective violence and interpersonal violence. The VPA (2014) reports that whilst these categories are not uniformly accepted, they prove essential to understand the motivation or function of violence, as opposed to understanding its nature.

Interpersonal violence can have two further distinct typologies within it; Reactive and Instrumental violence. Krug et al. (2002) believe it is vital to understand these typologies as they have implications for treatment. Reactive violence as described by Cornell et al. (1996) has two main characteristics; provocation and arousal of hostility. Walsh, Swogger, and Kosson (2009) describe instrumental violence as goal directed which has been planned and state that the function of this type of violence is to obtain a goal beyond inflicting injury and involves little or no provocation by the victim.

2.2.3 Violent Offenders and Mental Health;

Brooker and Gojkovic (2009) reported that over 70% of the prison population have two or more psychiatric disorders. Braham, Jones and Hollin, (2008) further found that in individuals with mental health difficulties, violence was more prevalent than any other offence. In 2004, 36% of those admitted to forensic psychiatric hospitals, under a restriction order, were either convicted or charged with a violent offence (Braham et al. 2008). Within high secure services 72.3% of the population had committed a violent offence (Nottingham Healthcare, 2006). The current statistics report that during 2013, there were over 3000 individuals residing in forensic secure units in the UK (NHS Statistics, 2013). Given these statistics, it is apparent that a large percentage of individuals within forensic care will have committed a violent offence.

2.2.4 Post Traumatic Stress Disorder and Violent Offenders;

During recent years there has been an increasing amount of research into the prevalence of mental health difficulties, such as, Post Traumatic Stress Disorder (PTSD) in forensic populations. Attention has also been directed towards the assessment of links between PTSD and violence. The prevalence of PTSD in the general population is between 5-15% (Norris, 2012). However, this figure rises by 48% in psychiatric populations (Singh & Olumoroti, 2007) and is as high as 52% in forensic populations (Sarkar et al. 2007). Therefore it seems that individuals who have offending histories and mental health difficulties have the highest rates of PTSD. The traumatic events most frequently reported by forensic inpatients experiencing PTSD are; childhood physical abuse, childhood sexual abuse, emotional neglect, rape and torture (Spitzer et al. 2001). Recent research by Sulivan and Elbogen (2013) has begun to explore the potential links between experiencing PTSD and the increased likelihood of engaging in violent behaviour.

2.2.5 Offence Related Trauma;

There has been a large body of research exploring the impact of combat situations on soldiers and military veterans. During World War II the psychological consequences of combat were first recognised (MacNair, 2002). It was found that individuals who served in the militarily and took the lives of others had high rates of PTSD (MacNair, 2002). Research also focused upon police officers who had taken the life of another individual through the course of their career. Manolias and Hyatt Williams (1993) reported that more than half of the police officers experienced intense sadness and guilt in relation to their actions and several went onto to develop PTSD.

These findings have posed questions around offenders of violent crime and if the psychological consequences maybe similar to that of veterans and police officers. A literature review was conducted exploring the links between violent offending and PTSD- ‘offence related trauma’. Papanastassiou, Waldron, Boyle and Chesterman (2004) reported that extreme crimes such as murder can lead to the individual or perpetrator, in this case, experiencing intense traumatic symptoms. In their study they concluded that 58% of individuals who had committed murder experienced symptoms of ‘offence related trauma’. Grey et al. (2003) further argue that there are high rates of ‘offence related trauma’ in adult prison populations and forensic mental health units and that staff need to be aware of this. The findings also suggest that offenders experience high levels of guilt and sadness in relation to their index offence (Grey et al. 2003). These findings therefore pose significant clinical implications for and challenges to the staff and services who work within a forensic population.

2.2.6 Gaps in Literature and Research Rationale;

Currently there is no research, to date, that explores the experiences of professionals working with violent offenders traumatised by their actions. This highlights a gap within current research that would be appropriate for the proposed study to explore. This understanding may prove vital when considering stigma, service user recovery and hope for the future (Munro & Baker, 2007). It is envisaged that the outcome of the study may highlight the level of professional

understanding when working with perpetrators of violence and associated trauma. The level of understanding may display a need for staff training and demonstrate the possible implications for therapeutic working.

In view of the fact that the recovery model is widely used in forensic services (Gudjonsson, Webster & Green, 2010) this research may also demonstrate staff views about inpatient ‘hope’ and its impact upon service user recovery. Gudjonsson et al. (2010) further highlight the importance of staff attitudes and the instilling of hope within service users to aid recovery. The experiences that staff have in relation to violent offenders and offence related trauma may therefore prove essential in the valuing and recovery process of inpatient populations.

2.3 Research Aims;

The original aim of the research was to explore the experiences of professionals, including those undertaking training, who were working with offenders who had committed violent crimes and were traumatised by their actions (offence related trauma). However, participants seemed unable to discuss their experiences of working with this type of trauma without additionally reporting their experiences of working with violent offenders in general. Therefore, this data was also included in the results and not discarded. Whilst this was not an original aim of the research project, this data could not be separated in the participants’ mind and this therefore is the phenomenon being studied.

Therefore the amended research questions are:

1) What are professionals’ experiences of the impact of working with violent offenders?
2) What are professionals’ experiences of working therapeutically with offenders experiencing offence related trauma?

2.4 Method

2.4.1 Participants;

The sample was drawn from two study populations. The first involved professionals and those undertaking professional training working in a low secure forensic hospital and the other a medium secure hospital. Five participants were recruited from the low secure unit and one participant was recruited from the medium secure unit. In total six participants took part in the study and the recruitment took place between January and March 2014.

Smith, Flowers and Larkin (2009) suggest that a substantial sample size and one that is robust enough to explore the lived experience of participants in student projects, is between three and six participants. They further emphasise the quality of the research data over quantity. However, as this study has been conducted to fulfil a Doctorate requirement, a sample size of between six and ten was deemed suitable.

Inclusion criteria were as follows; participants were over the age of 18, worked for the NHS, worked within a secure service and had direct experience of supporting someone who had committed a violent crime and was experiencing trauma as a direct result of their offending behaviour (offence related trauma). A range of professionals were asked to participate (health care support workers, occupational therapists, social workers, psychologists, psychiatrists, nurses and trainee psychologists) to increase the range of experiences and perspectives.

The Research and Development Department gave ethical approval for the recruitment of participants from two sites (see appendix 4). Participant selection occurred via the identification of service users who had experienced symptoms of psychological trauma as a direct result of their offending behaviour. Identification was carried out by the clinical supervisor who worked across both sites. It is important to note that the names of service users were not divulged to the researcher in order to protect their confidentiality. The clinical supervisor further identified staff teams who worked directly with the identified service users. A meeting was subsequently convened by the researcher during which the selected staff were informed of the study and its expectations in relation to themselves. Staff members were provided with the researcher’s contact details, invited to

contact the Psychology Team, or to return the opt in slip to the researcher if they wished to participate in the study. Four qualified professionals and two professionals undertaking professional training expressed an interest in participating in the study.

Interviews occurred over a period of one month and were conducted within non-clinical areas of the secure hospitals, in order to protect the confidentiality of service users and participants. Interviews were of 29-47 minutes duration. Table 2.1 outlines the demographics for each participant;

Table 2.1: Demographic details

Gender	Male Female	1 5
Age	Mean Range	30 years 26-37 years
Profession	Trainee Psychologist Staff Nurse Consultant Psychiatrist Occupational Therapist	2 2 1 1
Years working in forensic services	Mean Range	6 years 3-10 years

In order to further protect anonymity, participants were coded to avoid using names. Participants were made aware that extracts of their interviews would be used in the write up. Participants provided verbal and written consent (appendix 6) and re-read the participant information sheet (appendix 5) before the interview commenced. Participants were also made aware that interviews would be audio recorded and transcribed verbatim. Audio recordings would then be deleted. Transcripts were kept in a secure cabinet and all electronic data were encrypted.

2.4.2; Materials;

A semi-structured interview (appendix 7) was developed which was based upon the research aims. The interview consisted of nine questions and a series of prompts. The semi structured interview was devised using guidelines by Smith et al. (2009) and highlighted gaps in the current literature. The interview guide was used as a guideline as opposed to a rigid set of questions. The researcher was guided by the lived experience of the participants. However, all questions were covered in each interview.

2.4.3 Procedure;

Six professionals, including professionals undertaking professional training, working in either a low or medium secure forensic hospital were interviewed using a semi-structured interview to explore their experiences of working with offenders of violent crime and their subsequent trauma in relation to these crimes. A qualitative methodology was deemed appropriate for this study as the aim was to gain an in depth exploration of phenomena evolving out of the data. Interpretative Phenomenological Analysis (IPA) was considered the most appropriate quantitative methodology to fulfil the study aims. This was to gain in-depth insight into professionals’ experiences of working with offenders of violent crime and the trauma they may endure as a direct result of their offending. The objectives were to obtain insight into the professional’s thoughts and beliefs in relation to supporting offenders of violent crime and their thoughts about the trauma experienced as a result of this act. This therefore fits with the lived experience emphasis highlighted by IPA's phenomenological underpinnings.

IPA is a qualitative methodology that connects phenomenology, hermeneutics and symbolic interactionism (Smith et al. 2009). These theoretical underpinnings provide IPA's integral aim of gathering a better understanding of the nature of a phenomenon (Willig, 2008). The principles of IPA suggest that people are not passive perceivers of "what is out there", but co-construct their world by interpreting experiences into a way that makes sense to them (Brocki & Wearden, 2006) IPA involves a two stage process, or a double hermeneutic. Both the

person and researcher are trying to make sense of the participant’s world (Smith et al. 2009).

Qualitative methodologies have received criticism due to their apparent lack of quality and more importantly, how this quality is measured (Willig, 2008). Yardley (2000) therefore outlines several principles to assess and evaluate the quality of research using methodologies such as IPA;

Sensitivity to context;

This research has demonstrated sensitivity to the context by being underpinned with relevant literature, being conducted in an appropriate context, maintaining an ongoing awareness of the interactive nature of data collection and analysis and by including detailed verbatim accounts from participant interviews.

Commitment and rigour;

Adherence to this principle has been achieved by an ongoing commitment to remaining attentive towards the participants during the interview process and by a thorough analysis of each case during the analysis stage. The sample was also purposefully and carefully selected and was therefore as homogenous as possible.

Transparency and coherence;

The selection and recruitment of participants, the procedure and interview process and data analysis have been described in detail throughout the study. Each stage has been documented and openly discussed. This therefore provides an acceptable level of transparency and coherence.

Impact and importance;

The outcome of this research has generated a series of clinical implications and future research considerations. The findings have also been discussed with the Head of Psychological Services within both secure settings to promote service development and delivery. This will be additionally cascaded to staff working within the secure services and will hopefully lead to supportive interventions for them.

2.4.3.1 Analysis;

When the interviews were completed the transcripts were read several times. Smith et al. (2009) state that the reading and re-reading of transcripts is essential for the researcher to ‘submerge’ themselves in the experience of the participant, rather than quickly summarising and reducing data.

The researcher made initial notes in the margin whilst reading the transcript. These notes as Smith et al. (2009) state should be points of interest and exploration. The process of re-reading the transcript and production of initial notes began to reveal similarities, differences, key points and personal meanings for each participant. Any emergent themes that developed from the data were noted by the researcher. The development of themes produced concise statements of importance and sub-themes were devised.

The above stages were repeated for all transcripts and further themes were noted as master or sub-themes. The researcher then looked for connections and patterns between all emergent themes from all transcripts and attempted to make sense of these (Forrester, 2010). Super-ordinate and sub-ordinate themes were then created. The final aspect of IPA methodology was to reflect upon how the researchers’ subjective bias, epistemological positioning and original thoughts may have influenced the data.

2.4.3.2 Credibility of Analysis;

Rigour was demonstrated throughout the research process and credibility checks which seen as an essential part of IPA projects applied (Elliot, Fisher & Rennie, 1999). Descriptive data and emerging themes were discussed and checked with peers familiar with IPA and with the Academic Supervisor to ensure the presence of a deeper level of description. The researcher attended frequent IPA University groups where the emergent, sub-ordinate and super-ordinate themes were explored and validated. Supervision with the Academic Supervisor also ensured rigour and detailed amendments where necessary. Excerpts from the transcripts are provided to demonstrate the analysis conducted (see Appendix 8) and participant themes are also presented (see Appendix 9).

2.4.3.3 Ethics;

The research proposal was approved by Staffordshire University’s Research and Ethics Committee (Independent Peer Review) and South Staffordshire and Shropshire Foundation NHS Trusts’ Research and Development Department (appendix 4). The research was appropriately managed by the guidelines produced by the BPS regarding ethical research (2005; 2009a; 2009b). It was also regularly overseen by a clinical and an academic supervisor. Clinical supervision enabled the researcher to identify and recruit participants and academic supervision provided support and guidance in relation to methodology and design.

2.4.3.4 Researcher Reflexive and Epistemological Position;

The researcher was working as a trainee clinical psychologist in an NHS Trust at the time of the research. The researcher had previously worked with offenders of violent crimes and those who were experiencing trauma as a result of their offending behaviour. The researcher, therefore, had experience of working with this client group and had frequently been aware of staff discussions concerning certain individuals, their mental health and their offending behaviour.

The researcher’s epistemological position is described as a ‘social constructionist’. This position believes that there are multiple truths to reality and these truths are constructed throughout our engagement with the world and our experiences. Constructivism maintains that different people construct meaning in different ways, even to the same phenomenon (Feast, 2010).

The previous experience of the researcher, the current role and the epistemological position meant that the interview questioning and interpretation of the data is influenced by social constructivism. The researcher’s position and beliefs are derived from their own experiences of working with violent offenders and their education whilst being a Trainee Clinical Psychologist. The beliefs and positioning of the participants are also derived from their own individual experiences. This meant that the researcher held a position influenced by social constructivism, as did the participants and the data was further interpreted using the researcher’s epistemological position. This double hermeneutic is an integral

feature of IPA as it allows for subjectivity and the experiences of the researcher to be used during the analysis stages. However, credibility and validity checks are essential due to this subjectivity and were carried out throughout the research.

The researcher was also female as were five out the six participants. During the interviews and the analysis process the researcher experienced a greater association with the female participants. This enhanced connection may well have influenced data gathering, data analysis and indeed interpretation. However, supervision use, IPA group attendance and frequent validity and credibility checks ensured that this association did not significantly influence the findings.

2.5 Results;

The analysis of the data, using IPA, revealed three super-ordinate themes and eight subthemes (table 3). Both were present in over half of the sample, which accords with the guidelines produced by Smith et al. (2009). The following section will provide details about each theme and provide illustrative examples.

The first super-ordinate theme concerned 'psychological resilience of professionals' and this was important for all participants. This theme encapsulates the emotional responses that professionals experience when working with violent offenders and the mechanisms used to manage these emotional experiences. This super-ordinate theme contains three sub-themes; 'emotional response to working with violent offenders', 'internal coping mechanisms-self-protection' and 'external coping mechanisms'.

The second super-ordinate theme, 'barriers to engagement' includes three subthemes; 'incongruence of crime and personality' 'personal identification' and 'hierarchical process of crimes'. This theme concerns the challenges and conflicts that participants describe when working with offenders of violent crimes.

The final super-ordinate theme 'managing offence related trauma' arises from the descriptions of how offence related trauma requires certain skills and alterations to therapy. It further concerns participants' beliefs about this type of

trauma. It included two subthemes; 'avoiding re-traumatisation in therapy' and 'updating ideology'.

A summary of the super-ordinate and subthemes can be found in table 2.2;

Table 2.2; Super-ordinate themes and subthemes;

Super-ordinate Themes	Subthemes	Present in over half the sample
1) Psychological resilience of professionals	➢ Emotional response to working with violent offenders ➢ Internal coping mechanisms- self protection ➢ External coping mechanisms	Yes Yes Yes
2) Barriers to engagement	➢ Incongruence of crime and personality ➢ Personal identification ➢ Hierarchical categorisation of crimes	Yes Yes Yes
3) Managing offence related trauma	➢ Avoiding re-traumatisation in therapy ➢ Updating ideology	Yes Yes

The super-ordinate and subthemes will be detailed below using illustrative examples from participants' transcripts.

2.5.1 Subordinate Theme 1; Psychological resilience of professionals;

All six participants described the need to be ‘able’ to work with violent offenders and often described this as being internal or something “you either can or you can’t do” (participant 3). There was a strong recognition of some colleagues who were simply unable to do this, which contrasted with those ‘who could’. The subthemes reflect the emotional responses to working with violent offenders, especially when exploring the offence and the mechanisms adopted and used to manage these emotions.

2.5.1.1 Subtheme; Emotional response to working with violent offenders;

All participants described a strong emotional response to working with violent offenders. These emotional experiences ranged from “repulsion” (Participant 5) to feeling “subdued” (Participant 3) and “angry” (Participant 1). Participants further described how emotional experiences can rapidly fluctuate and change when thoughts are directed to the offender or the victim. This is an interesting concept, in view of the fact that, professionals working in forensic settings have to engage in offence related treatment programmes (Grey et al. 2003) that attempt to increase empathy towards the victim. Despite the strong emotional responses such as; repulsion and anger, participants demonstrated their ability to offer unconditional positive regard and held a powerful desire for offenders to progress and recover.

“You’ll find that the service user tells you about his life and I feel so sad and upset for them...and then they [the service user] are talking about trying to kill someone...and I’m shocked and disgusted...how do you make sense of that?”
(Participant 6, lines 201-203).

Participant 5 described the high emotions experienced when a client was disclosing an index offence;

"*I was listening to him talk and I wanted to be sick...I was absolutely repulsed...like sick to my stomach. Then I felt the anger bubbling away inside me...like how could you do that!"* (Participant 5, lines 167-168).

Further exploration reveals that managing emotional responses posed a significant internal conflict for participants when working with violent offenders;

"I really want patients to do well and recover...that's why I do this job...but sometimes I just can't shake off how I feel about them... anger, shock, disgust...but you just have to" (Participant 6, lines 324-325).

Participant 2 described the emotional experience of working with an offender that continued whilst at home. A strong emotional and behavioural response was described that lasted for several days. The current literature reports that an inability to 'leave' emotions at work is possibly related to the unprocessed nature of the emotional response and it 'spills over' into personal areas (Majomi, Brown & Crawford, 2003). This is something that could pose further difficulties for participants as the unprocessed nature of these powerful emotions could potentially lead to the experience of vicarious traumatisation (Conrad, 2011). This type of trauma is thought to be a psychological reaction experienced by professionals who engage in empathic relationships with individuals experiencing PTSD (Tehrani, 2011).

There also seemed to be an internal conflict which occurred whilst working with violent offenders. Participants described having to manage their emotional response on the 'inside' whilst projecting a 'blank slate' on the 'outside'. This was particularly apparent for participant 2, who at times, felt it was difficult to achieve. This conflict is consistent with research by Gordon and Kirtchuk (2008) and Boyle,

Kernohan and Rush (2009) and is reported to be a frequent ‘internalised’ work ethic of forensic staff.

Participant 2 further described a range of polarised emotions that they experienced. This is exemplified by their reports of feeling ‘horrified’ at the offence, but at the same time feeling empathic towards the offender and wishing to offer comfort. This internal conflict seemed to pose significant difficulties for all participants and they subsequently engaged in the process of trying to make sense of the conflict in order to adequately manage it. The process of managing the internal conflict is explored within the next two sub-themes.

The preceding subtheme and illustrative examples would seem to suggest that participants experience a range of very strong emotional responses to working with violent offenders. However, further questioning revealed that professionals demonstrated a positive desire for offenders to recover, to progress and to consider the future. This links to the following two subthemes which explore how participants manage their emotional responses and engage in therapeutic relationships with violent offenders.

2.5.1.2 Subtheme; Internal coping mechanisms- Self-protection;

The emotional experiences of working with violent offenders poses questions about how professionals contain or manage their emotional responses, engage in therapeutic relationships with violent offenders and maintain their emotional well-being. All participants engaged in what was interpreted as internal ways of coping. The subtheme of ‘internal coping mechanisms-self-protection’ is particularly important when trying to answer the above question. It appeared that a number of internal mechanisms such as; separating the person from the crime, avoiding thinking about the victim or the violent offence, purposefully not asking about the violent offence and detaching from the offender, were coping strategies employed by the participants to manage powerful emotional responses. Internal mechanisms were interpreted in this study as defence mechanisms utilised to prevent the participants from experiencing intolerable emotions and internal conflicts.

All participants' described a process of separating the person from the violent offence;

"In this environment you have to shut yourself off to the crimes and just think....yeah this is another young man in front of me and I am working with him" (Participant 1, lines 122-123)

"I work with the here and now... they didn't commit that crime in the here and now" (Participant 6, line 144)

Participants also reported a conscious process of avoiding thoughts about victims as this tended to increase personal difficulty in managing their own emotional responses.

"I try not to sometimes...I try to not think about the victims...even though...you do know... and you are very aware there are victims....I try to not think about them... it would be too hard" (Participant 3, lines 256-257)

Interpretation of the comments of the participants suggest a sense of the strategies of separating the person and crime, avoiding thinking about the victim and the process of desensitisation are internal coping mechanisms. It is further suggested that, on some level, these strategies serve as a defence mechanism to enable staff to engage therapeutically with offenders and to protect themselves from intolerable emotions.

The term 'defence mechanism' is derived from psychodynamic theory and describes a process that a person unconsciously engages in to protect themselves from difficult emotions (Lemma, 2003). The employment of defence mechanisms within this study was interpreted as an adaptive way of coping for participants as these serve to maintain personal coherence (Leiper, 2006). Interpretations in this study suggest that the use of defence mechanisms allows the participants to avoid

the experience of difficult emotions in relation to working with violent offenders. This avoidance appears to allow participants to engage in working relationships with violent offenders, maintain their personal well-being and contain their emotional experiences. This is consistent with studies that explored ways of coping in mental health staff (Ingledew, Hardy & Cooper, 1997).

2.5.1.3 Subtheme; External coping mechanisms;

Participants also described using what was interpreted as external mechanisms to manage difficult emotional experiences. Most participants recognised the psychological impact of working in a forensic setting and were pro-active in their use of external supports to manage this impact; personally and professionally.

Participant 1's description could be interpreted as both a conscious and unconscious means of using external resources in order to cope;

"I don't tend to...to...hold onto things [emotions] as I know other colleagues do more so. But I do things whether I mean to do it or not, so I do have my routines and I do keep to quite a good routine, I have my social life, I like to relax, watch films and things... so I guess actually, whether I pin point it to dealing with work, I don't know, but I do do things that I think are beneficial to me getting over things and giving me a time to reflect on things" (Participant 1, lines 467-473).

In contrast participant 2 was more active in engaging external support;

"the way I cope is I will go home and feel horrible and I will probably talk about, not the case, but talk about how I feel, with people, watch TV, distract myself...because you can't get away from it... erm so I tend to use those things and I guess with the supervision bit...you need to do that... you need to do something with how you feel...I think you get more into trouble if you pretend that they [emotions] are not there" (Participant 2, lines 231-235).

Participants 3 and 6 both maintained that they found comfort in having a shared understanding with the team and used their colleagues as a source of support. This could be interpreted as social coping to manage the emotional impact of working with violent offenders.

Participant 3 described using the team as a source of support and found this helpful as a means of sharing and diffusing stress;

"I think it's very much that we are part of a team and the team support each other, which I think carries a lot of weight when dealing with stressful situations, especially on a ward like this here, there is a lot of staff that work here and we all support each other and that does take a big chunk of the burden if you like..."
(Participant 3, lines 280-283)

It could be interpreted that for participants 3 and 6 social coping serves the function of validating and containing emotions. This is consistent with the literature that reports that mental health staff draw upon 'social coping' from their team (Edwards & Burnard, 2003) and identify team colleagues as a protective factor against difficult emotions (Edward, 2005). In contrast participants 1 and 2 appeared to use individual coping mechanisms, or ones which were not work related.

2.5.2 Super-ordinate Theme 2; Barriers to Engagement;

Participants were further asked to describe their experiences of working with a variety of offences and how this impacted upon them, personally and professionally. All participants described the challenges they faced working in a forensic setting. These challenges were interpreted in this study as the subthemes of; 'incongruence of crime and personality', 'personal identification' and 'hierarchal categorisation of crimes'.

2.5.2.1 Subtheme; Incongruence of Crime and Personality;

All participants discussed the challenge of the significant disparity between an offenders' personality, value base and the nature of their offence. Participants often described patients as being friendly, kind and approachable whilst in a secure environment. These personality attributes seemed to create a tension for the participants when considering the violent offence. This tension seemed to create a 'distance' between the participant and the offenders. Participants described finding it difficult to 'relate' (participant 2), 'connect with' (participant 6) and to 'understand' (participant 1) the offenders. This 'distance' a barrier to engagement.

Participant 1 describes a conflict between a patient's personality and values and their offence;

"*There just seemed to be such a disparity between that person and the crime and that was the...difficult thing for me... erm... so you know...I just couldn't match it up and I think that was difficult for me to kind of take home. If that person presented in a narcissistic way...in that "I couldn't give a fuck about...about women or any other shit" but his clearly his values were good...and he wasn't living by them...I really struggled to understand him"* (Participant 1, lines 401-406).

Participant 6 also describes a conflict between the type of offence and the personality traits of the offender;

"When I met this individual what was really noticeable to me was how I couldn't associate the crime with the individual. He came across such a sincere and actually caring, thoughtful young man...very innocent, very naive erm ... and it didn't match with the severity of the crime at all, in how I perceived it...this was really hard because it didn't sit comfortably with me. I found it difficult to connect with him...." (Participant 6, lines 114-118).

Participant 2 further describes the conflict between their own value base and the offence;

"It just seems so far removed from how I view my role in the world. Where as I can relate more, potentially, to how people might get in to doing other crimes"
(Participant 2, lines 241-243).

This subtheme is understood by Festinger's (1962) Cognitive Dissonance Theory. Cognitive dissonance was first described by Festinger (1962) as the internal conflict of holding two opposing beliefs, ideas or values at the same time. Cognitive dissonance is thought to cause psychological distress and is exacerbated when individuals become involved in situations which magnify their belief system or moral code (Birgden, 2004). This internal conflict motivates the individual to reduce the dissonance or to avoid situations that increase cognitive dissonance (Birgden, 2004). The interpretation of participants' cognitive dissonance is consistent with literature as participants seek to increase the 'distance' between the crime and the offender, thus reducing their cognitive dissonance, but creating a barrier to engagement.

2.5.2.2 Subtheme; Personal Identification;

Participants further discussed how identification with victims of violent offences increased their strong emotional responses and consequently acted as a barrier to engagement. Several participants also described how identification with the offenders' background or value base further prevented engagement. All participants reflected on the manner in which their relationship with the offender altered if personal identification was present. The main changes included professional interactions being increasingly boundaried and only interacting with the offender at set times.

Participant 1 talks about how being able to identify with the offenders' background made it more difficult to contain their emotions and this then made the participant alter their engagement with the client;

"What's particularly...erm...vivid in my feelings about this individual is that, he comes from a very similar background to me, from a similar area and so I can really...feel...kind of where he has come from and how it might have gone wrong for him and I can relate to him in a lot of ways in terms of his feelings about his family erm and kind of guilt in general and erm so it kind of makes me feel really upset...I know I'm feeling upset during our meetings and I'm scared of it spilling out...so I am very boundaried with him...I only see him during our allocated times...where as with other patients I see them more often and I feel I have a stronger rapport with them...." (Participant 1, lines 39-43)

Here personal identification with the client's background appears to change the manner in which participant 1 engages with this client in comparison to other clients.

Participants 6 described identifying with victims heightened their an attendant their emotional responses and there was a subsequent impact on their ability to engage with the offender;

"I find myself over-thinking things if I could have been the victim, if it could have been me. If it's a female victim of my sort of age... sometimes I feel on-guard...I imagine all the things that could happen to me... it sort of changes your perspective. That makes me angry you know... and then I'm like I don't want to sit in a room with you... [Patient]" (Participant 6, lines 311-316)

This subtheme suggests that identification factors can impinge on participants and serve to 'draw them closer' to the victim or the offender. In order to compensate for this, participants may try and resist and 'push themselves further away'. This consequently could impact on engagement with the offender and create another potential area of difficulty. It is possible that a different engagement level allows participants to avoid thoughts about personal connections and this reduces emotional distress. This is consistent with the literature about avoidant coping styles and engagement in mental health workers (Wastell, 2002). This also links to the first super-ordinate theme of internal mechanisms of coping.

2.5.2.3 Subtheme; Hierarchical categorisation of crimes;

Participants shared their experiences of working with a range of crimes and spoke of hierarchical categorisation of crimes. It appeared from the data that engagement proved more difficult with certain crimes and that this was also dependent on the severity of the offence. Some participants described the conflict of being empathic towards an offender and finding the severity of the offence difficult to tolerate. Others stated that the more severe the perceived offence, the less likely they were to engage in daily conversations and humorous interactions.

Participant 3 describes differing levels of engagement with offenders which seems determined by the type of crime committed;

"this is like, temporally people's homes and it would be hard to keep everything...you've got to have a laugh and a joke about things occasionally...you know very light hearted things... whatever it might be, or just have conversations about music or whatever, which I think you don't go down those routes as much with people who have committed ultimate crimes..." (Participant 3, lines 202-205)

Participant 5 appears to describe the normalisation of violence levels in certain offences and how this impacts on engagement;

"I think the... it's hard to say the normal as you are so used to a certain degree of violence...but you do get used to violence...it becomes the norm...but it's the worst crimes... the sexual stuff with children that's the hardest...it's very hard and the extreme violence is very hard erm...it's hard to work with...hard to connect with..."
(Participant 5, lines 242-244)

This hierarchical process appeared to be somewhat unconscious and largely determined by the participants' morals, attitudes, beliefs and experiences (Eva & Norman, 1995). This was interpreted using psychological theory known as 'heuristic reasoning' (Tversky & Kahneman, 1982). 'Heuristic reasoning 'suggests that as human beings we enter in an unconscious decision making process. This reasoning process results in categorical judgements that are based upon stereotypes that alter our perceptions (Elstein, 1999). This is consistent with the process that participants enter into when engaging with offenders. However, this process has potential biases and could result in the development of negative assumptions and stereotypes in relation to offenders solely on the basis of their offence.

2.5.3 Super-ordinate Theme 3; Managing Offence Related Trauma;

This theme emerges from the data which appears to suggest that trauma increases complexity, requires a skill set and requires beliefs and ideas which are prone to change over time. The data from participants supported the subthemes of: 'avoiding re-traumatisation in therapy' and 'updating ideology'.

2.5.3.1Subtheme; ‘Avoiding Re-traumatisation in Therapy’;

Participants described a sense of added complexity when working with offenders traumatised by their actions. It also seemed that the presence of trauma changed the way in which participants normally worked with offenders. Participants also made comparisons with previous work experiences and seemed to feel that demands increased when working in a forensic setting.

Participant 2 describes how working with offenders experiencing offence related trauma might differ;

“When you work with most offences, you know what you have to do... you’ve done it before...but when you have patients who are traumatised... it’s harder to do...most offences you want to deconstruct everything... but then of course if the offence itself is traumatising ...it becomes even harder to deconstruct as there is an extra layer...” (Participant 2, lines 85-88).

It could be interpreted that this perceived complexity increased professionals’ anxiety levels in relation to their therapeutic work. Further interpretations illustrated that professionals often felt out of their ‘depth’ with a consequent perceived reduction in outcomes in psychological therapy for offenders. This is consistent with the current literature examining the psychological process of mental health professionals working with trauma (Collins & Long, 2003).

The presence of offence related trauma also seemed to alter the perceptions that professionals held about offenders. They were sometimes viewed as “fragile” (participant 3 & 5) and more “vulnerable” (participant 2). These perceptions seemed to influence the therapy processes and participants reflected upon how this differed with offenders who were not traumatised. Changes to the therapy process were described as being more “gentle” (participant 1 & 5) and

less challenging. Empathy towards violent offenders seemed to increase when trauma was present.

"I think the trauma makes him seem more fragile... I mean he is fragile...he's so distressed by what he's done. I feel I have to look after him in sessions... make sure he isn't being thrown into something that's too difficult for him emotionally. I spend more time planning sessions for him than others." (Participant 5, lines 106-109).

"The guys that are traumatised by their offence, generally their self-efficacy is quite low and erm...they just seem like they need a cuddle and you know...and you know...someone to hold their hand whilst they try and make small steps...then probably whether I know it or not...I spend more time with them and try to engage with them in a more personal way..." (Participant 1, lines 302-307).

It was further interpreted that different perceptions may defend against the more intolerable emotions relating to the offender. This could be interpreted as an adaptive process for both professionals and offenders as the attitudes towards patients can undermine the recovery of forensic service users (Lammie, Harrison, MacMahon & Knifton, 2010 & Mezey, Kavuma, Turton, Demetriou, & Wright 2010). It could be interpreted that that the presence of offence related trauma can change the perceptions that professionals form about an offender. It seems to render the offender more vulnerable and requiring of extra caution during the therapeutic process. It can also be interpreted that professionals assume a greater responsibility for clients who are traumatised by their actions.

This subtheme demonstrates the complex perceptions that professionals have about offence related trauma and how this serves to change the nature of therapy. It is interpreted that the perceptions of offenders who experience offence related trauma are more positive and bring out caring schemas in staff. It is further thought that these perceptions serve as a mechanism to increase engagement with violent offenders and as a defence mechanism against the more intolerable emotions.

2.5.3.2 Subtheme; Updating Ideology;

Participants described how their thoughts and beliefs about offence related trauma had changed over time. The variables that seemed to impact upon this change included; the duration of time working in forensic settings, mental health training and direct experience with offenders who were traumatised by their actions. This change in ideology was interpreted as a positive process resulting in increased level of empathy towards offenders. The acquisition of a deeper understanding seemed to benefit participants and reflections were based upon the application of psychological theory to their work. This increased understanding should be of benefit to offenders.

“It’s easier now...years ago this kind of trauma was never in my mind...I don’t suppose I ever thought of it in fact...I don’t suppose you ever really thought that the person doing the crime would be...well traumatised... so my thoughts and awareness have definitely changed over the years... it exists now...not only does it exist... but it’s very real and you can understand it...” (Participant 3, lines 373-377).

Participant 1 describes how beliefs and ideas have changed as a direct result of working with people who experience offence related trauma;

“Yeah... I think that, I think that it is working with...there’s the odd guy that you work with that might be suicidal or erm... or just so emotionally hopeless about the future that resonates with you and you just think “shit that would be a horrible place to be in, in your life” and you put yourself in their shoes and think they just really have no hope, there is no hope in carrying on and for some reason they still have the strength to carry on. I think when you see a few people like that who are experiencing trauma especially, that’s when you think...you know... .... the effects of that offence [trauma] have had such a catastrophic effect on this person that you know...our job as a Psychologist it to try and do something about them things

erm... regardless of the offence we should do something about it" (Participant 1, lines 554-564).

It could be interpreted that an enhanced understanding or a shared understanding, increases engagement, empathy and psychological outcomes. The advantage of having a shared understanding with clients has long been reported in the literature (Rose & Buckell, 2008).

This subtheme clearly demonstrates the development of ideologies used by the professionals who work with offence related trauma. It appears that the process of development is constantly evolving and dependent on a variety of factors including; the length of time working in forensic services, training and qualification and increased empathy towards offenders who experience trauma as a direct result of their offence.

The transcripts of all participants described a desire to help offenders, a wish for recovery and detailed a strong sense of empathy towards violent offenders traumatised by their actions. This is demonstrated in the subtheme of 'updating ideology' and seems to be driven by a humanist psychological approach. A wider interpretation of the data is related to the theory of 'Unconditional Positive Regard' (Farber & Lane, 2001). Rogers (1951) described a set of conditions that are needed for an individual to 'grow' and 'flourish'. These conditions are observed in the data and include; empathy, genuineness and acceptance. The interpretation of unconditional positive regard, from the data, is consistent with the literature that describes the need for therapists to remain empathic, non-judgmental, accepting and to not withdraw positive regard if a person makes a mistake (Marshall *et al*, 2005).

2.6 Discussion;

2.6.1 Summary of Findings;

This study aimed to explore the subjective experiences of professionals, including those undertaking professional training, who work with violent offenders traumatised by their actions. Six interviews were conducted involving professionals, including those undertaking professional training, working in medium and low secure units in Staffordshire and Shropshire. Analysis, using IPA, established three super-ordinate themes; 'Psychological Resilience of Professionals', 'Barriers to Engagement' and 'Managing Offence Related Trauma'.

The findings revealed evidence of powerful emotional responses: anger, repulsion, sadness and frustration, that professionals experienced during work with violent offenders and the internal and external strategies utilised to manage these. Internal strategies included; the separation of the offender from the crime, thought suppression and detachment from the offender. The findings were interpreted using psychodynamic theory and revealed that internal mechanisms served as a defence mechanism to protect the professionals from 'feeling' the intolerable emotions they experienced when working with violent offenders (Lemma, 2003). External strategies utilised to contain the emotional experiences of working with violent offenders included the use of social support from the staff team, 'social coping' and maintaining a positive work life balance.

Further findings revealed that engagement levels with offenders varied and were dependent upon: identification with the victim and the disparity between the offender's personality and the nature and severity of the offence. Working with violent offenders and those experiencing 'offence related trauma' seemed to create an internal conflict for participants. Identification with the victim or the offender seemed to create a connection for the participant. There appeared to be a sense of 'anyone could be a victim', yet if the identification lay with the offender it became 'anyone could be an offender'. This connection proved difficult for participants to tolerate and the level of engagement seemed to alter dependent upon the strength of this connection (Wastell, 2002).The level of engagement with offenders also fluctuated in relation to the disparity of the crimes and the

personality of the offender. It appeared that if there was a mis-match between personality and offence, this proved difficult for participant comprehension and they found engagement challenging. Further interpretations from this study using psychological theory such as heuristic reasoning (Tversky & Kahneman, 1982) revealed that participants unconsciously engaged in a hierarchical categorisation of crimes that impacted upon understanding and engagement.

Finally findings from the study revealed that the presence of ‘offence related trauma’ seemed to add a sense of complexity for professionals working therapeutically with offenders. However, over time, participants experienced an increased level of empathy towards violent offenders especially those who experienced ‘offence related trauma’. The perceptions of violent offenders altered if ‘offence related trauma’ was present. Offenders were seen as ‘fragile’ and ‘vulnerable’, resulting in participants assuming greater responsibility for them. It was apparent however, that all participants possessed a strong desire for offenders to recover and progress. It was felt that using a theory such as ‘unconditional positive regard’ (Rogers, 1951) provided some measure of understanding the desire for offender recovery.

2.6.2 Implications for Clinical Practice;

The study’s findings offer new insights into and important understandings of the experience of working with violent offenders traumatised by their actions. The results suggest that professionals are likely to experience strong emotional responses to the offences and employ a variety of internal defence mechanism to defend against these powerful emotions. It is particularly important to consider the concept of vicarious traumatisation in light of the powerful emotional reactions experienced by participants. Several participants described intense emotional reactions which were of a considerable duration and which were experienced away from the work environment, following work with violent offenders traumatised by their actions. The reporting of professional’s experiencing vicarious trauma is increasing (Sabin-Farrell & Turpin, 2003). It is thought that engaging in an empathic relationship with an individual who is traumatised can lead to the clinician experiencing psychological and physical distress (Conrad, 2011). If

vicarious trauma is unidentified and untreated it can lead to significant changes in the way a professional may view themselves, others and the world (Dillenburger, 2004). It would therefore be paramount for professionals to be able to reflect upon their emotional experiences and be encouraged and supported to process their emotions in order to prevent them impinging on personal life and developing into vicarious trauma (Majomi, Brown & Crawford, 2003 & Conrad, 2011). This could be achieved by using reflective practice groups, via process focused supervision and mindfulness based practices.

It is also important to consider the concept of systematic desensitisation in view of the study's findings. Several participants described changes in their emotional responses to working with violent offenders as the course of their employment progressed in time. Initial emotions were often overwhelming or painful when certain offences or traumatic events were revealed. One participant described experiencing a sense of shock when she was informed of certain violent offences committed by an offender. She further felt a high level of anger towards the offender and found it difficult to detach, away from the work environment. This created a sense of emotional exhaustion and a further sense of detachment from people around her. Such a powerful response may well have developed into the participant experiencing vicarious traumatisation. However, the participant reflected upon her feelings and engaged in support via her colleagues and supervision. When questioned about the impact of work with violent offenders, participants reported that there had been significant changes in their emotional responses. They further revealed a sense of 'getting used' to hearing descriptions of violent offences and an attendant reduction in their emotional responses the more this occurred. It was apparent that this dampening of emotions was an adaptive process for both participant and offender as participants described an increased ability to engage on a 'deeper level' when their emotional reactions were less extreme. This reduction in emotional reactions is reported in the literature as a common feature when working with offenders (Edmunds, 1997 & Farrenkopf, 1992). It is thought that a process of systematic desensitisation occurs and this proves vital for professionals working in a forensic capacity (Edmunds, 1997). Systematic desensitisation was developed by Wolpe (1969) and it involves the diminishing of emotional responses when confronted with negative or aversive

stimuli after repeated exposure. It is apparent that the participants in this study were experiencing a process of systematic desensitisation after repeated exposure to hearing or reading about violent offences. Whilst this is clearly a helpful process for participants and offenders, it may also be problematic. It is not known if the emotional responses to repeatedly hearing about a violent offence become less vivid or if the emotional responses become supressed by the application of unconscious defence mechanisms (Lemma, 2003). If the participants’ emotional responses are suppressed, as they are intolerable, this could lead to participants being unaware of these strong emotions and this could possibly lead to participants being more vulnerable to the development of emotional burn out, stress, physical illness or vicarious traumatisation (Ellerby, 1998). It would therefore be vital for professionals to receive support in order to reflect upon the challenges of working with violent offenders and to understand the professional and personal impact of these challenges.

The challenges faced by participants were related to engagement difficulties with certain offenders due to their offence, identification with the victim or the disparity between the offender’s personality and the crime committed. The provision of clinical supervision is essential in identifying what participants can or more importantly cannot tolerate. This may also serve to increase self-awareness and reflection concerning work demands.

The findings of the study revealed that the participants’ beliefs and ideas about violent offenders, traumatised by their actions were subject to change due to increased levels of understanding and their ability to apply psychological theory to experiences and behaviours. It would therefore seem appropriate to foster and increase shared understanding (Ewers, Bradshaw, McGovern, & Ewers, 2002). This could be achieved using formulation sessions; here various professionals take the lead in presenting a shared understanding of a violent crime and offenders. The team psychologist could also provide consultation to members of staff on the application of psychological theory to practice.

Finally, there are a number of ethical issues that have important clinical implications with regard to the study’s findings. The first of these concerns the potential distress experienced by the participants due to their involvement in the

study. Several participants stated that they had not considered the personal nature of the impact, of working with violent offenders and those traumatised as a result of their actions. Furthermore, participants stated that they had not realised the levels of complexity and intensity involved in the work until they had started discussing this in the research interviews. Participants reflected on a process of consciously or unconsciously avoiding thoughts concerning work with offenders. This is consistent with the defence mechanisms employed by participants, to avoid thinking of, or experiencing the powerful emotions experienced by working closely with violent offenders. The process of exploring the participants' experiences of working with violent offenders and those experiencing 'offence related trauma', may well have caused a measure of distress for participants as unconscious thoughts and emotions could have been brought into their conscious awareness. This is clearly an integral implication for clinical practice in view of the fact that the majority of suggestions for professionals working with offenders is to acknowledge and reflect upon their emotional response to this work (Majomi, Brown & Crawford, 2003 & Conrad, 2011). It is important to remember however, that defence mechanisms such as avoidance, are often employed to foster personal coherence. Any intervention therefore that may change the management of professionals' emotions should be approached with sensitivity.

A second ethical issue that arises from the exploration of professionals' experiences of working with violent offenders and those traumatised by their actions, and which creates further clinical implications, concerns the reinforcement of a particular position, whether that be positive or negative. All participants displayed a positive desire for offenders to recover and progress and it is hoped that engagement in the study has further helped to reinforce this unconditional positive regard held by participants. However, one participant did feel that the experience of 'offence related trauma' was positive for offenders and would help to prevent re-offending. If this belief was further reinforced by involvement in this study, this could have implications for the therapeutic relationship with offenders. This belief may also pose implications and considerations for the treatment of 'offence related trauma'. Both of these ethical issues could impact upon the relationship, engagement and interventions with violent offenders and those experiencing 'offence related trauma'. It would therefore seem paramount that

adequate supervision, peer support, reflective practice and the maintenance of a healthy work life balance becomes an integral component of working with offenders.

2.6.3 Methodological Considerations and Limitations;

A qualitative methodology was chosen as an appropriate method of analysis for this study due to the limited amount of relevant literature. IPA was favoured in comparison to other methodology e.g. Grounded Theory as it offers a detailed analysis of the lived experience of participants (Smith, et al. 2009). The aims of this study were to understand a phenomenon of experience, rather than developing a theory from the data (Creswell. 2007). In order to ensure that the quality of research was at a suitable level, Yardley's principles for qualitative research were adhered to (Yardley, 2000).

There are several limitations which need to be considered in view of the study's findings. The first of these concerns recruitment. The Clinical Supervisor worked in the services that participants were recruited from. Whilst efforts were made to ensure that participants did not feel obliged to participate, this could not be guaranteed. A further ethical limitation involving recruitment centred the nature of the topic. Participants were asked to describe their experiences; including their thoughts, emotions and perceptions about violent offenders and their trauma. It is possible that participants may have been reluctant to take part in the study because of fears relating to the expression of perceived unacceptable answers. Participants who were involved may have been perceived to have described their experiences in a socially desirable way.

The second limitation of this study relates to gender imbalances in the sample. This may not be limiting in other IPA studies, but as all the offenders were male and five out of six participants female, this could have major implications for the experience that females have in working with male violent offenders. In addition, four of participants were qualified members of staff and two in the final stages of training. It is therefore difficult to gauge how the experiences of unqualified staff would differ from those who were qualified.

Due to the IPA method of analysis, the findings of the study are influenced by the biases of the researcher. These biases are considered to be part of the IPA process, but it is important to consider whether the study findings are based upon the researcher's interpretations of the data. The findings of this study therefore cannot be generalised to other populations. The implications of this would appear to suggest that different results might occur if the study was conducted by another researcher. Further methodological limitations included the lack of a focus group when developing the interview schedule and an absence of piloting the schedule. The use of a focus group and the piloting of the interview schedule would have increased result validity due to the close relationship between focus groups and pilot developed questions and the lived experience of professionals working with offenders of violent crime, traumatised by their actions.

On reflection the research area involving the exploration of professionals' experience of working with violent offenders, traumatised by their actions, is a substantial one. Whilst the researcher attempted to interpret and utilise all rich data, some may have been discarded and certain areas may have needed greater exploration.

Finally, the researcher's inexperience should be acknowledged. Whilst the necessary training in IPA was received and IPA study groups frequently used it was noted that occasionally closed questions were used during the interview process and that during analysis emergent themes were sometimes more descriptive than interpretive.

2.6.4 Recommendations for Future Research;

This is the only study, as far as the researcher is aware, that explores the experiences of professionals working with violent offenders who have been traumatised by their actions. There remain wide gaps in the literature that explore forensic mental health professionals' experiences of working with this client group and the challenges and conflicts that they may experience. Therefore, further research in this area is required in order to increase the understanding of differences and similarities in the experience of professionals working with violent offenders both in high secure hospitals and community settings.

The study's findings would suggest that further research into the aspect of emotional responses, their management and their impact upon service users may prove highly beneficial as this was an integral component of their experiences. Future research could further be directed towards the experience of violent offenders and their engagement with mental health professionals which would hopefully increase shared understanding between patients and staff.

Further research regarding professionals' attitudes towards violent and sexual offenders may prove beneficial with particular focus on perceptions about punitive practices versus the recovery model. Work directed towards differences between qualified and unqualified members of staff is warranted in order to further illuminate findings from this study.

2.6.5 Conclusion;

This study aimed to explore the experiences of professionals working with violent offenders traumatised by their actions. Six participants working in secure hospitals in the UK engaged in the study. IPA methodology was used to analyse the data and this revealed three super-ordinate themes; 'Psychological Resilience of Professionals', 'Barriers to Engagement' and 'Managing Offence Related Trauma'. Study findings revealed powerful emotional responses experienced by professionals working with violent offenders. Internal and external modes of coping were identified as coping strategies. Barriers to engagement related to the challenges that participants experienced when engaging with violent offenders. These challenges included, a disparity between offender personality and offence, an ability to identify with victims and difficulties and disparities associated with the tolerance of different crimes. Participants described a sense of increased empathy towards offenders who experienced trauma due to their violent offending and possessed a high level of unconditional positive regard for those offenders. A further understanding of the professional's experience of violent offenders in the community and in high secure hospitals would be beneficial, as would the experiences of unqualified members of staff.

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Chapter Three: Reflective Paper

Personal Reflections and Parallel Processes when Conducting Empirical Research with Forensic Mental Health Professionals.

This chapter is not intended for publication.

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3.1 Introduction;

This paper initially provides a brief reflective account of several methodological limitations and ethical dilemmas encountered when completing the empirical study. Due to a number of the limitations and dilemmas explored in chapter one and two, the main focus of this paper will offer a reflective account on the process of a novice researcher conducting an empirical study for a doctoral level programme. It will further reflect upon the important parallel processes which emerged between the researcher and participants. Reflections will finally concern the clinical implications of conducting this research and how this will progress post qualification. Due to the reflective element in this chapter, it will be written in the first person narrative.

The empirical study explored the experiences of professionals working with violent offenders traumatised by their actions. Six professionals working in forensic settings were interviewed. Data were analysed using Interpretative Phenomenological Analysis (IPA). A reflective journal was maintained throughout the research process and it is these entries which have provided the structure for this paper.

3.2 Methodological Limitations and Ethical Dilemmas;

Due to limited experience, I initially felt somewhat out of my depth conducting IPA interviews. I was aware on occasion, I presented as anxious and posed several leading questions at the same time. This limited experience could be considered as a methodological limitation. In future research, I would utilise a shorter interview schedule and allow participant involvement in its development. I feel this would have been an invaluable and important process as some questions seemed redundant in relation to the interview guide used.

However, as my familiarity with this type of interview process increased I relaxed and actively listened with interest to the experiences of the participants, rather than focusing on forthcoming questions. I found that I had ‘entered the participant’s world’ (Smith et al. 2009). This is essential to the double hermeneutic that underpins IPA (Smith & Eatough, 2006). However, this process did pose a challenge. I observed that when the participants were describing an event that was

emotive, I found myself experiencing a similar emotion. This could be viewed as counter-transference in Psychodynamic therapy i.e. where the therapist experiences the emotional position of the participant (Malan, 1995). This posed a further dilemma because I needed to refrain from engaging in a dialog that would be therapeutic in nature. I wanted to alleviate their distress and 'make it ok'. This seemed to highlight the role tensions of being a 'scientist-practitioner' (Beutler, Williams, Wakefield & Entwistle, 1995). On further reflection I also wondered if I also wanted to reduce my own uncomfortable emotive feelings. This is a common dilemma faced by researchers whose topic is sensitive in nature and management and containment of personal emotions is paramount (Watts, 2008). I did however, notice that as the interviews progressed I was able to contain my own responses and the participant's emotions, without using a therapeutic dialogue.

Participant recruitment could also be seen as a methodological limitation. Confidentiality requirements meant that participant recruitment was carried out by the clinical supervisor. He also worked with the participants. This may have resulted in the participants feeling obliged to participate in the study, although every effort was made to reduce this obligation. Due to the nature of the research topic, some participants may have provided socially desirable responses because of the dual role of the clinical supervisor. The research topic may well have been another factor resulting in a small sample size.

During the conduct of empirical research, I have been mindful of the ethical responsibilities involved. Whilst I maintained the general ethical principles set out by the British Psychological Society (BPS, 2009a; BPS, 2009b) e.g. 'informed consent', 'the right to withdraw' and 'confidentiality' I experienced difficulty in providing a full debrief to some participants. This appeared largely due to time pressures faced by several participants. Whilst all participants were provided with a debrief, it was not completed to my personal standards. I recognise this as a personal ethical dilemma which may increase due to current time pressures faced in the National Health Service.

3.3 Conducting Empirical Research;

During the research process I was struck by a number of processes that I experienced. Some of these were short lived, but others remain and are still

present at the time of writing. The following section will discuss and explore the processes I encountered when conducting empirical research.

3.3.1 Self efficacy;

After being accepted on the Clinical Psychology Doctorate Course the initial sense of excitement subsided to be replaced with feelings of anxiety and fear in relation to the impending research project. I always considered that this element would pose a significant personal and professional challenge. I had some substantial doubts about my abilities in relation to conducting a major piece of research and tended towards a good deal of self-criticism. When reviewing my reflective journal, I have been struck by thoughts such as;

"I am not a researcher, I won't be able to do it"
"Everyone else is very good at research…I am not!"

Self-efficacy is described as an individual's belief about their abilities to complete a certain task (Zimmerman, 2000). It is apparent that my initial levels of self-efficacy in relation to competing research were relatively low. I additionally, felt that my lack of self-efficacy had a detrimental effect on my level of motivation, a factor which was somewhat 'out of character'. I also found that when I did engage in my research planning, the duration of the work was short and infrequent- a feature which is also uncharacteristic (Schunk, 1991).

However, via clinical and academic supervision I was able to reflect upon my beliefs and self-efficacy and identify their origins. The use of supervision was paramount in enabling me to feel supported, motivated and sufficiently confident in order to begin the research process. I also found the use of Cognitive Behavioural Therapy (CBT) highly beneficial is challenging and addressing my thought patterns.

3.3.2 Perfectionism;

Having commenced the research process my anxieties began to subside. I remember that whilst I felt more confident in my abilities, I was confronted by the

need to manage levels of perfectionism. This involved the choice of an 'appropriate' topic, making 'sound' independent decisions and 'getting things right'. This in part seemed to be a positive process as I routinely followed the BPS (2009) and Smith, Flowers and Larkin's (2009) guidelines on completing ethical and methodologically sound research. However, I found myself overly focused on certain elements which had implications for time constraints and seemed to increase feelings of uncertainty.

It is these traits which I need to be mindful of, not only when conducting future research, but also during my career as a clinical psychologist (Mollon, 1989). During this research process the use of supervision, reflective practice groups and personal exploration has enabled me to acknowledge and become increasingly aware of these perfectionist tendencies and to manage them (Reid et al. 1999).

3.3.3 Updating Ideology;

The use of IPA methodology has proved a fascinating and daunting process. This was my first experience of its usage and I was initially overwhelmed by requisite interpretation levels. I was reassured however, to discover that this is a common response experienced by novice researchers using IPA methodology (Smith, Flowers & Larkin, 2009 & Shinebourne, 2011). I feel that my attitude and responses to IPA became much more positive during the course of my research.

Reflections on the commencement of the research process reveal that my beliefs about it were negative and my self-efficacy low. However, as the process progressed, I noticed an observable shift in my beliefs and feelings. I was able to increase my engagement and discussions about research and IPA methodology, attended IPA peer groups and shared analysis for validation. My ideology appeared to have changed as had my self-efficacy. I felt enthused by the research and surprised myself by noting the possibility of future research projects.

3.4 Parallel Processes;

Reflection on the participants' experiences of working with violent offenders, traumatised by their actions, has led to observations involving the parallel

processes that have occurred between the participants and myself. These parallels appear to be closely linked to emotional responses and coping. Therefore, the following section will be considered in relation to the first super-ordinate theme which emerged from the empirical data; Psychological Resilience of Professionals, which encompasses emotional responses and coping. I have chosen to explore the parallel processes as I feel it serves to highlight the complexity of working with violent offenders.

3.4.1 Emotional Responses;

During the research stages involving data collection and analysis I noticed that I experienced a vast array of emotional responses ranging from sadness to repulsion. This aspect was also described by participants in relation to their work with violent offenders. Perhaps the most significant personal emotional response was in response to Participant 1 describing an individual who had raped an elderly woman. The entry in to my reflective journal was as follows;

"I can't stop thinking about it, that poor woman. How can anyone do that? It makes me angry!"

I remember that as the interviews progressed, I found myself experiencing emotional responses towards the offender, the victim and also the participants. On occasions I felt anger and fear in relation to the offender whilst in other stances I experienced feelings of sadness for the circumstances which had led to the offenders' involvement in the offence and the implications that this had for their life. In relation to victims my overwhelming response was one of sorrow, especially when considering the impact on their life and future. I wrote in my journal in response to one of the victims;

"I'd like to know how she is now. Has she recovered? Is she ok?"

Several participants described the need for a balance in their thoughts in relation to the offender and victim and the 'danger' of focusing on one at the expense of the other. I had personal experience of this following one interview where I spent a good deal of time focused on the victim, perhaps to the detriment of the offender.

I was further struck by the emotional responses displayed by certain participants. I felt, on occasion, that I either wanted to offer recognition of their strength and resilience during their work or to offer reassurance when they described the emotional aspects of their work. In general, I felt inspired by participants' attitudes and their desire to promote offender recovery.

I further noticed that when participants described violent offences I experienced powerful feelings such as; sadness, anger, fear and repulsion. I therefore, questioned my ability to actively listen to the participants when I was experiencing such strong emotions. This sense of conflict was also reflected in the participant's experiences of working with violent offenders. The narratives often illustrated a need to find a way of managing their own feelings in order to adequately empathise with and support offenders. I too needed to manage my own feelings.

3.4.2; Internal and External Coping Mechanisms;

During the course of my research I noticed that entries into my reflective journal dramatically decreased. Colleagues also noted that my engagement in research discussion became increasingly infrequent. During this period I did experience difficulties in managing the competing demands of the research process, clinical placements and my personal life. During one particular reflective practice group I found myself unable to express how emotional I actually felt. This was somewhat 'out of character' as personal reflection as a process which I normally engaged in. I was, however, able to concede that, at times, I felt 'numb' and 'cut-off'. It appeared that I had psychologically separated the various components of my life and that all emotion had been unconsciously removed.

Using a Psychodynamic framework, further reflection suggested that I had in fact experienced heightened levels of emotion in response to the research process, placement activities and personal difficulties. In response, I had unconsciously

implemented strategies in order to cope and defend myself against unmanageable emotions (Leema, 2003 & Leiper, 2006).

This internal process is similar to that experienced by the participants who described a series of internal coping mechanisms utilised in work with violent offenders. Coping mechanisms by participants included; person and crime separation, cognitive avoidance and the process of desensitisation. It appears therefore that for both the participants and myself, the implementation of such strategies provided an appropriate defence mechanism against emotional responses.

In addition to the use of internal coping strategies, I was aware that I had been exercising and socialising more frequently. I made a conscious effort to maintain a healthy work-life balance. At times, however, this balance seemed difficult to achieve and I often felt overwhelmed. This process seemed to reflect the external coping mechanisms implemented by the participants when working with violent offenders.

However, via supervision, reflective practice groups and mindfulness based practice I felt able to connect with my emotional experiences again. During the research process, although sometimes challenging, I have been able to identify personal coping mechanisms whist in stressful situations. The process of feeling emotionally ‘cut off’ and ‘numb’ is something that I have no great experience of and that I will need to be mindful of in future practice. The expression and reflection of emotive experiences and the maintenance of a healthy work-life balance is something that will be beneficial in my work as qualified psychologist (Jones & Westman, 2013).

3.5; Clinical Implications;

The completion of the empirical research has been an invaluable process professionally and personally and will inform my work as a qualified psychologist in the future.

3.5.1; Professional Practice;

Due to the methodological limitations of the papers reviewed in the literature review and the use of Interpretive Phenomenological Analysis (IPA) to analyse the empirical study, only tentative conclusions can be drawn about violent offenders experiencing trauma as a result of their actions. Additionally the experience of professionals working with violent offenders cannot be generalised to wider populations.

However, the findings of both the literature review and empirical study have clinical implications for practice. It will be important for myself and professionals working with offenders to consider the psychological impact of committing a violent act and to assess for Post-Traumatic Stress Disorder (PTSD) in response to such an act. The early assessment and treatment of 'offence related PTSD' is integral for offender recovery and the reduction of re-traumatisation. The experiences of professionals working with violent offenders are also important for the well-being of staff and also for offenders. Findings from the empirical paper revealed that professionals working with violent offenders experience a range of emotional responses and implement coping strategies to manage these emotions. Further interpretation suggested that there are certain factors that prevent engagement with professionals and offenders and that the presence of 'offence related PTSD' alters the therapeutic processes. These conclusions will therefore be beneficial to me as a qualified psychologist during the provision of supervision and consultancy to professionals working with violent offenders. I further envisage that this new knowledge will be paramount for professionals working in forensic practice in engagement with and recovery of violent offenders.

3.5.2; Personal Practice;

The process of conducting empirical research has been overall a positive one. Although on occasion, I have felt overwhelmed and held limited self-efficacy this in itself has led to new personal insights. I have been able to reflect on my ability to cope in stressful situations, particularly when confronted with competing demands. I have further identified personality traits such as perfectionism and how this can impact upon my work. These experiences have enabled me to consider

new coping mechanisms, which will not only be beneficial in personal relationships, but more importantly in my role as a qualified psychologist. I have also developed an increasing confidence in the conduct of research.

3.6; Conclusions;

Whilst reflecting on the conduct of empirical research, it was apparent, that, on occasion, I possessed low levels of self-efficacy and had a tendency to engage in traits such as perfectionism. However, as the process progressed these facets i.e. self- efficacy and personal ideology did manifest definite signs of improvement.

It also became apparent that in the empirical study parallel process occurred between myself and the participants. These parallels involved emotional responses to violent offenders and coping mechanisms when confronted with difficult emotions. The findings from the literature review and empirical study, although, tentative in nature, highlight clear clinical implications for practice involving assessment and treatment of ‘offence related PTSD’ and supervision requirements for professionals working with violent offenders.

Reflections on the conduct of empirical research has enabled me to identify that the use of supervision, self-reflection and practices such as CBT and mindfulness have been integral to my professional and personal development.

3.6; References;

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Appendices

Appendix One; Author Guidelines; Journal of Forensic Psychology

Instructions for Authors

Our mission is to link the science and practice of forensic psychology by making research and applications directly available to all forensic psychologists.

Contributions should be of interest to forensic psychologists, and must survive peer review. Within those broad parameters, we welcome empirical research, case studies, review articles, theoretical papers, practical applications, policy recommendations, and articles relevant to the teaching of forensic psychology. When warranted, the editors will solicit other papers such as critical commentaries, debates, exchanges, and replies to published articles. We also invite reviews of books, psychological tests, or other materials that would be of professional interest or use for forensic psychologists (including practice, research, teaching of forensic psychology, etc.).

By submitting a manuscript, the authors attest that the article is not currently under review or published elsewhere (including journals, newspapers, blogs or web sites).

For all submissions, include an abstract of approximately 100 words that appears after the title page, but before the main text. Immediately following the abstract, please provide up to 8 key words.

Although one of the virtues of an on-line journal is that we are not subject to the same page limitations as print journals, we must be sensitive to our readers' time and patience. Hence, contributors are strongly urged to be concise, using no more words or pages than necessary. A typical manuscript might be about 20-30 double-spaced pages. Shorter articles are fine, when that fits, and we expect that some important articles will run up to 50 pages. We can publish longer works, but we encourage this alternative: Submit a moderate-length manuscript for us to publish on our website, with a link to external content (perhaps in appendix form) on an external site, such as your own website.

Manuscripts should be submitted using Microsoft Word templates. See below for additional information. We recommend and request that you perform a spelling and grammar check with the writing style set to Technical (see Preferences - Spelling and Grammar - in Word). Alternatively, a clean manuscript saved in rich text format (rtf) is acceptable.

Author Guidelines

To decrease the delay between submission and publication of accepted manuscripts, we are asking authors to use a template for creating their manuscripts for submission. The template file is a downloadable .doc file that has fields for author modification. Use of these templates will make post-proof processing of manuscripts significantly faster, producing noticeable decreases in time between submission of final proof-edited manuscript and publication.

An author submitting an original article should download the file OAJFP submission template-4.doc and insert into this file the manuscript text, figures, tables, references, etc., and save the file with a unique identifying name (e.g., johnson_OAJFP_final.doc).

Email manuscripts to the editor at gregdeclue@me.com with OAJFP in the subject line. The body of the email should include name and contact information for the author(s) and the title of the manuscript.

Manuscripts should be prepared according to the latest edition of the Publication Manual of the American Psychological Association, but with all materials and attachments single-spaced. Note that APA Style now recommends two spaces at the end of a sentence (except in the reference section of the paper).

The authors are responsible for obtaining written permission (for nonexclusive world rights in all languages for current use, both electronic and in print, and in future editions) from copyright owners for quotations of greater than 500 words or reprinting tables or figures. Contributors should include a cover letter containing their email addresses, a statement that the findings are original, unreported except as noted in the document, and not submitted elsewhere. Contributors of original research should state that the work contained in the submitted manuscript conforms to the human and/or animal ethical legislation appropriate to the country in which the work was carried out, and should cite that legislation. The methods of informed consent should be specified, and the name of the approving Institutional Review Board reported. Instructions for submitting final electronic manuscript copy will be provided upon acceptance of the manuscript.

Check APA style for citing legal cases.

Graphs, tables, etc. should appear in the manuscript where they should appear in the final document.

We encourage the use of hyperlinks, both within the manuscript (e.g., from text to the reference page) and to external content on the Internet (e.g., author's email or website, or the article you are citing).

In order to keep copy-editing costs down, we strongly encourage authors to submit manuscripts that are as error-free as possible. Very strongly. Ask a colleague to read the manuscript carefully before you submit the manuscript, and send us the manuscript in the best condition you can.

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Appendix Two; Author Guidelines; Journal of Forensic Practice

Submissions to the *Journal of Forensic Practice* are now made using ScholarOne Manuscripts, the online submission and peer review system. Registration and access is available at http://mc.manuscriptcentral.com/jofp
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- Submit your manuscript

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Each paper is reviewed by the editor and, if it is judged suitable for this publication, it is then sent to at least two independent referees for double blind peer review. Based on their recommendation, as well as consultation between relevant Editorial Board members the editor then decides whether the paper should be accepted as is, revised or rejected.

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In addition to the manuscript requirements detailed below each paper should also include a bulleted list of the specific **implications for practice** of the paper/research. This should be placed at the end of the paper and before the references.

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Manuscript requirements

Please prepare your manuscript before submission, using the following guidelines:

Format	All files should be submitted as a Word document
Article Length	Articles should be between 5000 and 7500 words in length. This includes all text including references and appendices. Please allow 350 words for each figure or table.
Article Title	A title of not more than eight words should be provided.
Article Title Page	An **Article Title Page** should be submitted alongside each individual article using the template provided. This should include: • Article Title • Author Details (see below) • Acknowledgements • Author Biographies • Structured Abstract (see below) • Keywords (see below) • Article Classification (see below)
Author Details	Details should be supplied on the **Article Title Page** including: • Full name of each author • Affiliation of each author, at time research was completed • Where more than one author has contributed to the

	article, details of who should be contacted for correspondence • E-mail address of the corresponding author • Brief professional biography of each author.
Keywords	Please provide up to 10 keywords on the **Article Title Page**, which encapsulate the principal topics of the paper (see our "How to... ensure your article is highly downloaded" guide for practical help and guidance on choosing search-engine friendly keywords). Whilst we will endeavour to use submitted keywords in the published version, all keywords are subject to approval by Emerald’s in house editorial team and may be replaced by a matching term to ensure consistency.
Article Classification	Categorize your paper on the **Article Title Page**, under one of these classifications: • Research paper • Viewpoint • Technical paper • Conceptual paper • Case study • Literature review • General review.
Headings	Headings must be concise, with a clear indication of the distinction between the hierarchy of headings. The preferred format is for first level headings to be presented in bold format and subsequent sub-headings to be presented in medium italics.
Notes/Endnotes	Notes or Endnotes should be used only if absolutely necessary and must be identified in the text by consecutive numbers, enclosed in square brackets and listed at the end of the article.
Research Funding	Authors must declare all sources of external research funding in their article and a statement to this effect should appear in the Acknowledgements section. Authors should describe the role of the funder or financial sponsor in the

	entire research process, from study design to submission.

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Appendix Three; Letter of Ethical Approval from Staffordshire University

STAFFORDSHIRE UNIVERSITY

Faculty of Health Sciences

ETHICAL APPROVAL FEEDBACK

Student name:	Hannah Cowan
Title of Study:	Staff perceptions of 'perpetrator induced' trauma experienced by service users in inpatient forensic mental health settings.
Award Pathway:	DClinPsy
Status of approval:	Approved

Action now needed:

Your project proposal has now been approved by the Faculty's Ethics Panel and you may now commence the implementation phase of your study. You do not need to approach the Local Research Ethics Committee. You should note that any divergence from the approved procedures and research method will invalidate any insurance and liability cover from the University. You should, therefore, notify the Panel of any significant divergence from this approved proposal.

You should arrange to meet with your supervisor for support during the process of completing your study and writing your dissertation.

Comments for your consideration:

Thank you for forwarding the amendments requested by the Panel

pp **Signed**: Professor Vish Unnithan
Chair of the Faculty of Health Sciences Ethics Panel

Date: 28th May 2013

Appendix Four; NHS Research and Development (R&D) Approval

South Staffordshire and Shropshire Healthcare NHS
NHS Foundation Trust

Our Ref: AB/R285

23 October 2013

Research and Development
Block 7
St George's Hospital
Corporation Street
STAFFORD
ST16 3AG

Tel: (01785) 221168
Email: audrey.bright@sssft.nhs.uk

Ms Hannah Cowan
Trainee Clinical Psychologist
Staffordshire University
Clinical Psychology Department
Faculty of Sciences
Leek road
Stoke on Trent ST2 4DF

Dear Hannah

Study title: Staff perceptions of 'perpetrator induced' trauma

We have considered your application for access to staff from within this Trust in connection with the above study.

On behalf of the Trust the Lead Officer for Research Governance and the Responsible Care Professionals within the Psychology Directorate have now satisfied themselves that the requirements for Research Governance, both Nationally and Locally, have been met and are happy to give approval for this study to take place in the Trust, with the following provisos:

- That all researchers coming into the Trust have been issued with a letter of access by ourselves
- That you conform to the requirements laid out in the letters from the University Ethics committee dated 28 May 2013 which prohibits any changes to the agreed protocol
- That you keep the Trust informed about the progress of the project at 6 monthly intervals
- If at any time details relating to the research project or researcher change, the R&D department must be informed.

Your research has been entered into the Trust database and will appear on the Trust website.

As part of the Research Governance framework it is important that the Trust are notified as to the outcome of your research and as such we will request feedback once the research has finished along with details of dissemination of your findings. You will be asked to provide a copy of the final report and receive an invitation to present final feedback via our research seminar series. To aid dissemination of findings, copies of final reports are placed on our Trust Website. To this end, please contact me towards the completion of the project to discuss the dissemination of findings across the Trust and a possible implementation plan.

If I can help in any other way please do not hesitate to contact me.

Yours sincerely

Mrs Kim Thompson
Acting R&D Manager

Appendix Five; Participant Information Sheet;

South Staffordshire and Shropshire Healthcare NHS
NHS Foundation Trust

STAFFORDSHIRE UNIVERSITY

Keele University

Participant Information Sheet Version 2. 12/02/2013

Professionals Experiences of Working with Offenders of Violent Crime and Offence Related Trauma

My name is Hannah Cowan and I am a Trainee Clinical Psychologist. I am studying at Staffordshire and Keele Universities and as part of this I need to conduct a piece of research.

You are therefore being invited to take part in a research study. Before you decide please take time to read the following information so that you understand why the research is being conducted. If you have any questions please do not hesitate to contact me.

What is this research project about?

This project aims to speak to staff members who work in inpatient forensic mental health settings who have been identified as directly working with service users who experience psychological trauma as a direct result of their offending behaviour or their behaviour that has put others at risk. This type of trauma is known as 'offence related' trauma.

For the purpose of this study, psychological or 'offence related' trauma is defined as intense emotional, cognitive and/or physical reactions in relation to committing and therefore witnessing a threatening or violent event. This response can include emotional, cognitive (how people think), behavioural (what people do) and physiological difficulties (how peoples' bodies responds).

What is the purpose of this study?

The primary purpose of this study is educational i.e. to increase understanding of the factors affecting relationships between staff and service users. This research project is a requirement of a Clinical Psychology Doctorate Course at Staffordshire and Keele University. The Clinical Psychology Doctorate Course is funded by the NHS.

Who will be taking part?

The project requires 6-10 participants all of whom work for the NHS at secure hospitals. The participants can be any staff member that has direct contact with service users who experience psychological trauma due to their offending behaviour or behaviour that has out others at risk. This trauma is known as 'offence related trauma'.

What will it involve for me?

Your involvement in this project is entirely voluntary.

If you decide to take part you will be asked to talk about your experiences of working with violent offenders and understandings of the trauma that is

experienced by service users as a result of their offending or behaviour that has put others at risk. You may also be asked how working with these service users impacts upon yourself. You do not have to talk about anything that makes you uncomfortable or is distressing to you. You will be asked to take part in one interview only. The interview will last approximately 60 to 90 minutes and will be audio taped. The interview will take place in the outpatient meeting room.

I will also collect information about things such as your age, gender, ethnicity, job role and employment history. The purpose of collecting this information is purely to help us describe the people who choose to take part in the study.

Will my participation be confidential?
Yes. All information about you will be handled in confidence (although in the event that any participant discloses harm or potential harm to themselves or others, or criminal activity, it will be necessary to breach confidentiality in order to notify someone in an appropriate position).

However your responses are anonymous but not confidential. This means whilst no identifiable information (e.g. names, job roles) will be used anywhere in the study, any response you do give during your interview will be read by my clinical and academic supervisors, and if the study is published in an academic journal, other people will also be able to read your responses. Your name will not be quoted in the findings, although direct quotes from interviews will be used in the write-up of the study (with no information to show who has said what in the interviews). Your name or personal details will not be used in any part of the study. Instead you will be given a code number for the research team to identify data.

Only the research team will have access to the audiotapes of the interviews and interview data. The audiotapes and interview data will be kept locked away and then destroyed after 10 years (which is a Staffordshire University procedure).

What are the advantages and disadvantages of taking part?
We hope that the study may highlight the level of awareness that staff have of 'offence related trauma' and the way in which this is perceived. The level of awareness and perceptions held by staff may help the general understanding of therapeutic relationships between staff and service users who experience psychological trauma related to their offending and may inform the development of future staff training.

It is possible that talking about your personal experiences may cause you to feel some difficult emotions. The person interviewing you will be sensitive to this and has previous experience of interviewing people with similar experiences to yours. You will have the opportunity to discuss any concerns at the end of the interview and you are free to withdraw from the project at any point. You will also be told about the support networks available to you if necessary.

Do I have to take part?
It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form.
If you decide you do not wish to take part we would like to thank you for taking the time to read this information.

Can I withdraw from the study if I change my mind?
If you decide to take part you are still free to withdraw at any time, without giving a reason.

Will taking part in the study cost me anything?
You will need to make the time to attend the interview session. This might mean agreeing with your manager to attend the interview during work time, or attending during a convenient time for yourself. It may mean that the interviews take place on your day off or before you start or after you finish work. However, the researcher will try and make the interviews at the most convenient time for you.

What should I do if I decide to take part?
If you decide you want to take part please either email XXXX on XXXX to express your interest or complete the 'opt in' slip at the bottom and place in the box provided. The researcher will then contact you to arrange a convenient time for the interview to take place. You will be asked to sign a consent form stating that you have read the information sheet and that you agreed to take part in the project. If you need more information before making a decision please contact the researcher on the email address given.

Who is conducting the research?
The research is being conducted by Hannah Cowan who is a Trainee Clinical Psychologist at Staffordshire and Keele University.

Who has reviewed this study?
All research is looked at by several panels, to protect your safety, rights, well being and dignity. This study has been reviewed and given favourable opinion by Staffordshire University Ethics Committee and South Staffordshire and Shropshire Foundation NHS Trust's Research and Development Department.

What if there is a problem?
Complaints;
Taking part in the study should involve no particular risks to you. However any complaints about the way you have been dealt with during the study or any possible harm you might suffer will be addressed.

If you have a concern about any aspect of this study, you should ask to speak to the researcher who will do their best to answer your questions. Please speak to XXX on XXXXX

If you remain unhappy and wish to complain formally, you can do this by contacting XXX, Clinical Studies Officer/Research Governance Administrator, South Staffordshire and Shropshire NHS Foundation Trust, on XXXX or XXXXX

You can also contact an independent service for advice or to discuss any concerns about this project. You can do this by contacting the Patient Advice and Liaison Service (PALS) on XXXX between 9.00 am – 5.00 pm Monday to Friday or by emailing XXXX

Further information;
For further information from the researcher for this project, please contact XXXX on XXXXX.

If you would like to participate in this study or you would like to find out more information before you agree to take part, please fill in your details below and leave this slip in the box provided within 2 weeks. Many thanks for taking the time to read this information sheet.

Appendix Six; Informed Consent Form

South Staffordshire and Shropshire Healthcare NHS
NHS Foundation Trust

STAFFORDSHIRE UNIVERSITY

Keele University

INFORMED CONSENT FORM
Version 2. 12/02/2013

Title of study: Professionals Experiences of Working with Offenders of Violent Crime & Offence Related Trauma

Name of Principal Investigator: Hannah Cowan
Site; Secure Hospitals
REC approval number:
Participant ID:

Thank you for reading the information about my research project. If you would like to take part, please read and sign this form.

PART A: Consent for the current study

PLEASE INITIAL THE BOXES IF YOU AGREE WITH EACH SECTION:

1. I have read the participant information sheet dated 12/02/2013 for the above study and have been given a copy to keep. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my care or legal rights being affected. ☐

3. I agree to my interview being audio recorded and I understand that transcripts of my interview will be anonymised. ☐

4. I understand that data collected during the study, may be looked at by individuals from Staffordshire University, or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my data. I understand that the information will be kept confidential. ☐

5. I am interested in future research studies and give permission to be contacted. ☐

6. I agree to the use of anonymised quotes being used within the final report ☐

7. I agree to participate in this study ☐

Participant: name surname	Date	Signature

Researcher taking consent: name surname	Date	Signature

Appendix Seven; Interview Schedule

Semi structured interview guide; Version 2. 12/02/2013

Title of study: Professionals Experiences of Working with Offenders of Violent Crime and Offence Related Trauma

Introductions;

- Introduce the researcher
- Introduce the purpose of the research
- Explain structure of interview and timing (60-90 mins)
- Consent form/confidentiality and signature
- Queries or questions

Basic demographics;

- Gender
- Age
- Job role
- Length of time working at this secure unit
- How much patient experience do you have

Offence Induced Trauma;

Firstly the interviewer is to describe the concept of 'offence related trauma' and to check that the participant understands this before asking any questions.

1) Could you please tell me about someone you have supported that experiences psychological trauma as a result of their offending behaviour or their behaviour that has posed a significant risk to others?

2) What gave you the idea that that person was experiencing psychological trauma?

3) When did you notice that they were experiencing difficulties with psychological trauma?

   - What did you think about it?
   - What were your opinions?

4) If you know, could you please describe in a way that is comfortable for you, the type of offending behaviour or behaviour that posed a significant risk to others that this person carried out?

5) Knowing that this person was experiencing psychological trauma as a direct result of their behaviour, did it a make a difference to how you supported them?

    - What are your opinions about this trauma?

6) Has there been any impact on you when supporting someone with these difficulties?

    - If yes, how did you manage this?
    - What have been the challenges?
    - If no, why do you think that was?

7) How has the type of offending behaviour/behaviour that has posed a high risk to others affected your ability to support someone?

    - If it has- how have you looked after your own needs?
    - If it hasn’t- why do you think that is?

8) The questions you’ve just answered were about the psychological trauma caused by that type of behaviour (based on the answers given). Would there be any offending behaviour/risks to others that you found more difficult? E.g. involving children? Family members?

    - Why?
    - What would your thoughts/understanding about the psychological trauma be then?

9) Would there be an offending behaviour/behaviour that posed a high risk to others that would be easier to support?

- What would your thoughts/understanding about the psychological trauma be then?

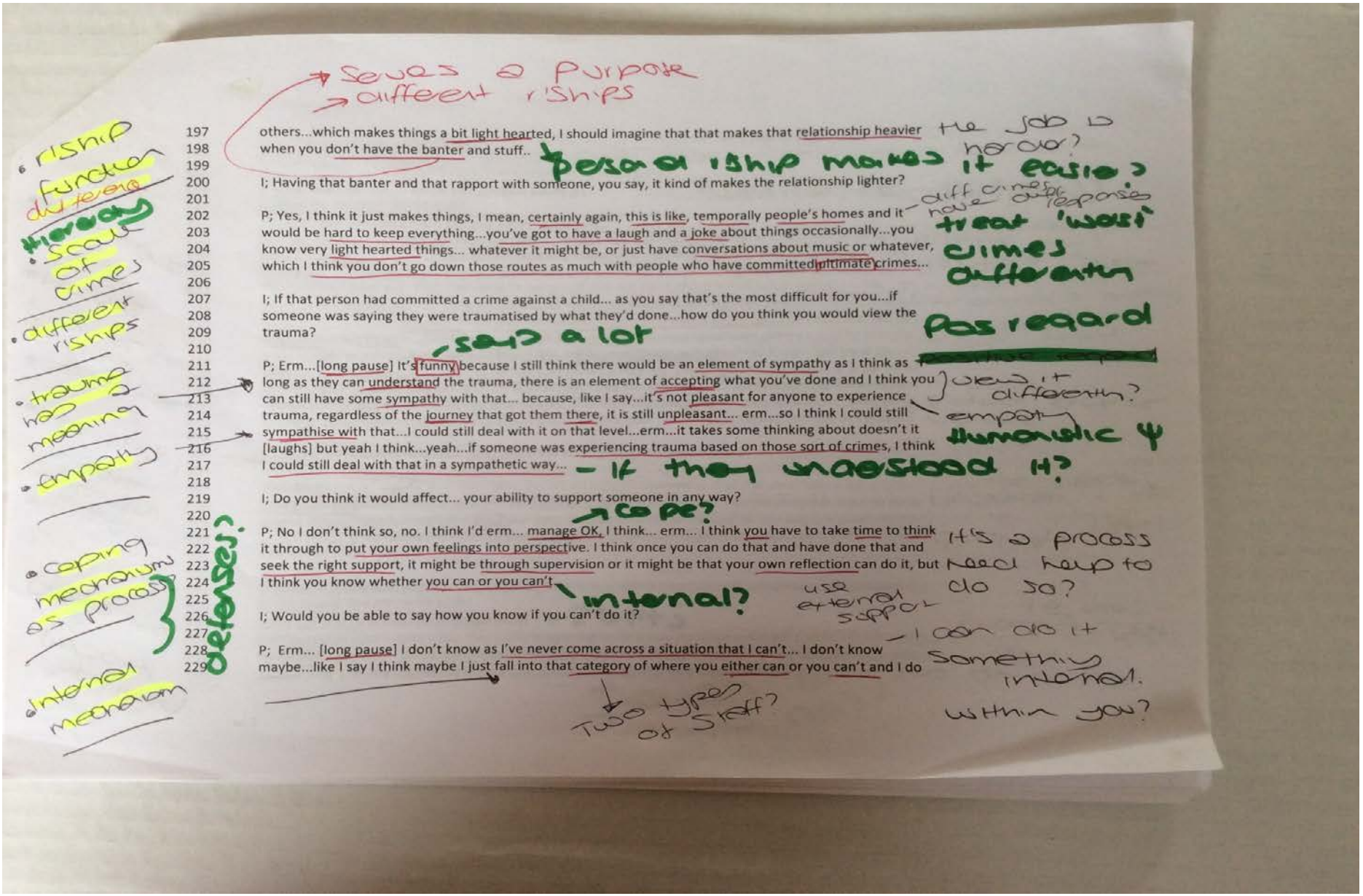
10) Do you think your attitudes/thoughts about this kind of trauma/client group were different when you first started working here?

- Has your attitude towards different crimes changed?
- Has the length of time working here influenced anything?
- Have your attitudes about service user trauma changed anything?

Session close;

- Thank you
- Debrief/support networks
- Questions and concerns

Appendix Eight; Examples of Analysis; Two Participant Transcript Extracts



others...which makes things a bit light hearted, I should imagine that that makes that relationship heavier when you don't have the banter and stuff..

I; Having that banter and that rapport with someone, you say, it kind of makes the relationship lighter?

P; Yes, I think it just makes things, I mean, certainly again, this is like, temporally people's homes and it would be hard to keep everything...you've got to have a laugh and a joke about things occasionally...you know very light hearted things... whatever it might be, or just have conversations about music or whatever, which I think you don't go down those routes as much with people who have committed intimate crimes...

I; If that person had committed a crime against a child... as you say that's the most difficult for you...if someone was saying they were traumatised by what they'd done...how do you think you would view the trauma?

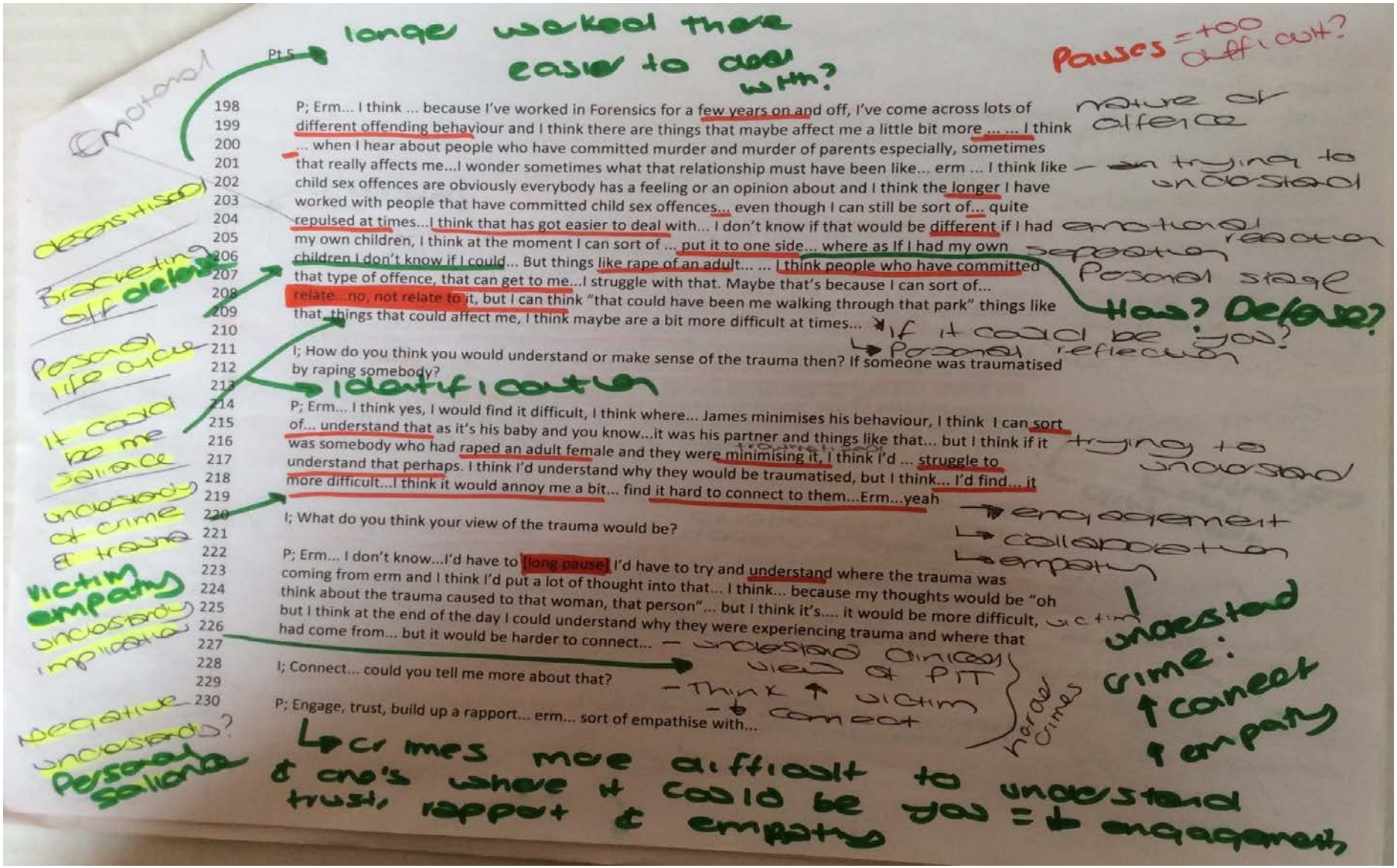
P; Erm...[long pause] It's funny because I still think there would be an element of sympathy as I think as long as they can understand the trauma, there is an element of accepting what you've done and I think you can still have some sympathy with that... because, like I say...it's not pleasant for anyone to experience trauma, regardless of the journey that got them there, it is still unpleasant... erm...so I think I could still sympathise with that...I could still deal with it on that level...erm...it takes some thinking about doesn't it [laughs] but yeah I think...yeah...if someone was experiencing trauma based on those sort of crimes, I think I could still deal with that in a sympathetic way...

I; Do you think it would affect... your ability to support someone in any way?

P; No I don't think so, no. I think I'd erm... manage OK, I think... erm... I think you have to take time to think it through to put your own feelings into perspective. I think once you can do that and have done that and seek the right support, it might be through supervision or it might be that your own reflection can do it, but I think you know whether you can or you can't

I; Would you be able to say how you know if you can't do it?

P; Erm... [long pause] I don't know as I've never come across a situation that I can't... I don't know maybe...like I say I think maybe I just fall into that category of where you either can or you can't and I do



P; Erm... I think ... because I’ve worked in Forensics for a few years on and off, I’ve come across lots of different offending behaviour and I think there are things that maybe affect me a little bit more ... ... I think ... when I hear about people who have committed murder and murder of parents especially, sometimes that really affects me...I wonder sometimes what that relationship must have been like... erm ... I think like child sex offences are obviously everybody has a feeling or an opinion about and I think the longer I have worked with people that have committed child sex offences... even though I can still be sort of... quite repulsed at times...I think that has got easier to deal with... I don’t know if that would be different if I had my own children, I think at the moment I can sort of ... put it to one side... where as If I had my own children I don’t know if I could... But things like rape of an adult... ... I think people who have committed that type of offence, that can get to me...I struggle with that. Maybe that’s because I can sort of... relate...no, not relate to it, but I can think “that could have been me walking through that park” things like that, things that could affect me, I think maybe are a bit more difficult at times...

I; How do you think you would understand or make sense of the trauma then? If someone was traumatised by raping somebody?

P; Erm... I think yes, I would find it difficult, I think where... James minimises his behaviour, I think I can sort of... understand that as it’s his baby and you know...it was his partner and things like that... but I think if it was somebody who had raped an adult female and they were minimising it, I think I’d ... struggle to understand that perhaps. I think I’d understand why they would be traumatised, but I think... I’d find... it more difficult...I think it would annoy me a bit... find it hard to connect to them...Erm...yeah

I; What do you think your view of the trauma would be?

P; Erm... I don’t know...I’d have to [long pause] I’d have to try and understand where the trauma was coming from erm and I think I’d put a lot of thought into that... I think... because my thoughts would be “oh think about the trauma caused to that woman, that person”... but I think it’s.... it would be more difficult, but I think at the end of the day I could understand why they were experiencing trauma and where that had come from... but it would be harder to connect...

I; Connect... could you tell me more about that?

P; Engage, trust, build up a rapport... erm... sort of empathise with...

Appendix Nine; Super-ordinate and Emergent Themes

PT1

Engagement factors;

Shared value base increases engagement	256-257
Personality influences engagement	306-307

Skill set;

Recovery focused	62-63
Empathic towards offender	42-43, 450-452
Ability to change/inspire	513
The need for unconditional regard	382
Therapy completion & satisfaction	55-56
Perception of offenders	77-78
Therapy does help	176-177
Bracketing off crimes & person	122-123
'Forgetting' about crimes	126-127
Avoiding discussing the crime	222-224
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Pre-conceived ideas	115-116
Identification to crime	411-413
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Predictability of offence	140-141
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Understanding the environment;

Psychological

Clients' 'playing the system'	164-166
Living in a 'faulty system'	179-181

Desire to understand;

Making sense of the crime	12-18
Understanding why the offence happened	232-236

Considerations of offence related trauma;

Resources to manage feelings;

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Trauma as a punishment	421-422
Mindful of trauma	538-539
Belief system changes	554-564

Challenges to therapeutic relationship:

Personal identification with offender	39-43
Utilising support	48-49
Identification with values of offender	249
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Personal versus professional conflicts	333-337
Professional groups perception of progress	206-208
Work demands	489-490

PT2

Offence related trauma is different; **Perception of crime;**

Function of trauma	442-443
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Scaling of crimes	205
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PT5

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Trying to make sense	92-93
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Positive regard	181

Support mechanisms;

Team support	293-294
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Placing self in victim role	325
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