VIOLENT THOUGHTS AND FANTASIES IN A HIGH-SECURE MENTALLY DISORDERED OFFENDER GROUP: AN EXPLORATORY STUDY

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ABSTRACT

There is a well established association between thinking and doing and so it is no surprise that thinking about violence can sometimes be associated with risk of violent behaviour. Violent thoughts are recognised as a treatment target in many offender treatment programmes (e.g. Wong & Gordon, 2013), yet given the multi-faceted nature of violent cognition and absence of integrating theory of violent offenders' cognition it can sometimes be difficult to assess and treat the cognition (cognitive product, structure or process) that is associated with violent behaviour (Gannon, 2009). In addition, there is a paucity of research examining violent thoughts and fantasies, particularly non-sexual violent thoughts and fantasies. Consequently, there is little understanding about how violent thoughts and fantasies (VTF) are experienced and what they may represent for offenders.

This research project aims to explore VTF in a clinical and forensic mental health population. The study explores what VTF are for mentally disordered offenders, what function these experiences serve and crucially attempts to address what role VTF play in the commission of violent behaviour.

The thesis begins with a review of violent cognition and related constructs in chapter one. Chapter two presents a systematic review of the literature on violent cognitions in violent offenders (to include sexually violent offenders) and provides some context for the empirical studies presented in the thesis. The systematic review highlights the multi-faceted construct of violent cognition. The role of violent cognition at various stages in the offending process is also discussed.

The main empirical study uses qualitative methodology to explore violent thoughts and fantasies amongst a sample of mentally disordered offenders detained within a high secure hospital. The data collected for the main study were analysed using two methods of data analysis: thematic analysis and functional analysis, in line with the aims of the project. The findings from the thematic analysis indicated that VTF were generally characterised as both negative and positive experiences; many patients reported that the experiences were generally

unwanted and unhelpful, yet simultaneously recognised that they served important and helpful functions for the individual. Violent thoughts and fantasies appeared to be integral to one's self concept and functioned to sustain the individual in some way, depending on individual need.

A range of functions of VTF were identified in the functional analysis and these included: emotional regulation, dealing with provocation and using VTF to plan or guide violent offending. While the latter highlights a role for VTF in the commission of violent behaviour it was also noted that some patients attempted to inhibit action by using a series of distraction techniques. Taken together the overall findings indicate that VTF serve many different functions for mentally disordered offenders. While some of these functions do not appear to have a direct or observable relationship with violent behaviour, the likelihood of future violent behaviour remains. As such, there continues to be a need to carefully assess and manage these experiences as the link between thinking about violence and acting in a violent way continues to be a likely possibility.

Clinical implications are directed towards a thorough assessment of violent thoughts and fantasies. In particular, there is emphasis on assessing the underlying function or motivation for the experience of VTF and supporting offenders to find alternative ways of addressing the need that the fantasy currently fulfils. This may help to reduce the individual's use of, and dependence on, violent thoughts and fantasies. Beliefs supportive of violence should also be addressed alongside issues pertaining to the self; identity and self-esteem, particularly in relation to social problem solving.

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CHAPTER ONE

INTRODUCTION & OVERVIEW

Origins of Interest

The idea for this thesis occurred during a research seminar in which a Clinical Psychologist presented a clinical case study about a client who disclosed having violent thoughts and fantasies. However, the client did not have a forensic history and so his disclosure of violent thoughts and fantasies was considered ambiguous, leaving the clinician unsure about what the experience represented and furthermore, whether this experience was related to risk of future violence. The case presentation encouraged a discussion over whether or not a disclosure of violent thoughts and fantasies was indicative of risk, given the paucity of guiding evidence on this topic and details on how these experiences should be managed in a clinical setting. Following a review of the literature in this area it became apparent that there was a general lack of empirical research examining violent thoughts and fantasies, and thus the study of violent thoughts and fantasies in a clinical group was recognised as an area of intrigue and one that would make for a hearty PhD research project.

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1.1 INTRODUCTION

The research presented in this thesis describes a study exploring violent thoughts and fantasies (VTF) in a sample of mentally disordered offenders detained within a high secure hospital in the UK. This exploratory study largely employs qualitative research methods in an attempt to understand violent cognitions in detail; how these phenomena are experienced and conceptualised amongst a sample of men who have seriously offended in the past. As part of this exploration the thesis also attempts to identify the functions of VTF, considering the purpose of

these experiences and how they are utilised within a group of clinical and forensic patients. In doing so, the research simultaneously attempts to elucidate the role of VTF in violent offending, yielding both research and clinical implications.

The current chapter is an introduction to the research presented in this thesis. It begins with an overview of the physical setting for the empirical studies that were conducted as part of this PhD to place the research in context. The chapter then reviews some key terms that are used within the literature in this domain in an attempt to offer some conceptual clarity and generate consensus understanding of what is understood by the terms 'violent thought' and 'violent fantasy'. The final section of this chapter provides a brief summary of the subsequent chapters in the thesis.

1.2 THE RESEARCH SETTING

The research presented within this thesis was conducted at Rampton High Secure Hospital. Rampton Hospital is one of three high secure hospitals in England and is provisioned by the National Health Service (NHS). Individuals who are admitted to a high secure hospital are considered to pose a grave and immediate danger to the public if at large. They are therefore placed in conditions of high security equaling that of a maximum security prison (Burns et al., 2011). An offender's detention in a prison or hospital will largely be governed by whether or not they have a mental health problem and/or whether it is thought that their mental health contributed to their offending. Although, it is worth recognising the high prevalence of offenders detained in prisons who are thought to suffer from severe mental health difficulties (e.g. Fazel & Danesh, 2002; Senior et al., 2013), including the transfer of individuals between prison and hospital facilities (Burns et al., 2011; Sheldon, Tetley, Thompson and Krishnan, 2009). Whilst there is some provision of in-reach mental health services for offenders detained in prisons, these have been criticised as being ineffective (e.g. Her Majesty's Chief Inspectorate of Prisons, 1996). An offender's detention within a mental health hospital allows for a

more tailored application of clinical interventions compared to prison healthcare. These interventions are not only geared towards improving mental health but are also aimed at reducing the risk of violent and/or sexual recidivism. Individuals who are detained within a high secure hospital are detained under sections of the Mental Health Act (1983) for assessment or treatment of their mental health.

There are five patient services within Rampton Hospital: Mental Health (MH), Personality Disorder (PD), Dangerous and Severe Personality Disorder[1] (DSPD), Learning Disability (LD) and a Women's Service (WS). The Learning Disability Service at Rampton Hospital is the country's sole provider of high secure care for individuals with a learning disability and covers a catchment area of England and Wales. The Women's Service at Rampton Hospital is also a national service and aims to provide assessment and treatment for female offenders with mental health difficulties (including personality disorder) and/or learning disabilities, within the context of a high secure mental health facility.

At the time the research was carried out the DSPD Unit at Rampton Hospital was one of four DSPD sites in England; two were within high secure hospitals (Rampton & Broadmoor) and two within the prison services (HMP Frankland & HMP Whitemoor). The DSPD programme was an initiative of the UK Government that was set up in 2004 designed to treat a group of individuals once thought to be untreatable (DSPD, 2008; National Institute for Mental Health in England, 2003). The DSPD Unit continues to be a shared responsibility of the National Health Service (NHS) and the National Offender Management Service (NOMS). Patients admitted to the service pose a significant risk to themselves and others as a result of their severe personality disorder(s) combined with high levels of psychopathy

[1] The DSPD initiative was recently superseded by the development of a new national personality disorder strategy – the 'Offender Personality Disorder Strategy' which resulted in characteristic changes to the Unit's clinical composition. However, as the research was carried out prior to this change, the classification 'dangerous and severe personality disorder' or DSPD is used within this thesis for consistency and to acknowledge the client group that comprised the DSPD Unit at that time.

(Hare, 2003). This group of individuals also present a higher risk than patients in the Personality Disorder (PD) service within the same hospital and thus DSPD patients are recognised as a treatment priority in terms of reducing risk (Sheldon et al., 2009).

Rampton Hospital was identified as a suitable location for the study of violent thoughts and fantasies given that most, if not all, of the hospital's population comprised serious offenders, to include those who had convictions for violent and/or sexual offences. In addition, assessing violent cognitions within this group would also afford an opportunity to consider the influence of mental disorder on violent cognitions, making the findings useful to those who work therapeutically with forensic clients too.

1.3 VIOLENT COGNITION: A REVIEW OF RELEVANT TERMS AND CONCEPTS

There is a widely recognised link between what people think and how they behave and indeed many therapeutic models and interventions in clinical psychology are premised on the basis of such a relationship (e.g. Beck, Rush, Shaw & Emery, 1979; Wells, 1997, 2011). Violence-related cognitions (such as criminal attitudes) are no exception and accordingly many intervention programmes within forensic settings are aimed at bringing about a change in behaviour (i.e. offending) by modifying cognition, for example the Reasoning & Rehabilitation Programme, (Antonowics, 2005) and the Think First Programme (McGuire, 2005). However, cognition takes many forms which can make its treatment complex. Moreover, given the range of cognitive processes that operate under the umbrella term of cognition and in the absence of an integrated theory of violent offender cognition it can sometimes be difficult to recognise which cognitive processes are related to offending behaviour (e.g. Gannon, 2009; Mann and Beech, 2003). This may have important implications for the management and rehabilitation of offenders, making the study of violent cognitions worthy of attention.

If violence is defined as a range of behaviours intended to harm a living being who is otherwise motivated to avoid harm (Baron & Richardson, 1994), and if cognition relates to the integration of memory, perception and thinking processes that facilitate cognitive processing (Solso, 1998), violent cognition could be described as broadly referring to any manner of mental process in which violence is represented. The research presented in this thesis is a study of violent thoughts and fantasies and therefore it is timely to review these constructs and delineate how they are similar and distinct from other forms of cognition within the offender literature.

1.3.1 Cognitive content, cognitive structures and cognitive processing

Collie, Vess & Murdoch (2007) provide a useful way of distinguishing between types of violence-related cognition, separating the many concepts out into three categories: cognitive content, cognitive structure and cognitive processing. Although, due to the complex nature of cognition and inter-relationships between content, processing and structure, Collie et al., recognise that these are not discrete categories. Nevertheless, this broad classification system provides a useful structure for the following discussion of violence-related cognitions.

1.3.1.1 Cognitive Content

Cognitive content refers to the basic stored elements of information that an individual may possess. These include beliefs, thoughts and attitudes. In the context of violent offending this content might specifically relate to beliefs, thoughts and attitudes that occur in the pre-offence, during-offence or post-offence periods. Specific types of cognitive content (e.g. beliefs or attitudes) are also sometimes regarded as cognitive products, which Hollon & Kriss (1984) suggest occur as a result of complex interaction between structures, content and processes. In addition, some of these products are sometimes regarded as surface-level cognitions, in that they are assumed to be relatively accessible through some degree of introspection and are therefore available for self-report. The assessment

of cognitive content is useful as it allows for inferences to be made about underlying schema that are less directly accessible, although some methods that use grounded theory methodology have been used to infer schema related to violent offending (e.g. Polaschek, Calvert & Gannon, 2009). For consistency however, the terms cognitive content and cognitive products are used in this section to reflect the same type of cognition, unless otherwise stated.

A number of these cognitive products are noted within the literature and these include criminal attitudes (e.g. Wong & Gordon, 2003), criminal sentiments (attitudes and beliefs that support criminal behaviour; Simourd, 1996, 1997; Walters, 1990), attitudes towards violence (e.g. Archer & Haigh, 1997a) and violent thoughts (e.g. Firestone & Firestone, 2008). These cognitive products are often assessed through self-report and a number of specific tools have been developed to facilitate this. For example, the Criminal Attitudes to Violence Scale (Polaschek, Collie and Walkley, 2004) measures violence-related attitudes, the Criminal Sentiments Scale (CSS-M; Simourd, 1997) measures antisocial attitudes, values and general beliefs about criminal activity, the Maudsley Violence Questionnaire (Walker, 2005; Walker & Gudjonsson, 2006) measures rules and beliefs associated with violence and the EXPAGG-M (Archer & Haigh, 1997a) measures beliefs about aggression. Despite the subjectivity and bias that may be inherent within some self-report measures, many of these scales have been found to be associated with actual or self-reported incidents of violence, which suggests that they may be reliable indicators of violent behaviour. For example, Milner & Webster (2005) found that positive instrumental beliefs about aggression were positively related to self-reported violence amongst a prison sample and Archer & Haigh (1997b) similarly identified that instrumental beliefs about aggression were both positively and strongly correlated with self-reported physical aggression, verbal aggression, anger and hostility in a non-offender sample.

In a recent review, Bowes & McMurran (2013) reviewed the impact of violence-related cognition on physical violence. Bowes & McMurran used Walker's (2005) definition of violent cognition in their search criteria which included

"thoughts, beliefs and attitudes which may principally relate to violence (p. 188)". The search yielded a number of papers that examined beliefs about violence (including positive outcomes of violence), moral reasoning and attitudes towards violence and aggression. Although a number of different facets of violent cognition were identified, there were some thematic similarities across the studies. Bowes & McMurran collated these findings and concluded that viewing aggression as positive, or as a means of achieving a positive outcome, was a risk factor for violence and furthermore that treatment of violent offenders should also consider challenging scripts that are supportive of violence. Despite thematic similarities it is important here to recognise the different products that fall within the remit of violent content.

Thoughts and fantasies are also recognised here as two different forms of cognitive content. Thoughts are argued to be distinct from fantasies and some attempts have been made at highlighting differences between the two. For example, Jones and Barlow (1990) argue that thoughts occur at a higher rate than fantasies and Barlow, Hayes & Nelson (1984) observe that thoughts are externally triggered phenomena compared to fantasies which are recognised as being internally generated.

Within the sexual offender literature it is argued that the act of fantasising allows an individual to create an elaborate and emotionally anchored mental image that is sexually arousing (e.g. Crepault & Couture, 1980; Leitenberg & Henning, 1995; Rockach, 1990). Jones & Wilson (2009) suggest that sexual fantasies represent an individual's most uninhibited thoughts, aspirations and desires and that these internal phenomena are developed and maintained privately, free from judgment and criticism from others. Maniglio (2010) offers a useful definition of fantasy by drawing on a series of collective definitions from the literature on sexual homicide (e.g. Burgess, Hartman, Ressler, Douglas, & McCormack, 1986; MacCulloch, Snowden, Wood, & Mills, 1983; Prentky et al., 1989; Ressler et al., 1986) and describes sexually deviant fantasy as:

> an elaborate set or sequence of cognitions (such as thoughts, images, feelings and internal dialogue) containing themes involving the infliction of harm or pain during sexual intercourse, illegal or socially unacceptable sexual behaviour, or otherwise inappropriate or non-consensual sexual activity (p. 295).

The conceptualisations presented above have some similarities and collectively appear to regard fantasy as a (more) complex phenomena; in that fantasies are *comprised of thoughts*, as well as other cognitive (e.g. images and internal dialogue) and affective qualities. Bartels (2014) argues that elaborated thought (i.e. a fantasy) is a more deliberate and controlled process that also involves greater cognitive effort. It therefore seems sensible to argue that fantasies may originate from a thought but with elaboration may develop into more complex experiences. This may provide some argument for a fantasy as phenomena that the individual has control over; in the creation and elaboration of a thought. While thought and fantasy are both regarded here as cognitive products there may be some argument for *fantasising* i.e. the *process* of creation and/or elaboration that is applied to a thought, to be considered as a *cognitive process*. This will be reviewed again in a later section.

There is a need to consider why some thoughts become elaborated however; is this a conscious process and if so, what might the purpose of it be? Within the sexual offender literature there is a breadth of evidence that recognises fantasy as providing a number of functions to the sex offender. These functions include sexual arousal (e.g. Crepault & Couture, 1980; Gee, Ward & Eccleston, 2003; Hicks & Leitenberg, 2001; Howitt, 2004; Sheldon & Howitt, 2005), a feature which is also readily observed within the characteristics of sexual fantasy described earlier. A range of other functions of sexual fantasy have also been identified. In addition to sexual arousal, Gee, Ward & Eccleston (2003) identified sexual fantasy as a mechanism for coping, affect regulation and a way of modelling behaviour. The function of 'coping' was used to describe an offender's use of a fantasy to exert actual or perceived control over internal or external threats and/or use of this

fantasy to escape reality. The 'affect regulation' function encapsulated an offender's use of fantasy to alleviate a dysphoric mood or affective state and/or elevate an ambivalent or pre-existing positive mood. Gee, et al., observed these functions for sexual fantasies to include sexually violent fantasies. Moreover, Gee and colleagues found that some fantasies that detailed the intentional infliction of harm actually created or intensified sexual arousal. A similar observation was made in a much older, descriptive study by MacCulloch, Snowden, Wood, & Mills (1983) who found that sexually-violent fantasies that included themes of sadism, torture and rape were often frequently paired with sexual arousal and masturbation. It therefore seems that some individuals may be motivated to elaborate thought and create fantasies with specific content, in order to satisfy particular needs or desires, such as sexual arousal. It is currently unclear whether violent fantasies provide similar functions to violent offenders and this remains to be investigated.

1.3.1.2 Cognitive Structures

Clusters of highly associated beliefs are recognised as schemas. Schemas are overarching knowledge structures stored in memory, within which cognitive content is stored and connected with other content. Schemas represent substantial knowledge about any given concept, its attributes and relationship to other concepts (Huesmann, 1988). Schemas are therefore often relied upon to facilitate the prompt processing of information from the social environment (Augostinos & Walker, 1995; Fiske & Taylor, 1991). Polaschek, Calvert and Gannon (2009) attempted to determine schemas for violent offenders by examining offenders' offence narratives to identify any violence-relevant statements that may have been illustrative of schemas relating to violence. Polaschek et al., (2009) identified schemas that included beliefs and attitudes about violence as a normal occurrence (normalisation of violence) and beliefs and attitudes about not being able to regulate violent offending alone (I get out of control).

Huesmann (1998) defines scripts as collections of simple event schema. Scripts are another form of cognitive structure in that they contain both procedural

and declarative information about any given event or situation that facilitates a prediction about the behavioural sequence and likely outcomes, including how one might respond. Behavioural scripts develop as a result of interaction with the world and are therefore acquired through a process of experience and learning (Huesmann, 1998).

Huesmann's (1988, 1998) information processing model was developed out of a need to explain the development of habitually aggressive behaviour in children. The theoretical model draws on social learning theory (Bandura, 1973) to provide a more comprehensive account of how children acquire aggressive scripts, how these are maintained and activated. Huesmann's script theory (1988, 1998) asserts that aggressive behaviours are initially observed or attended to before the behavioural sequence is encoded and stored in memory. Non-violent individuals may also have violent scripts encoded in memory but the presence of scripts alone does not determine action; the activation of a behavioural script is dependent on a series of other processes.

Huesmann's (1988, 1998) script theory stresses the importance of script rehearsal. The more that scripts are rehearsed the greater the number of associations with other scripts. Script rehearsal takes many forms including simple recall to elaboration or fantasising. Huesmann (1989) noted that the more elaborate the rehearsal, the greater the connectedness of that script to other scripts, increasing its accessibility in a cue-dependent situation (e.g. Anderson, 1983). Furthermore, under high levels of arousal, the script that is more accessible is most likely to be retrieved and put into action (Anderson, 1983; Luria, 1973). In other studies, research has also indicated that increased rehearsal of aggressive scripts has been found to be associated with increased aggression (Nagtegaal, Rassin & Muris, 2006) and violent behaviour (e.g. Grisso, Davis, Vesselinov, Appelbaum, & Monahan, 2000). In the study by Grisso, Davis, Vesselinov, Appelbaum, & Monahan (2000) it was argued that adults who had been victimised as children were more likely to entertain scripts relating to violence than those who

had not been victimised, thereby emphasising the role of prior knowledge and experience of the world.

Behavioural scripts related to aggression have been extensively studied by Huesmann and colleagues (e.g. Huesmann, 1988, 1998; Huesmann & Eron, 1989; Huesmann & Reynolds, 2001). Script theory provides a useful theoretical framework for understanding aggressive behaviour yet the application of script theory to clinical practice has been argued to be limited, on the basis that the theory is perhaps too vague to underpin offender rehabilitation (Sestir & Bartholow, 2007). However, some aspects of script theory have been integrated into the social cognitive information processing model (Crick & Dodge, 1994; Dodge, 1980) which provides a more comprehensive account of how violent or aggressive scripts can become activated. As described, the process of script activation might be increased following rehearsal, rendering the well-rehearsed script more accessible for recall. However, script rehearsal as a process is itself thought to be determined by normative beliefs about violence or aggression. Normative beliefs are another type of knowledge structure that comprise beliefs about the typicality and appropriateness of aggressive behaviour. Therefore it appears that there is an interaction between cognitive structures that collectively contribute to increased script accessibility and activation.

To summarise, this section has reviewed cognitive structures to include schema, scripts and normative beliefs. Cognitive structures provide a framework within which cognitive products (e.g. thoughts, fantasies and attitudes) exist. Moreover, the structures allow for the complex integration of information held in memory and facilitate the processing of internal and external stimuli.

1.3.1.3 Cognitive Processing

Cognitive processing refers to the complex integration of information that collectively determines information processing. Collie et al., (2007) describe how cognitive processes include acquisition, rehearsal and retrieval of information and in doing so indicate that cognitive processes not only produce cognitive content

(such as violent thoughts and fantasies) but are also responsible for the maintenance of this content. Furthermore, the way in which this content is maintained (or processed) will have a subsequent effect on how we continue to understand and engage with the world. Some cognitive processes have already been highlighted in previous sections e.g. script selection and evaluation. This section will review some of these processes in more detail with a view to demonstrating integration of the three different forms of cognition (content, structures and processes).

In a review of the social-cognitive theories surrounding aggression, Anderson & Huesmann (2003) describe a sequence of macro-processes that exist to facilitate our understanding of social interactions. Processing begins with the encoding and interpretation of social cues from the environment. However, these interpretations may be biased based on our prior knowledge and experience of the world. Moreover, there is evidence to suggest that individuals who are higher in trait aggression are more likely to perceive aggressive cues across a wider array of social settings than individuals with lower levels of trait aggression (Hughes & Hasbrouck, 1996). There appears to be some perpetuating effect whereby schema or scripts become self-fulfilling; in that with increasing activation (in hostile settings) they become more chronically accessible and thus continue to influence the (hostile) interpretations we make (Gannon, 2009).

The social-cognitive information processing theory (e.g. Crick & Dodge, 1994; Dodge, 1980) suggests that after the interpretation process the individual is prompted to consider their goals within the situation i.e. what they would like to achieve and how this may be achieved. There is some potential bias for processing at this stage too and some evidence has suggested that chronically aggressive people are more likely to see aggressive responses as more successful (Toblin, Schwartz, Gorman & Abou-ezzeddine, 2005; Yoon, Hughes, Cavell & Thompson, 2000). Possible responses are then generated in the form of scripts and the individual goes through a process of evaluation to review and then select the most

appropriate script for use in that situation. It appears therefore that biases in information processing may increase the likelihood of violent behaviour.

Some therapeutic programmes that are premised on social-cognitive information processing theory have been developed. Guerra and Slaby (1990) sampled adolescent offenders and found that while the programme increased social problem solving and decreased aggression-supportive beliefs, it was still difficult to ascertain whether addressing information processing deficits and working at this level of cognition were sufficient to reduce violent recidivism. As Sestir & Bartholow (2007) note, longitudinal observations may provide more robust evidence for the efficacy of such information processing programmes.

It is important to briefly review the concept of social cognition. Social cognition relates to how people perceive themselves and their relationship with other people; how they interpret social behaviours and choose appropriate behavioural responses (Gannon, 2009; Gannon, Ward, Beech, & Fisher, 2007). Social cognition therefore draws on and integrates different aspects of cognition and as Huesmann (1998) suggests, could be characterised as a mediating process that integrates cognitive products, schema and scripts in the processing of social information.

1.3.2 Cognitive content related to mental health

The research described within this thesis is conducted within the context of forensic mental health. Accordingly, it is useful to highlight other thought processes that are often found within mental health settings alongside some description to illustrate how they fit within the context of violent cognition.

1.3.2.1 Rumination

The most widely used definition of rumination is that proposed by Nolen-Hoeksema (1991) as part of their Response Styles Theory (RST). According to the RST, rumination is characterised as a passive process that involves repetitively thinking about causes, consequences and symptoms of one's negative affect

(Nolen-Hoeksema, 1991). More recently this conceptualisation has been revised to "the process of thinking pervasively about one's feelings and problems rather than in terms of the specific content of thoughts" (Nolen-Hoeksema, Wisco & Lyubomirsky, 2008 p. 400). Rumination is a process frequently observed within depression (e.g. Mor & Winquist, 2002; Papageorgiou & Wells, 2004; Watins & Moulds, 2005) and has also been shown to prolong depressed mood (Nolen-Hoeksema & Larson, 1999; Nolen-Hoeksema & Morrow, 1991). Moreover, Nolen-Hoeksema, Wisco & Lyubomirsky (2008) assert that rumination inhibits active problem solving (e.g. Donaldson & Lam, 2004; Lyubomirsky, Tucker, Caldwell & Berg, 1999; Watkins & Moulds, 2005) and interferes with instrumental behaviour (e.g. Lyubomirsky & Nolen-Hoeksema, 1993), both of which may consequently prolong distress.

These features generally characterise rumination as a negative or unhelpful process, yet some authors argue a role for rumination as a functional process. Martin & Tesser (1989, 1996) for example, define rumination more broadly as "a class of conscious thoughts that revolve around a common instrumental theme and that recur in the absence of immediate environmental demands requiring the thoughts" (1996, p. 7), which might infer goal-directed utility. Indeed, Wells (2011) suggests that as part of the metacognitive model of depression (Wells & Matthews, 1994) rumination is employed as a type of thinking strategy aimed at self-regulation. Wells (2011) suggests that rumination is triggered by internal events such as negative thoughts and emotions, but that it is intended to help the individual to cope with their distress. While rumination in this context may be functional, it is still recognised as a process that is maladaptive in that it is generally argued to bias thinking processes (Spasojevick, Alloy, Abramson, Maccoon & Robsinson, 2004), whilst simultaneously maintaining and intensifying depression (Nolen-Hoeksema, 1991; Wells, 2011). Rumination is also recognised within anxiety disorders such as Obsessive Compulsive Disorder (OCD) where it is also reported to be experienced as an involuntary, persistent and intrusive experience (Wells, 1997). Moreover, Wells (1997) suggests that rumination in the context of OCD may

maintain pre-occupation with mental events, making intrusive thoughts even more likely, thereby maintaining this process. Consequently, cognitive interventions designed to target depression, generalised anxiety disorder and other anxiety disorders often include a feature of challenging ruminative thinking styles as part of therapeutic intervention (e.g. Wells, 1997, 2011).

Rumination shares some similarities with other thought processes such as worry and intrusive or obsessive thoughts, yet Wells (1994) and Wells & Morrison (1994) highlight some notable differences to separate these processes. For example, worry appears to be ego-syntonic, past-orientated and aimed at problem-solving (Wells, 2011). Furthermore, worry appears to be a voluntary process, compared to obsessive or intrusive thoughts which are less so (e.g. Conner-Smith, Compass, Wadsworth, Thomsen, & Saltzman, 2000), and are often ego-dystonic experiences (Clark & Purdon, 1995; Clark & Rhyno, 2005; Wells, 2011). Worrisome and anxious thoughts tend to contain themes relating to danger, while rumination predominantly includes themes of loss, failure and personal inadequacy (Wells, 2011).

In an earlier section on cognitive structures and cognitive processing rumination was described by Huesmann (1988) as a method of rehearsal and elaboration which, according to Huesmann's script rehearsal theory, may result in the increased accessibility of scripts relating to a particular behaviour. Rumination might therefore be considered as a cognitive process of rehearsal and consequently bears some similarities with fantasising. While there has been extensive research on rumination little attention has been paid to how rumination and fantasising may differ. Having summarised the literature on both of these phenomena it may now be sensible to discuss similarities and differences between the two.

Both ruminating and fantasising could be recognised as cognitive processes in that they involve the processing of a repetitive thought. Whilst rumination appears to be involuntary (Wells, 1997) and uncontrollable (Smith & Alloy, 2009), fantasies, in contrast, appear to be more self-directed; creative and controllable processes as noted by Jones & Wilson (2009) and by Bartels (2014), in relation to

sexual fantasies. Both fantasies and rumination appear to be purposeful; sexual fantasies for example are associated with sexual arousal and affect regulation. Wells (2011) argues that rumination is instrumental; it is a thinking strategy aimed at self-regulation. However, the question as to whether rumination is effective in achieving self-regulation remains unclear, given that rumination is also a treatment target for some anxiety programmes (e.g. Wells, 1997, 2011). However, while the literature tends to suggest that rumination is paired with a negative affective state like depression (e.g. Nolen-Hoeksema, 1991; Wells, 2011) there is less evidence for fantasy as being associated solely with one affective state. Instead, from what can be inferred from the sexual offender literature, fantasies appear to serve the function of affect regulation, which includes both elevation of a pre-existing positive mood and down-regulation of a negative mood (e.g. Gee et al., 2003). Furthermore, it may be sensible to conclude that fantasies serve some affect-regulatory function as opposed to being associated with any one type of mood. However, this is based on the available evidence from the sexual offender literature and therefore we cannot infer whether the same affective qualities are associated with non-sexual, violent fantasies.

Ruminating and fantasising are both forms of rehearsal which are governed by different processes. For example, Sestir & Bartholow (2007) suggest that normative beliefs about violence determine violent script rehearsal and thus determine the script's increased accessibility. It could be argued therefore that the way in which a simple thought is processed i.e. whether it is ruminated on or actively elaborated in a fantasy, may be a result of the way in which the theme or content is appraised e.g. as acceptable or unacceptable, in line with existing scripts, normative beliefs or schemas about a particular concept. Thoughts that are deemed unacceptable or morally and socially wrong are likely to be paired with an ego-dystonic affective state, which might encourage suppression or elimination of that product. Thoughts that are appraised as acceptable, or at least not unacceptable, will likely be processed in a different way. Therefore, it seems that the appraisals made about the theme or content of a thought may affect how it is

processed; less about the content or theme itself, but more about the associated affect, scripts and schema that are triggered, which may either diminish or support active engagement in it. In sum, it seems that fantasising and ruminating are both cognitive processes characteristic of repetition, which may both be applied to a thought. However, the appraisal of the thought and associated affective responses may determine whether this repetitive thought process is a process of rumination or a process of fantasising. In either case, ruminative thoughts or fantasies may both become more strongly represented in memory as a consequence of their repetitive nature.

1.3.2.2 Intrusive Thoughts and Images

Intrusive thoughts and images were briefly reviewed in the context of intrusive thoughts within OCD in section 1.3.2.1 above, however there is additional relevant information presented in this section to more fully describe these experiences. Intrusive thoughts or intrusive images are commonly reported by patients across a range of disorders including anxiety disorders (Hirsch & Holmes, 2007), but most notably within the context of Post-Traumatic Stress Disorder (PTSD) (e.g. Ehlers & Clark, 2000). Intrusive images are, by their very description, involuntary and occur spontaneously in consciousness (Berntsen, 2009; Mace, 2007). These phenomena appear to be repetitive, uncontrollable and distressing (Brewin, Gregory, Lipton & Burgess, 2010). Intrusive images, including intrusive memories, may sometimes be representative of past traumatic experiences that the individual has witnessed or been exposed to (Horowitz, 1976). Alternatively, Schultze, Freeman, Green & Kuipers (2013) argue that intrusive thoughts represent current perceived threats or stressors, notably for individuals experiencing persecutory delusions, for example. Accordingly, it is likely that some intrusive thoughts may contain images of violence, which may perpetuate distress. Indeed, Steil & Ehlers (2000) found that the meaning individuals gave to their intrusive memories and the strategies they used to control the intrusions played a major role in maintaining the PTSD symptoms. Moreover, they found that the way in which

intrusions were appraised, i.e. as normal or abnormal, was also related to lower and higher levels of distress respectively. This is also true for intrusions as described within the obsessive-compulsive disorder literature (Rachman, 1998; Salkovskis, 1989).

There is evidence to suggest that a minority of perpetrators of violent crime develop PTSD (Kruppa, Hickey & Hubbard, 1995; Spitzer et al., 2001) and furthermore, Evans, Ehlers, Mezey and Clark (2007) suggest that the intrusive images that some offenders experience may also be related to the offences they have committed. Evans et al., also observed that antisocial beliefs at the schema level were actually protective against the development of intrusive memories of violent crime. A similar observation was reported by Palermo (2012) who noted that psychopaths (as recognised by the Psychopathy Checklist - Revised; Hare, 2003) who minimise traumatic events, or experience less anxiety in reaction to a traumatic event, are at reduced likelihood of developing post-traumatic stress, which might therefore suggest that they experience less intrusions than those who have greater anxiety responses to violent crime. This not only highlights the importance of core beliefs as providing a structure and framework within which to organise aversive material, but also highlights the importance of individual difference, personality and attributions in contributing to how these events are appraised and thus whether an individual is likely to develop intrusive thoughts or images.

1.3.2.3 Delusional Beliefs

Delusional beliefs are other clinical phenomena worthy of review here, given the context of the research that is set within a mental health setting. Delusions are characterised as strongly held beliefs that are unreal, but which are perceived to be real by the person who experiences them. A delusional belief system may be comprised of various thoughts and assumptions that encourage the processing of internal and external stimuli in a way that is consistent with the belief (e.g. Freeman, 2007). As such, delusional belief systems could be considered akin to

cognitive structures, but with added biases that distort information processing. For example, Garety, Hemsley & Wessely (1991) describe the 'jumping to conclusions' bias which is a data-gathering bias in which rapid and over-confident judgements are sometimes made in the absence of supporting evidence. Similarly, attributional biases proposed by Kinderman & Bentall (1997) are thought to arise from faulty reasoning processes of normal events.

Some delusional beliefs, in particular paranoid or persecutory beliefs, may be related to the development of thoughts about defending or protecting oneself from imminent danger, which may include the use of aggression and/or violence. Garety and Freeman (1999) argue that the content of the delusional belief is not problematic, however they identify several factors which may be particularly salient. These include the degree of conviction in the belief, level of associated distress, frequency and relatedness to behaviour. Furthermore, one might argue that the latter two are associated, in line with script theory (Huesmann, 1988, 1998). However, it is unclear whether violent thoughts and fantasies that are derived from an over-arching delusional belief are more or less problematic than violent thoughts that are derived from a true belief or belief based on factual events. Such an investigation would no doubt need to consider the wider context of mental health and symptoms of psychosis, but might nevertheless lead to an increased awareness of risk-related cognitions in this area.

This section has presented a review of concepts that are commonly used in the domain of offender cognition and has attempted to clarify what the different structures and processes are. The terms 'violent thoughts' and 'violent fantasies' were selected for use in the main study (described across chapters 3-9) as these were terms that most participants could probably relate to (i.e. patients might have been less familiar with the concept of a script and/or may not have been able to identify with this construct). However, some flexibility was allowed within the interview so that patients could articulate how they recognised and experienced their violent cognitions. These descriptions were recorded and discussed in context throughout the interview and are also reflected in the findings at the end of the

thesis. As such, the conceptualisations presented here may be revised in light of findings that emerge from this research, pertaining to how violent cognitions are experienced within a sample of mentally disordered offenders.

1.4 THESIS OVERVIEW

Chapter two presents a systematic review that explores the question 'what is the role of violent cognition in violent offending behaviour, for mentally disordered offenders' in an attempt to review the state of the literature in this area and provide some context to the empirical research described in the thesis.

Chapter three describes the methodology employed in the main empirical study that explores violent thoughts and fantasies within a sample of mentally disordered offenders. This chapter also describes the methods used to collect and analyse the data. The research questions are:

1. What are violent thoughts and fantasies according to mentally disordered offenders? *What is the nature and quality of violent thoughts and fantasies as experienced by mentally disordered offenders?*
2. Why do mentally disordered offenders experience violent thoughts and fantasies; *what is the functional utility or purpose of these experiences?*
3. Is severity of mental disorder related to the function of VTF?
4. Is there a role for VTF in violent behaviour?
    a. What are the implications of this for clinical practice?

Qualitative methodology was identified as the most appropriate method to answer these questions. Two complementary methods of qualitative analysis were selected to analyse the data. Thematic analysis (Braun & Clark, 2006) was used to explore the nature of violent thoughts and fantasies in line with research question 1. Secondly, a functional analysis methodology was identified as being appropriate to the identification and assessment of functions of violent thoughts and fantasies (research questions 2 & 3). The outcomes of the systematic review and both

methods of qualitative analysis were collectively reviewed to answer the final research question.

The thematic analysis yielded 4 super-ordinate themes and chapters 4 – 7 are dedicated to describing and discussing each of these themes in detail. The thematic results chapters are presented in a sequential way and are designed to illustrate the experience of violent thoughts and fantasies, starting with how they developed through to how they may be used. The *part of who I am* theme (chapter four) captures the origins of VTF and how patients make sense of these experiences in terms of their relevance to their identity as an offender and/or mental health patient. The *emotion regulation* theme (chapter five) illustrates the utility of violent thoughts and fantasies as a way of regulating affect; up-regulating positive affect such as feelings of power and control, and down-regulating negative affective states such as anger. Chapter six presents the *aware of the need to be careful* theme which illustrates the experience of anxiety that often accompanies violent thoughts and fantasies, with patients self-reporting a need to be careful in terms of effectively managing these experiences in order to reduce or eliminate the risk of violent action occurring. Finally, chapter seven describes the *thinking to doing, to thinking, to doing* theme, which is designed to illustrate the circular relationship between thinking and doing; describing the interaction of violent thoughts and fantasies with reality, through the planning and commission of violent action.

Returning to the second research question asked of this research, chapter eight then attempts to address why mentally disordered offenders might experience violent thoughts and fantasies. This chapter provides a more detailed review of the method of functional analysis and describes the process of how a checklist of functions was initially generated and how this checklist was then applied to the data collected within the main thematic analysis (chapters 4-7). A series of sub-group analyses were conducted to assess whether there was a relationship between clinical psychopathology and function of violent thoughts and fantasies.

Finally, the discussion section presented in chapter nine draws on the findings identified from all of the empirical work conducted as part of this thesis and discusses the overall findings in terms of existing psychological theories. The findings appear to be fairly well explained by a social-cognitive information processing model (Crick & Dodge, 1994) and the findings are discussed in this context. The discussion chapter also discusses the relevance of the findings to clinical practice. For example, the functional assessment of violent thoughts and fantasies may indicate areas of therapeutic need, which could be incorporated into an individualised care or management plan as part of a mentally disordered offender's therapeutic or rehabilitative treatment plan.

CHAPTER TWO

SYSTEMATIC REVIEW OF THE LITERATURE ON VIOLENT THOUGHTS AND FANTASIES WITHIN VIOLENT OFFENDER GROUPS

2.1 INTRODUCTION

There is a well-established relationship between cognition and behaviour and many therapeutic programmes are premised on the basis of this relationship (e.g. Beck, Rush, Shaw & Emery, 1979; Wells, 1997, 2011). Offence-related cognition is no exception; it is recognised as an indicator for criminal behaviour and thus worthy of attention and management (e.g. Wong & Gordon, 2003). Indeed, many offender treatment programmes follow a cognitive-behavioural approach. For example, the Reasoning & Rehabilitation Programme (Antonowicz, 2005), Think First Programme (McGuire, 2005) and the Sexual Offender Treatment Programme (e.g. Beech, Fisher & Beckett, 1998) are premised on the basic assumption that a change in cognition will produce a change in behaviour. The efficacy of such programmes has far-reaching implications for offender management and treatment, to include reduced societal and economic cost whilst increasing public safety (e.g. Ministry of Justice, 2013).

Offence-related cognition has received much attention within the sexual offending literature. Specifically, there has been extensive empirical work exploring different sexual cognitions; cognitive products and processes and their relationship to sexual offending. These include, for example, studies of sexual fantasies (e.g. Gee, Ward & Eccleston, 2003; Howitt, 2004; Sheldon & Howitt, 2007, 2008), cognitive distortions (e.g. Abel, Becker & Cunningham-Rathner, 1984; Beech, Swaffer, Multra & Fisher, 2009; Ward, Hudson, Johnson & Marshall, 1997) and implicit theories (Polaschek & Ward, 2002; Ward, 2000).

Cognitive distortions are broadly acknowledged to reflect attitudes and beliefs that sexual offenders hold and that have been associated with offending (Gannon, Ward & Polaschek, 2004; Marshall, Anderson & Fernandez, 1999; Ward, 2000, Ward et al., 1997). Although, for some years there has been debate as to the validity of these articulated beliefs and whether they might actually be examples of self-deceptive beliefs or attempts at justifying offending (Gannon & Polaschek, 2005; Maruna & Mann, 2006). An agreed definition and conceptual understanding of cognitive distortion remains absent but despite this several researchers have continued to elucidate such offence-endorsing statements and demonstrate their role in the offence process (e.g. Polaschek & Gannon, 2004). Ward (2000) proposed that cognitive distortions arose from causal theories offenders have about the nature of people and the world in general (general level), beliefs about categories of people, such as women or children (middle level), and beliefs about a particular victim (specific level). Within this literature such theories could be characterised as schemas or as implicit theories, which are described by Ward (2000) as knowledge structures that attempt to "explain, predict and interpret cognitive phenomena" (p. 494). Ward and Keenan (1999) and Ward (2000) presented the idea that child molesters held a set of beliefs that included *entitlement, dangerous world, children as sex objects, uncontrollable and nature of harm*. Polaschek & Ward (2002) also found similarities between these implicit theories and those held by rapists. The *entitlement* and *dangerous world* theories were present in both groups however, for the rapist group *dangerous world* was found to reflect a necessity to fight back and to achieve dominance and control, while the same theme within the child sex-offender group was found to represent others as abusive and malevolent (with children being less threatening).

As these implicit theories are not readily accessible through introspective methods they are considered to be less susceptible to information processing biases and thus may provide a more robust indicator of underlying cognitions that may motivate and perpetuate sexual offending (e.g. O'Ciardha & Ward, 2013; Ward, 2000). Implicit theories have been widely studied in relation to sexual

offending and in a recent review O'Ciardha & Ward (2013) found that the evaluation of implicit theories in sexual offenders provided the strongest evidence. However, studies of implicit theories in violent offenders remain scant, with the exception of those studies involving sexual-violence (e.g. Fisher & Beech, 2007; Polaschek & Ward 2002).

Sexual fantasies have been widely acknowledged to have some role in sexual offending. Gee, Ward & Eccleston (2003) present a preliminary model of sexual fantasy, the Sexual Fantasy Function Model (SFFM), which attempts to elucidate the functions of sexual fantasy in the offence process. Gee et al., identified four functions which were: affect regulation, coping, sexual arousal and modelling. The affect regulation function was one of the more fundamental functions in that it was used to: a) regulate mood through the suppression or alleviation of a dysphoric mood; b) elevate an ambivalent mood; or c) enhance a pre-existing positive mood or affective state. Gee et al., recognised that where sexual fantasy was used to elevate or enhance mood that this was also observed within the context of sensation-seeking behaviour. Sexual fantasies were also found to induce or enhance sexual arousal, a function that is not limited to offender groups (e.g. Jones & Barlow, 1990). Gee and colleagues also found that fantasies provided some support to offenders as they functioned as a coping mechanism (providing a means of escape or to gain pseudo control over a situation). Typically, this process emerges from childhood. For example, in a recent review Maniglio (2011) highlighted the importance of early childhood experiences such as trauma, victimisation and abuse in contributing to low self-esteem in children and subsequent dependence on fantasy as a means of escaping a difficult reality. These fantasies are thought to provide the child with a pseudo sense of control and feelings of omnipotence that are reinforcing (Burgess et al., 1986; MacCulloch, Snowden, Wood & Mills, 1983; Maniglio, 2010), which promote engagement and dependence on the fantasy. Maniglio (2011) goes on to suggest that fantasising, paired with later psychological problems and lack of effective coping strategies may increase the risk of an offender acting their fantasies out in reality.

Gee et al., (2003) also identified a role for sexual fantasy in offending within the context of the modelling function. As part of this function sexual fantasies are used to simulate offending sequences and scenarios, some of which may have been intended for enactment, i.e. used to plan future offences (Gee, Devilly & Ward, 2004) as they provide an opportunity to visualise the offence in order to better prepare for action and overcome obstacles (Turvey, 1995). Moreover, Gee, Devilly & Ward (2004) found that some offenders appeared to deliberately escalate their fantasies for the purpose of re-offending. Gee et al., (2004) also noted that the frequent use of fantasies resulted in the creation of offence scripts that could be activated in a cued setting, thereby highlighting the significance of fantasy, or more specifically, rehearsed fantasy, in the commission of sexual offending. While these findings might suggest a somewhat causal relationship between fantasy and offending, other studies have found evidence to suggest that this might not always be true.

Moreover, Sheldon & Howitt (2008) suggest that fantasy and behaviour are not causally linked. Instead, they suggest that fantasy and offending have shared common origins, such as through sexually abusive childhood experiences, and/or that offending provides material for sexual fantasies. Sheldon & Howitt report findings that seem to question any simple, direct model linking sexual fantasy to sexual offending. They argue that if fantasy drives behaviour then internet sexual offenders would report the lowest levels of paedophilic fantasy as they have no reported acts against children, yet the reverse was true. It was their contact sex offenders that reported fewer sexual fantasies involving female children than internet-only or mixed sex offenders (those who have both internet and contact offences). This might also support the idea that some offenders are driven to offend in order to obtain material for their fantasies, thereby proposing fantasies may be the consequence of offending as opposed to the antecedent (Howitt, 2004).

It is also interesting to note however that deviant sexual fantasies are not limited to offender groups (Becker-Blease, Friend & Freyd, 2006; Williams, Cooper, Howell, Yuille & Paulhus, 2009). Furthermore, Howitt (2004) argues that the range

of sexual fantasies found in non-offending groups include themes that would be regarded as deviant if they were revealed by an offender. The prevalence of deviant sexual fantasies amongst non-offending groups suggests that these processes may not be directly aimed at guiding behaviour and may have another purpose or serve another function. In addition, some research from the non-offending literature also highlights the prevalence of violent fantasies in non-offending groups. For example, Kenrick and Sheets (1993) found that 68% of their undergraduate sample endorsed homicidal fantasies and Crabb (2000) specifically commented on weapons selected for violent fantasies, in his study conducted within a similar non-clinical, non-offending group. More recently, Patel, Doyle & Browne (2013) found that 89% of their student sample had experienced some form of violent thought or violent fantasy. Here, while some participants reported that they found these experiences distressing, some endorsed that violent fantasies, compared with violent thoughts, were also associated with a level of desire; described by participants as providing a source of subversive pleasure. While these findings may present a biased representation of violent fantasies in the general population, given the focus on student samples, they helpfully provide some indication as to the nature of non-sexual violent fantasies in a general population, therefore contributing to the somewhat scant literature in this field.

Nevertheless, from the review of the literature on sexual cognition and offending it seems that there may be potential areas of overlap, some of which may apply to violent cognition in violent behaviour, although this has not been fully explored until now. A review of violent offender cognition will facilitate an appreciation of existing research in this area and a careful synthesis of the findings will contribute to improved understanding about violent cognition and the role of these phenomena in violent offending. In addition there is also a unique opportunity to explore violent cognition within groups of mentally disordered offenders. This will help to highlight the significance of offence-related cognition for this group of offenders and also provide context for the empirical study described within this thesis.

Aims:

1. To investigate the nature of the relationship between violent cognitions and violent offending
    a. Identify the role of violent cognitions in violent offending
    b. Establish whether, and by what means, violent cognitions increase the risk of violent behaviour
2. Consider the influence of mental disorder on violent cognitions and related violent behaviour.

2.2 METHOD

2.2.1 Data Sources

Two search methods were used to obtain relevant studies; an electronic search using online databases followed by a manual hand-search. The search was conducted on 11th August 2014. Five electronic databases related to healthcare research were searched for relevant publications: AMED (1950-2014), Science Direct (1949-2014), PsycInfo (1806-2014), Medline (1948-2014) and Embase (1980-2014). The search included both free text searching and indexed keywords (e.g. MeSH). Articles were limited to full-text articles that were written in English as translation from other languages was not available. No date limits were placed on the search.

A list of search terms were generated for use in the search. These included keywords for cognition (fantas*OR thought* OR daydream* OR imag* OR script* OR cogniti* OR rumination*), violence (violen*OR aggress*OR murder*OR kill*OR homicid*OR "sexual* violen*" OR AGGRESSIVE BEHAVIOUR OR VIOLENCE) and offender ("mentally ill" OR psychiatric* OR hospital* OR criminal OR prisoner* OR offender*). The Boolean operator AND was used to merge the results of the searches. A full list of the search strategy used is presented in the appendix 2-A.

Additional articles were identified through a manual search of reference lists from retrieved papers. Grey literature such as conference proceedings, theses and book chapters were not searched.

2.2.2 Study Selection

Studies were included if they: a) were written in English; b) appeared in peer-reviewed journals; c) had primary and sufficient data or provided original theoretical accounts derived from case-study, cross-sectional, case-control or cohort studies about the mechanisms by which violent cognition may be relevant to violent offending behaviour. Included studies sampled violent offenders, to include those who had committed sexually-violent crimes e.g. sexual murder. Narrative and systematic review studies were excluded from the current review to avoid double-counting of empirical studies that had been selected for inclusion. In addition, studies that merely cited violent cognition without explaining how and why these phenomena are involved in violent offending were excluded.

Population: Included violent-only or sexually-violent offenders who were male or female, who had committed violent crime (including sexually violent crime), including both single and serial offenders. Studies that sampled mentally disordered offenders, including those with personality disorder, were included. Age limits were not imposed on the population criterion so as to include any youth or juvenile offenders. Studies that sampled non-violent sexual offenders were excluded. Mixed samples of violent and/or non-violent offenders were permitted but only where there was clear differentiation in results relating to role of violent cognition for both types of offender i.e. not merged findings.

Phenomena: The phenomena of interest were violent cognitions to include offence-related cognitions, aggressive cognitions and sexually-violent cognitions. Cognitions were to include, but were not limited to, thoughts, fantasies, scripts, beliefs and schema. Non-violent cognitions and cognitions about violence or harm towards the self were excluded (e.g. thoughts of self-harm or suicidal ideation).

Outcome: The outcome criteria included actual violent or aggressive behaviour to include objectively recorded incidents of violent or aggressive acts. This included convictions or retrospectively collated data relating to violent or aggressive incidents. Self-reported violence or prospective re-offending variables (including recidivism predicted using risk assessment scales) were excluded to keep the outcome limited to actual incidents of violence or aggression.

2.2.3 Procedure

One researcher performed the electronic search, the hand-search and independently inspected the title of each reference to determine potential relevance. Abstracts were retrieved for articles that appeared to be potentially relevant, followed by a hand-search through the reference lists of these papers to identify any other relevant articles. The 36 articles that were potentially suitable were then scrutinised against the inclusion and exclusion criteria. A second researcher also independently reviewed all 36 articles for inclusion to minimise selection bias. A study was included where both authors agreed that it met criteria for inclusion. Disagreements were resolved through discussion and consensus agreement.

A diagram illustrating the stages of the study selection process is illustrated in Figure 2.1. A total of 942 articles were identified through the electronic search. Eight articles were additionally identified through a hand-search of reference lists. The screening and selection procedure resulted in 13 papers being included in the review. Details of excluded papers can be found in appendix 2-B.

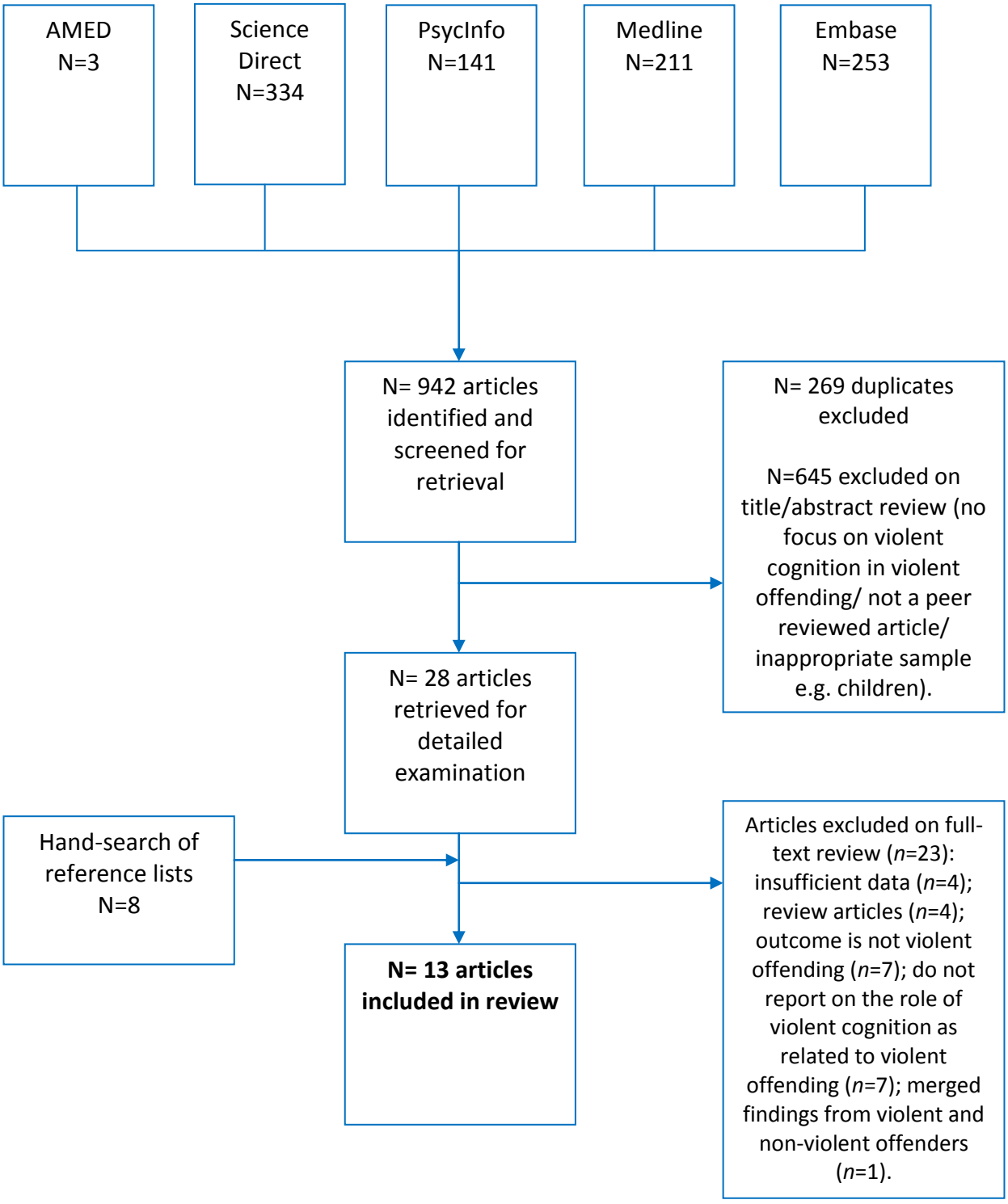

Figure 2.1 Flow diagram summarising the study selection process

2.2.4 Data extraction and quality assessment

Key characteristics of the included papers are presented in Table 2.1. All articles were assessed for quality using a brief quality assessment checklist. These data are presented in Table 2.2 alongside a summary of the methodological quality of each study, which is intended to increase the transparency of how the quality ratings were derived. It was felt that the assessment of quality should not be overly rigid as this was the first review in the area and as such the aim was to maximise eligibility. As the included articles were comprised of different study designs (e.g. case-study, cross-sectional and cohort studies) it was important to use a broad quality assessment checklist that could be consistently applied across all studies. Items were taken from the quality assessment criteria suggested by Greenhalgh (1997) which include: originality, sample, design, bias, and conclusions. All items were rated as poor (0), fair (1) or good (2). The quality assessment was completed by one researcher and therefore it was not possible to assess inter-rater reliability. Despite this, Shamilyan, Kane & Dickinson (2010) argue that while formal scaling is widely used, such a method may detract from a more qualitative evaluation and they argue that evaluation of quality should be based on the components of the criteria. Therefore, the scores reported in Table 2.2 provide a relative indication of quality for all papers included in this review, but the overall quality is reflected through a subjective summary of each paper that is also presented in the table.

2.3 RESULTS

Of the 13 studies included in the review, 7 were primary studies (Beauregard, Stone, Prolux & Michaud, 2008; Burgess, Hartman, Ressler, Douglas & McCormack, 1986; Deu, 1998; Grisso, Davis, Vesselinov, Appelbaum & Monahan, 2000; MacCulloch, et al., 1983; Milner & Webster, 2005; Prentky et al., 1989). Five papers were dissertation articles which reported on different typologies of violent offender, as related to violent cognition and violent offending (Hazelwood & Warren, 2000; Keppel & Walter, 1999; Knoll, 2010; MacCulloch, Gray & Watt, 2000;

Schlesinger, 2007) and one paper described a single case study (Carabellese, Maniglio, Greco & Catanesi, 2011).

Table 2.1

Data Extracted from Studies Included in Review

Quantitative Studies						
Authors	**Sample**	**Design**	**Type of cognition(s) studied**	**Outcome / Dependent Variables**	**Specific Results *(quantitative studies only)***	**The role of violent cognition in violent offending**
Beauregard, Stone, Prolux & Michaud (2008)	N=77 detained male violent offenders; *n*=11 murderers of children, *n*=66 murderers of adult women. Sample represents 85% of convicted and incarcerated sexual murderers detained in penitentiaries in Qubec, Canada.	Observational - Case Control Group comparison: sexual murderers of children compared with sexual murderers of adult women.	Sexual scripts that were developed in childhood. Actualisation of deviant fantasy in reality.	Groups compared on developmental factors (e.g. life and sexual history) as well as pre-crime, crime and post-crime factors.	Sexual murderers of children were more often victims of sexual abuse in childhood compared to sexual murderers of women (χ^2=6.26, p<0.01). In addition, sexual murderers of children presented more deviant sexual fantasies (χ^2=3.85, p<0.05), were more likely to use pornography prior to the crime (χ^2=4.22, p<0.01) and demonstrate evidence of premeditation of the crime (χ^2=4.31, p<0.05) compared to sexual murderers of women.	Sexual fantasies that are paired with masturbation create a conditioned association between sexual fantasies and sexual arousal. This may increase the risk of acting out the sexual fantasy in reality, resulting in sexual offending.
Deu (1998)	N=43 male offenders detained at	Cross sectional study. Patients	Cognitive processes relating to	Planning and organisation of previous crime	Significant Stroop by Weigl interaction for the offence being planned	Fantasies can be used to organise and plan crimes, particularly

	Broadmoor High Secure Hospital, UK. Sample comprised violent and sexual offenders. No evidence of psychosis amongst the sample.	grouped according to performance on cognitive assessments and compared.	problem-solving and criminal fantasies.	was assessed using a four-point scale devised by Prentky & Knight (1986).	(F=8.38, p<.01) and organised (F=54.38, p<.01). Degree of planning was not related to differences in cognitive flexibility or impulsivity (χ^2(3)=0.48, p<0.92). Organisation of crime was related to interpersonal violence (r_s=0.25, p<0.01), elaboration, (r_s=0.10, p<.01), and planning (r_s=0.32, p<0.01). Elaboration was related to planning (r_s=0.51, p<.01).	those that involve interpersonal violence. Offenders with good cognitive flexibility and high levels of impulsivity are more likely to report repeated crimes.
Grisso, Davis, Vesselinov, Appelbaum & Monahan (2000)	N=1136 mentally disordered offenders detained in psychiatric	Observational cohort study.	Violent thoughts as scripts for violent behaviour	The frequency of violent incidents[2] were recorded at three time-points:	Higher prevalence of 'SIV+' status amongst non-white patients compared to white participants (χ^2(1)=10.90, p<0.01).	Violent thoughts reported in hospital predicted violent behaviour post-discharge. Furthermore,

[2] Violence was defined as "battery resulting in physical injury, sexual assaults, assaultive acts that involved the use of a weapon, or threats made with a weapon in hand" Grisso et al., (2000) p. 392.

hospitals in the USA. Nearly 80% of this sample had a history of violence and/or aggression. Diagnoses at admission included depression (22.8%); bipolar disorder (35.5%); schizophrenia (20.0%); alcohol or other drug abuse (57.7%); personality disorder (37.4%); or an organic disorder (9.1%).	1) in hospital (baseline) 2) 10 weeks post discharge 3) 20 weeks post discharge. SIV status [3] was also recorded at each time point.	Prevalence of violent behaviour at baseline and within 20 weeks of discharge: • 16% for SIV- individuals • 26% for SIV+ individuals The difference was significant ($_x^2$(1)=14.88, p<0.001). Violent behaviours at follow up: • 37% for SIV+ persistent • 17% for SIV+ non-persistent • 15% for SIV+ not classified as persistent. The difference was significant ($_x^2$(1)=25.34, p<0.01). Baseline SIV status predicted violent behaviour post-discharge, even after controlling for other variables such as anger and impulsivity ($_x^2$(1)=4.30, p<0.05).	persistent reporting of violent thoughts (both in hospital and post-discharge) was also related to significantly higher rates of violent behaviour compared to non-persistent violent thoughts.

[3] SIV status: SIV+ (positive) status assigned to individuals who reported that they sometimes have daydreams or thoughts about physically hurting other people *and* that they have had such thoughts within the past 2 months. Patients were classified as SIV- (negative) if they failed to meet either criterion.

Milner & Webster (2005)	Thirty-six male offenders detained within a high secure prison in the UK. Sample comprised *n*=12 rapists, *n*=12 child molesters[4] and *n*=12 violent offenders. Violent offenders had a history of at least 1 violent offence and no recorded sexual offences.	Observational case control study. Three different offender groups were compared on a number of assessments relating to cognition.	Cognitive structures – schemas related to offending.	Two measures to identify schema: 1) My Life Questionnaire to establish schemata (Mann & Hollin, 2001). 2) Life Maps Exercise (theme analysis to construct list of common thinking styles, followed by content analysis to assess prevalence of schemata in the group).	*My Life Questionnaire:* • Rapists had higher levels of hostility towards women compared to violent offenders (F_t=7.2, p<0.001). • Violent offenders had greater 'need to protect' than rapists (F_t=3.5, p<0.001). *Life Map Thinking Styles* Violent offenders had significantly higher scores compared to rapists in three domains: • Passive Victim (F_t=0.79, p<0.05) • Vengeful Entitlement (F_t=1.04, p<0.015) • Need for control (F_t=0.75, p<0.010).	Schemas may play a causal role in contributing to violent interpersonal offending.
Prentky et al. (1989)	Twenty-five serial sexual murderers (committed three or more murders)	Observational case control study.	Fantasy	Single and serial murderers were compared on:	86% of serial murderers and 23% of single murderers evidenced violent fantasies and this	Paraphilias suggest a preference for fantasy. Moreover, paraphilias provide incentive for

[4] Data for sample of child molesters was not included in the analysis due to the unknown variance in this group relating to violent and non-violent offending.

	and seventeen single-incident sexual murderers. Ten of the single-incident murderers were resident within a treatment centre.		• Prevalence of violent fantasies • Prevalence of paraphilias • Organisation of crime scenes	difference was significant ($\chi^2(1)=14.02$, $p<0.001$). There were a higher number of paraphilias in the serial offender group, with significant differences for fetishism ($\chi^2(1)=4.54$, $p<0.03$) and cross-dressing ($\chi^2(1)=4.38$, $p<0.05$). Over two-thirds of serial murderers' first sexual homicides were organised, while three-quarters of single murderers' homicides were disorganised ($\chi^2(1)=8.00$, $p<0.005$). Planning of offences did not differ between the two groups.	carrying out fantasy-consistent behaviours in reality, in the pursuit of stimulating material or experiences. Violent fantasies may be related to the level of organisation at a crime scene.

Qualitative/Descriptive Studies				
Authors	**Sample**	**Design**	**Type of cognition(s) studied**	**Qualitative description of the role of violent cognition in offending**
Burgess Hartman,	N=36 males. All were sexual	Non-comparative	Cognitive mapping and	Cognitive mapping and processing (which includes fantasies and biased interpretations), paired with kinaesthetic arousal levels move the offender

Ressler, Douglas & McCormack, (1986)	murderers. Data extracted from USA FBI files.	descriptive case series study. All data collated into a motivational model.	processing (fantasies and biased interpretations).	to murder. The violent or sexually-violent actions lead to increased arousal, feelings of dominance, power and control which are fed-back into the cognitive mapping and processing system, thereby maintaining a cycle of cognition and action.
Carabellese, Maniglio, Greco & Catanesi, (2011)	Male serial sexual offender, aged 38, who assaulted 39 women in Italy over a period of approximately 3 years. Diagnosed with: paraphilic disorder, anxiety, depression. Also recognised as having borderline and narcissistic personality traits and high levels of impulsivity.	Non-comparative single case study.	Fantasies	Fantasies of forced sex, sexual coercion and dominance, which may have been linked to his narcissistic personality, appeared to be a primary drive mechanism for his offences. Offender described feeling aroused and excited before an assault when he first began to think about selecting a victim and then having her under his power. This sexual arousal linked to the predatory actions (all deliberate, carefully planned and executed) fuelled fantasies of dominance, coercion and aggression. The offender also fantasised about the offence afterwards, reliving the offence to reach arousal and practicing masturbation to sustain arousal in order conclude intercourse with his wife. These fantasies therefore sustained pleasure and increased sexual activity (perhaps in preparation for an offence), whilst simultaneously reducing behavioural inhibition.
Hazelwood and Warren (2000)	N/A. Based on multiple case	Dissertation - Descriptive	Fantasy	Two types of sexually-violent offender are theorised: impulsive and ritualistic. Fantasy plays a key role for the ritualistic offender's crimes in

	studies.	synthesis based on single case reports.		that they are thought to provide a conscious and repetitive template for multiple offences. This type of offender will attempt to recreate a scenario from his fantasies in real life, including engaging in pre-offence behaviours such as acting out fantasies with inanimate objects, paid and consensual partners. While the impulsive offender also experiences fantasies, these are simplistic and concrete in comparison to those of the ritualistic offender. The impulsive offender's offences are also motivationally driven but do not appear to be fantasy based, with no indication of pre-selection of victim, complex ruses or attempts at deceptive disguise.
Keppel and Walter (1999)	N/A. Based on multiple case studies.	Dissertation - Descriptive synthesis based on single case reports.	Fantasy	Four types of sexually-violent offender are theorised: power-assertive, power-reassurance, anger-retaliatory and anger-excitation. Power-assertive and power-reassurance rapists both plan their rape offences; the latter is motivated to acting out his seduction and conquest fantasies in an attempt to procure feelings of sexual competency and personal adequacy. The anger-excitation offender has highly specialised fantasies that become energised in the commission of an offence. Excitement is heightened by the realisation of an imagined or rehearsed scenario. Sadistic themes are also observed in the process of the killing for the anger-excitation murderer.
Knoll (2010)	N/A. Based on multiple case studies.	Dissertation – Descriptive synthesis based on single case reports.	Fantasy	Feelings of social inadequacy dominate the pseudocommando mass murderer. Persecutory cognitions are experienced as threatening undeserved attacks on the self. This leads to an intense hatred of the world and a desire to take revenge through the commission of mass murder. The revenge fantasies are positively reinforcing and provide sustenance to his self-esteem. He also gains feelings of power and control during the planning of his offence. Acting out the fantasy in reality is his final attempt at restoring a grandiose self image.

MacCulloch, Snowden, Wood & Mills (1983)	N=16 male patients detained within a high secure psychiatric hospital in the UK. All patients were violent or sexually violent murders; *n*=13 identified as sadistic offenders. Sample age ranged from 17-37 years. All patients were identified as having 'psychopathic disorder' and did not have a diagnosis of schizophrenia or affective psychosis.	Observational Non-comparative case series study involving retrospective review of case notes and subsequent synthesis of two groups based on pattern of fantasy and offending.	Sadistic Fantasy	Sexually deviant fantasies provided a forum for internal rehearsal of the offence both prior to its commission and post-offence review. Offences prior to the index offence were behavioural try-outs of the fantasy in reality and a review of offending history indicated that the index offence itself was one of a series of prior progressive behavioural try-outs. The sadistic offender is motivated to offend to ensure that the fantasy continues to function as an effective source of arousal.
MacCulloch, Gray & Watt (2000)	N/A. Based on multiple case studies.	Dissertation - Descriptive synthesis	Sadistic Fantasy	Sadistic fantasies (developed through repeated pairings of sexual arousal and aggression) may be causally related to offending in that they provide the affective motivation to offend.

		based on single case reports.		
Schlesinger (2007)	N/A. Based on multiple case studies.	Dissertation - Descriptive synthesis based on single case reports.	Fantasy	Distinguishes between catathymic and compulsive murderers. Compulsive murderers are driven by a powerful urge to act out their deviant fantasies; their initial attempt to resist the compulsion results in anxiety, creating a state of tension which is relieved through offending. There is also an increased likelihood of repeat offending for this type of offender. The fusion of sex and aggression in the fantasies of the compulsive murderer means that the murders are sexually motivated and that the violence that ensues is sexually arousing and stimulating. Catathymic murderers may also experience homicidal ideas, which can become fixed and obsessive. For this offender, highly charged affect can trigger a violent assault.

A meta-analysis was considered unsuitable due to the heterogeneity of the studies included in the review. However, a narrative synthesis method was used instead as this can be more appropriate when a research question yields a wide range of research designs. The guidance provided by Popay et al., (2006) was used to guide the narrative synthesis conducted as part of this review. A *preliminary synthesis* process was initially undertaken to extract and present relevant information from each study pertaining to the research question i.e. what each study concludes about the role of violent cognition in violent behaviour. These data are presented in Table 2.1 and Table 2.2, with the latter intended to facilitate a review of each study's methodological strengths and weaknesses so that findings can be evaluated with these qualities in mind. These data have been presented in tables to facilitate a comparison of the main features of each study across the whole set of papers that were included in the review.

The second stage of the analysis involved a process of *exploring relationships* between the articles and this was facilitated by grouping papers together based on what they contributed to various stages of the offending process. In addition, findings were compared between studies of sexually-violent offenders (Beauregard et al., 2008; Burgess et al., 1986; Carabellese et al., 2011; Deu, 1998; Hazelwood & Warren, 2000; Keppel & Walter, 1999; MacCulloch et al., 1983; MacCulloch et al., 2000; Milner & Webster, 2005[5]; Prentky et al., 1989; Schlesinger, 2007) and non-sexually violent offender (Grisso et al., 2000; Knoll, 2010; Milner & Webster, 2005). This process of exploring relationships is completed as part of the discussion.

[5] Note, Milner and Webster (2005) sampled both violent offenders and sexually-violent offenders (rapist group), so these groups are referred to separately as part of the discussion.

Table 2.2

Quality Ratings for studies included in review.

Quantitative Papers	Methodological Quality Summary	Quality Criterion					
		Originality	Sample	Design	Bias	Conclusions	Modal Rating
Beauregard et al. (2008)	Study included a sample that was representative of 85% of sexual murderers within a region of Canada, although sexual murderers of women were over-represented in the sample. Study design was appropriate and data collection was thorough, however it is unclear whether blinding was used in the retrospective collection of data to reduce bias.	2	1	2	1	1	1
Deu (1998)	An assessment of executive function skills provides a more objective measure related to cognition, which is a relative strength of this study. There is a lack of clarity regarding recruitment of participants to the study; participants appear to have been recruited on the basis of pre-existing scores on neuropsychological tests, which could introduce some bias to the overall findings. Conclusions appear appropriate.	2	1	2	1	2	2
Grisso et al. (2000)	This was an original study that recruited a large sample of violent offenders and non-offenders. Conclusions appear appropriate although there may have been potential for further analyses to provide additional support to the overall findings.	2	2	2	1	1	2

Milner & Webster (2005)	A strength of this paper is the use of both qualitative and quantitative measures of violent cognitions which are used to integrate findings. Inter-rater reliability was calculated for qualitative rating measures. Participants were randomly selected for participation and there is clear reporting of the sampling and recruitment process.	2	2	2	2	2	2
Prentky et al. (1989)	Sample consisted of single and serial sexual murderers although slightly larger sample of serial murderers (25 compared to 17 single). Appropriate design and methods used to compare groups. Conclusions appear consistent with the results of the study.	1	1	1	1	2	1
Qualitative Papers							
Burgess et al. (1986)	A small number of sexual offenders were selected based on their existing case records. Data from case records were used to create the motivational model of sexual homicide. Model appears to be consistent with the data although it is unclear whether any measures were taken to reduce bias.	2	1	1	0	2	1
Carabellese et al. (2011)	The rich description provides a thorough account of the case; highlighting complexity and detailing the role of sexually-violent cognition in his offending. However, the single case report has limited generalisability and therefore the conclusions drawn are not considered in isolation, but instead are used to support the findings of other studies where similarities exist.	2	0	1	0	1	1

Hazelwood and Warren (2000)	Synthesis of several case studies contributing to the description of an impulsive versus ritualistic offender typology. Conclusions seem appropriate from the data presented, although there may have been some selection bias in the case studies that were reviewed to collate these data.	1	N/A	N/A	0	1	1
Keppel and Walter (1999)	Synthesis of several case studies contributing to the description of sexual murderer typology, of which four types are presented with case study material to support each. Conclusions seem appropriate from the data presented, although there may have been some selection bias in the case studies that were reviewed to collate these data.	1	N/A	N/A	0	1	1
Knoll (2010)	Synthesis of several case studies contributing to the description of a pseudocommando mass murderer, with case study material to support. Conclusions seem appropriate from the data presented, although there may have been some selection bias in the case studies that were reviewed to collate these data. Furthermore, data are of limited quality and their interpretation may be subject to interpretation bias.	1	N/A	N/A	0	1	1
MacCulloch et al. (1983)	Original and descriptive study yielding rich data, however these data were only collected through a review of case notes. Sadistic murderers were also only identified through review of case notes; it is unclear how this	2	1	1	0	1	1

	screening process was undertaken. However, conclusions drawn appear to be consistent.						
MacCulloch et al. (2000)	Synthesis of several case studies contributing to the development of a sensory preconditioning model of sadistic behaviour. The model is based on a review of case studies and empirical studies of sadistic offender. The model appears to be appropriate.	1	N/A	N/A	0	1	1
Schlesinger (2007)	Synthesis of several case studies contributing to a typology of catathymic and compulsive murderers. Conclusions seem appropriate from the data presented, although there may have been some selection bias in the case studies that were reviewed to collate these data.	1	N/A	N/A	0	1	1

Methodological Quality Criteria (taken from Greenhalgh, 1997)

Originality: Was the study original; is it larger or more substantial than previous studies and is the methodology more rigorous (if it is a replication); is the clinical issue addressed of sufficient importance.

Sample: Appropriate method of recruitment of participants from target population; details of excluded/withdrawn participants are reported; sample is appropriate to research question/study aims.

Design: Was the design appropriate for the research question/aims?

Bias: Is there evidence of selection bias, performance bias, attrition bias, detection or reporting biases (taken from Higgins & Altman, 2008). Have appropriate efforts been made to ensure that bias is minimised where necessary, as relevant to the sample and design for the study?

Conclusions: Do the conclusions drawn seem appropriate; do the results or generated theory seem credible in light of the design and results of the study?

2.4 DISCUSSION

This chapter provides a review of the literature on violent cognition to address the question, *what is the role of violent cognition in violent offending*. The chapter also functions as an introduction to the empirical studies detailed within the thesis to provide some context relating to violent cognition within a sample of mentally disordered violent and sexually-violent offenders. Violent cognition, in its many forms, appears to have many roles relating to violent behaviour and spans pre-offending, during-offending and post-offending periods.

2.4.1 Origins and Pre-offending Stage

In the first instance, there is evidence to suggest that violent cognitions are grounded in childhood experiences. Beauregard et al., (2008) described how many of the sexual murderers of children had either witnessed or been exposed to sexual abuse when they were children themselves and this is not uncommon in the

literature on sexual offending (e.g. Ogloff, Cutajar, Mann & Mullen, 2012). Moreover, Beauregard et al., suggested that these experiences of physical, psychological and/or sexual abuse may have led to the development of a set of core beliefs about the self, relationships to others and the world, and more specifically scripts about violence. Interestingly, Beauregard et al., describes the development of *scripts* about violence, but describes sexually-violent offending as a consequence of deviant *fantasy*. While little explanation is given to distinguish the different products it may be appropriate to assume, for now, that these are two separate processes which contribute to offending in different ways. This will be addressed further, later in this discussion. Nevertheless, similar observations in relation to script development were also made by Burgess et al., (1986) which collectively suggest that formative and traumatic experiences may predispose some individuals to developing scripts related to (sexual-) violence. However, the presence of scripts alone does not determine violent behaviour as not all scripts are rehearsed or accessed (e.g. Huesmann, 1998) and therefore there is a need to consider factors influencing script processing and rehearsal.

Burgess et al., (1986) describes how frequent exposure to criminal activities (e.g. in the family), paired with parental failings in the provision of adequate protection and supervision, might contribute to normative beliefs regarding the acceptability of violence. At the same time, Huesmann & Eron (1989) would argue that the absence of parental guidance doesn't permit the unlearning of instinctive and evolutionary aggression that is innate. Collectively, such experiences may contribute to normative beliefs about violence, which may influence script rehearsal (Sestir & Bartholow, 2007). In a recent study Gilbert, Daffern, Talevski & Ogloff (2013) found positive associations between normative beliefs about aggression and frequency of script rehearsal, and they concluded that aggression-supportive beliefs functioned as a gateway or filter for the rehearsal of aggressive scripts. Therefore, it seems that early experiences may not only contribute to the development of violent or aggressive scripts, but that they may also shape beliefs

and attitudes towards violent and aggressive behaviours, which may collectively increase risk of violence.

Grisso et al., (2000) used the theory of script rehearsal (Huesmann, 1988; 1998) to explain their findings of an association between violent thinking and violent behaviour. However, this pattern was only observed for non-white patients in the sample. This led Grisso and colleagues to conclude that prior victimisations, which they assumed to have been more prevalent across their non-white participant group, might have also strengthened scripts for violence, in line with social-cognitive and script rehearsal theories (Huesmann, 1988; 1998). Although histories of victimisation were not recorded as part of Grisso and colleagues' study, the hypothesis does appear to be consistent with findings from other studies, suggesting that this might have been a likely explanation for the difference between groups in their study.

Beauregard et al., (2008) also acknowledge the impact of abuse on offenders within their sample. Beauregard et al., theorised that this may have led to attachment difficulties and subsequent difficulties engaging in social interaction with others, which is also consistent with the literature on attachment and violent offending (e.g. Ogilvie, Newman, Todd & Peck, 2014; Savage, 2014). Moreover, Beauregard and colleagues suggest however, that such attachment difficulties may encourage isolation and social withdrawal and it is this that leads to the creation of a *fantasy* that meets the offender's needs in a way that reality does not. These observations were similarly noted by MacCulloch et al., (1983), MacCulloch et al., (2000), Carabellese et al., (2011) and Knoll (2010). MacCulloch and colleagues (1983) described how feelings of rejection and sexual inadequacy contributed to the development of sadistic fantasies within which the offenders themselves were omnipotent. Moreover, these more deviant themes appear to have emerged during adolescence and MacCulloch et al., (1983) observed increases in masturbation to sadistic fantasies following this content change. Similarly, the case study described by Carabellese et al., (2011) describes how the offender may have been motivated to create fantasies of dominance, coercion and aggression against women in an

attempt to overcome feelings of impotence and inadequacy related to sex and is therefore consistent with findings from other studies. It therefore seems that sexually-violent fantasies are not only developed to overcome obstacles in reality, and in doing so create an alternative reality, but moreover these fantasies are also related to sexual arousal. Such pairings of deviant fantasy with sexual arousal have implications for sexually-violent offending and will be discussed in the relevant section below.

The pseudocommando mass murderer described by Knoll (2010) is a non-sexual, violent offender who is also reported to have developed deviant fantasies in adolescence. Whereas sexual offenders reported the creation of fantasies that were associated with sexual arousal, the pseudocommando mass murderer on the other hand develops fantasies that instead appear to be directed at self-preservation; protecting against feelings of shame, loss and defectiveness. This offender was described as suspicious, with strong feelings of persecution and victimisation. Knoll argues that revenge fantasies for the pseudocommando mass murderer provide much needed sustenance to a fragile self-esteem. Moreover, the pseudo sense of control that is consequently achieved is also positively reinforcing.

While Knoll's (2010) observations may be limited in terms of their generalisability, they do however share some thematic similarities with another study of violent offenders, which may provide additional support. Milner & Webster (2005) sampled three groups of offenders: rapists, violent offenders and child molesters, in a study aimed at identifying schemas within different offender groups. Of particular relevance, the violent offender group had significantly higher scores, compared to the other two groups, on three schemas which included passive victim, vengeful entitlement and need for control. Milner & Webster concluded that the most prevalent schematic theme for violent offenders was related to grievance and revenge and thus the broad thematic similarities across the findings provide some substantiation to Knoll's observations.

Taken together it seems that violent cognitions in the form of normative beliefs about violence, behavioural scripts and fantasies have origins in early

experience. Beliefs and scripts persist into adolescence and adulthood and continue to provide a framework for the interpretation of social cues and selection of appropriate behavioural responses. Fantasies, on the other hand, appear to develop out of a need to achieve something which is absent in reality e.g. a pseudo-sense of power and control or dominance. These feelings appear to sustain the individual through a process of affective regulation and/or sexual arousal in the case of sexually-violent offenders.

2.4.2 During Offending

There appear to be some differences in the way in which violent cognitions i.e. scripts or fantasies, move the individual to offend. Fantasies appear to be related to offending for the sexually-violent offender in particular. MacCulloch et al., (1986) described deviant sexual fantasies for all members of their sadistic group. These appear to have started in adolescence by providing a source of sexual arousal for the sadistic offender, which was also often paired with masturbation. Although, in later works MacCulloch et al., (2000) suggest that the origins for deviant fantasies may even start in childhood; from abuse, children are thought to develop associative links between aggression and sexual arousal which, they argue provide the origin for sadistic fantasy. MacCulloch et al., (1983) observed some similarities between the fantasies that offenders held and the offences they committed and this association was not only consistent over time but also demonstrated escalation; increasingly deviant content and associated offending. This prompted MacCulloch et al., (1983) to consider whether fantasies functioned as a rehearsal template for offending and although this was one of the conclusions that was drawn, there appeared to be more to the escalation of both fantasy and offending that warranted consideration. It seemed that the motivation for offending for the sadistic offender was borne out of a need to procure a more intense state of arousal than what the fantasy could provide alone. Moreover, as the material from offending or behavioural trials was recycled back into renewed fantasies, this ensured that the fantasy continued to function as an effective source of arousal.

Therefore, it seemed that the fantasy may have provided some of the motivation for offending for the sadistic offenders, but moreover it appeared to be the affective or even physiological need within the fantasy that prompted this drive.

These findings are augmented by Schlesinger (2007) who suggests that the sadistic offender feels compelled to act on his fantasies and moreover that this compulsion is both psychological (e.g. Meloy, 2000) and physiological (Miller, 2000). Schlesinger suggests that the sadistic fantasies for his theoretical conceptualisation of a *compulsive murder* are paired with a compulsion to act. Moreover, this compulsion creates a state of anxiety and tension that the murderer is then motivated to alleviate through action (offending). Therefore, it seems that there is some evidence for sexual fantasies providing the motivation for offending, through affective or physiological drives.

Similar findings were also observed by Prentky and colleagues (1989). Serial murderers in the Prentky et al., sample not only experienced more violent fantasies than single offenders, but also had a higher number of paraphilias. Prentky and colleagues concluded that increased pairing of fantasy with paraphilias strengthened the association between fantasy and sexual arousal and moreover, that this provided a template for repetitive sexual offending. Prentky et al., also looked at the planning and organisation of sexually-violent crimes between their groups of serial and single sexual murderers. They found that the percentage of organised murders (as evidenced through order at the crime scene and attempts at preventing detection) was almost three times as high in the serial offender group compared to the single offender group; i.e. that repeat offenders were more organised. Prentky and colleagues had also hypothesised that the two groups might also differ with respect to planning, however this was not supported in their study. Despite a non-significant finding here, there was evidence from another study to suggest that planning may have some role in the conduct of violent crime.

Deu (1998) assessed planning more objectively using a battery of assessments which included measures of executive functioning to assess impulsivity using the Stroop Task (Trenery, Crosson, DeBoe, & Leber, 1989) and cognitive

flexibility using a card-sort task (Nelson, 1976). The Criminal Fantasy Technique (Schlesinger & Kutash, 1981) and Planning of Index Offence Scale (PIOS; Prenky & Knight, 1986) were also used. Although there were no significant correlations between the criminal fantasy themes and planning of the index offence, Deu did find a series of other interactions. For example, elaboration was related to planning and was also related to the offence being committed again. Moreover, Deu found that highly impulsive offenders, but only those who also had good cognitive flexibility, were more likely to report repeated crimes. Deu suggested that good cognitive flexibility may enable the offender to more carefully execute his crimes (problem-solve challenges and allude apprehension) and thus the interaction between these variables was significant to consider for the organisation and planning of interpersonally violent crimes.

As Deu's (1998) findings are drawn from a sample of high-secure hospital patients, these findings also have some relevance to the empirical study, which sampled a similar population. Nevertheless, despite novel and interesting findings from Deu, it is difficult to assess the level of generalisability of the findings to other groups, given the limited description of sample and the way in which participants were selected. However, the findings appear to be reliable and consistent with other studies that have subjectively observed interactions between organisation and planning (e.g. Hazelwood & Warren, 2000; Schlesinger, 2007), which therefore highlights an important interaction that may be expanded in subsequent research.

Keppel and Walter (1999) present a typology of four different types of sexual murderers who are motivated to offend in different ways. The sexual homicides committed by the anger-excitation murderer are precipitated by highly specialised fantasies and there appears to be a high level of sadistic arousal gained from the realisation of the fantasy in reality. Subsequent offending simultaneously re-energises his fantasies, thereby fuelling a continued cycle of fantasy and sexual murder. This murderer also invests a great deal of time in his fantasies, engages in ritualised behaviours, demonstrates escalation in his crimes and shows evidence of organisation at the crime scene, therefore highlighting some similarities between

the anger-excitation murderer and the ritualistic offender described by Hazelwood & Warren (2000). Both the anger-excitation murderer (Keppel and Walter, 1999) and the ritualistic murderer (Hazelwood and Warren, 2000) similarly appear to be motivated to offend to procure some form of arousal. Moreover, Hazelwood & Warren suggest that the ritualistic offender is driven by intense affect to include power, anger or a combination of the two and that his fantasies provide the conscious repetitive template for his multiple crimes. Due to the descriptive nature of both studies it is not possible to draw direct comparisons between the two. However, it is useful to highlight the similarities in how fantasies appear to be used in the commission of sexual murder. From a review of studies that included sexual murderers it seems that arousal or intense affect provides strong motivation for the commission of sexually motivated crimes. Moreover, given the significance of fantasies for some sexually-violent offenders, and their association with strong affect, it seems appropriate to suggest that they may also be related to offending.

The relative literature on non-sexual violent fantasies is limited and only three papers (Grisso et al., 2000; Knoll, 2010; Milner & Webster, 2005) were available for the review. The synthesis of data from these studies is also varied which makes it difficult to recognise consistent patterns but nevertheless, some attempt will be made to review the relevant contributions. From the description provided by Knoll (2010) it seems that the violent fantasies held by the pseudocommando mass murderer provide much needed sustenance to self-esteem. In his fantasies the pseudocommando mass murderer can exact his revenge on the world in an extreme way and this contributes to feelings of power and omnipotence, which then help him to overcome feelings of shame and low self-worth. His intense anger that is directed towards the world appears to provide some motivation for his offending. However, there is more evidence of pre-planning with this offender, in the purchasing of substantial ammunition and preparation of departing manifestos as he prepares to end his own life, following his mass murder.

The violent thoughts that were studied by Grisso et al., (2000) offer less detailed description than some of the other studies that have been described here, but nevertheless provide some dimensional assessments of violent thoughts for analysis. The study conducted by Grisso et al., was the only other study in this review (in addition to Beauregard et al., (2008)) to refer to scripts. Grisso et al., found a positive association between frequency of violent thoughts and violent behaviour for some patients who were discharged from a mental health facility. Grisso et al., also assessed anger and found that when this variable was entered into a regression model, with violent behaviour as the outcome variable, anger along with other variables such as impulsivity and psychopathy did make a significant contribution to the model, suggesting that these variables were important, yet further interaction was not found. Despite this, anger has been found to be associated with violent scripts and a recent study by Gilbert et al., (2013) identified a positive relationship between anger and more frequent rehearsal of scripts. Therefore, there may be some interaction whereby angry affect is also important in contributing to violent behaviour, but additional research is necessary to further elucidate the influence of this variable.

The schemas for violent offenders that were identified by Milner & Webster (2005) were described earlier in this section and will not be repeated here. However, the reader is directed to consider the common themes that relate to the self as a victim. There appear to be some similarities between these schema for violent offenders and the way in which the pseudocommando mass murderer views the world and others. Despite thematic similarities, direct comparisons cannot be drawn given the differences in methodology between the studies and the different cognitions being assessed e.g. schema versus fantasy. However, there may be some argument to hypothesise that what motivates the violent offender to offend may be related to a threat to the self; threat to self-esteem and/or need for self-preservation. However, this is a tentative suggestion based on limited evidence but one which would warrant further investigation. A recent systematic review by Bowes & McMurran (2013) however did conclude that the treatment of violent

cognition for violent offenders might be supplemented by interventions that are targeted at addressing issues of self-esteem or social embarrassment related to decisions not to use violence. Therefore there may be a potential influence of low self-esteem in contributing to violent offender's cognition, but this was not expressly identified in the current study.

2.4.3 Post Offending

After the offence has been committed the offender may entertain memories of the event and these may be recycled to provide new material for the fantasy. MacCulloch et al., (1983) describes how offence memories could be recycled and their content used to shape and enhance existing fantasies to ensure that the fantasy continued to function as a source of arousal. Similarly, Burgess et al., (1986) extended these findings and suggested that as part of the feedback filter, violent behaviour becomes justified and the individual also becomes more practiced at offending e.g. foreseeing and overcoming obstacles for the next time. It is assumed that the repeat offender is therefore more likely to be well-practiced and display evidence of organisation in his crimes. Indeed, organisation and repeat offending was a key characteristic of the ritualistic offender as described by Hazelwood and Warren (2000). In addition, given that fantasies appear to have some role in contributing to the organisation of crime it might by hypothesised that fantasies can be used to plan offences, however this is a speculative assumption at this stage given the lack of empirical data to support the hypothesis.

2.4.4 The influence of mental disorders and personality

One of the aims of this review was to consider the role of violent cognition in violent offending for mentally disordered offenders. Of the studies that were included in the review, only two sampled mentally disordered offenders (Deu, 1998; Grisso et al., 2000) but only Grisso et al., (2000) described the possible influence of mental disorder on violent thoughts and violent behaviour. Grisso et al., found that patients with high symptom severity were more likely to have been

imagining violence than patients with low symptom severity and furthermore, non-white patients were also found to be more likely to engage in violent behaviour post-discharge if they were within the medium or high symptom severity groups. Grisso et al., were able to explain the findings in line with Huesmann's (1988, 1998) script theory, this time suggesting that under high levels of stress (i.e. more symptoms) one is more likely to retrieve scripts that are more accessible i.e. those scripts that are related to violence.

While other studies were less explicit in their considerations of mental disorder, some observations were made about biased interpretations which might be timely to review here. For example, Knoll (2010) reported that the pseudocommando mass murderer experienced persecutory cognitions, which were experienced as threatening and undeserving attacks on the self. These beliefs then fuelled anger and associated fantasies of taking revenge. While delusional beliefs were not explicitly reported by any other study it might be sensible to suggest that information processing deficits or biases may contribute to violent thoughts or fantasies (as described here), and furthermore that this risk may be augmented for people with information processing biases such as those with delusions (e.g. Garety, Hemsley & Wessely, 1991; Garety, Kuipers and Fowler, 2001)

In addition, some studies also referred to personality characteristics that may be relevant. Burgess et al., (1986), Carabellese et al., (2011) and Knoll (2010) all similarly described narcissistic personality traits and a sense of entitlement amongst the samples they studied. However, as these findings emerged post-hoc and largely as a result of the observational designs used in these studies, personality variables were not outwardly recognised as important contributors, but would nevertheless be worthy of future research. Furthermore, it is widely recognised that personality and personality disorder are related to violent offending (see McMurran & Howard, 2009). However, there has been little attempt at exploring personality in relation to violent thoughts and violent behaviour specifically; in particular, which personality traits might perpetuate violent thoughts or fantasies and thus perhaps make the

potential for violent behaviour more likely. This would be an interesting area for future research.

2.4.5 Limitations

The findings from this review are based on a small selection of studies that assess different types of violent offence-related cognition. While the review included mentally disordered offenders, this group of patients were often not clearly defined. Mental disorder as a variable was therefore not well represented across the set of papers reviewed and thus readers are encouraged to consider the limitations that this poses to generalisability. In addition, there were also more papers that explored sexually-violent cognition over non-sexually-violent cognition amongst the set of reviewed papers. The findings may therefore be overly representative of the former.

2.4.6 Clinical Implications

Clinicians may be motivated to consider the importance of early childhood experiences, in particular any abusive or trauma related experiences or adverse events that may contribute to the development of violent scripts or fantasies, which may be related to violence. These experiences may predispose individuals to developing violent scripts and fantasies and are therefore significant in contributing to the maintenance of violent thoughts that may be problematic. Therapeutic work may be directed towards reducing the sexual arousal that is associated with deviant fantasies, which appears to be related to motivating the sexually-violent offender to act on his fantasies.

2.4.7 Research Implications

More research is needed in this area. To make any conclusions about differences in offender cognition and their relatedness to behaviour more plausible, it would be useful to compare groups of violent and sexually-violent offenders on violent cognition and offending variables. It would also be important for future

research to consider multiple versus single offenders in an attempt to explore differences in cognition between these two groups. Generally, more stringent methods to consistently assess violent cognition are needed. This review has detailed the Schedule of Imagined Violence (SIV; Grisso et al., 2000) which assesses the quality of violent thoughts. While this measure provides some indication of relative indices of violent thinking, one of the weaknesses of this assessment is the schedule's reliance on self-report. One of the implications for research assessing violent thoughts might therefore be to consider using a range of assessment methods in order to triangulate scores across measures. In addition, future studies may also wish to consider the use of social desirability scales.

Secondly, this review has highlighted a relative dearth of literature examining non-sexual violent fantasies and a lack of studies specifically exploring the role of personality and mental illness in violent cognition. These should be considered in future research.

Finally, it is worth noting that future studies may benefit from clearly defining the type of cognition that is under study; whether this is a cognitive product, structure or process, with a view to moving the research forwards in this area towards a model of violent offender cognition.

2.5 CONCLUSION

In conclusion it seems that violent cognition is involved in various stages of the offence process. Violent scripts originate in childhood as a consequence of exposure to trauma and/or abuse. Behavioural scripts about violence are subsequently strengthened through repeated activation of these scripts, which may be frequent in an environment that is fraught with aggression and/or in the absence of protective factors, which might serve to counteract some of the associated effects. The routes from cognition to offending are not linear and it is likely that there are a range of additional variables which influence such an

association e.g. impulsivity and cognitive flexibility. However, factors which have been found to be associated with a link between violent cognition and violent behaviour include cognitive rehearsal (e.g. strengthening of behavioural scripts related to violence or frequent engagement with fantasy) and for sexually violent offenders specifically, the use of deviant fantasy for sexual arousal, paying particular importance to escalation in fantasy content and/or offending behaviour.

The findings from this study are not too dissimilar to those identified by Maniglio (2011) who conducted a systematic review into the role of deviant sexual fantasy in the etiopathogenesis of sexual homicide. However, the current findings offer some extension of Maniglio's findings by highlighting some distinction between sexually-violent offenders and non-sexually violent offenders. For example, violent fantasies appear to provide some form of sexual arousal for the sexually-violent offender and this appears to provide some of the motivation for sexually-violent offending. For violent offenders, violent fantasies may be related to sustaining self-esteem. Although, it is noted that there was limited evidence to draw firm conclusions for arousal and sustaining functions for violent offenders. Further research might be directed to explore the functions of non-sexual violent fantasy.

In addition this study offers some review of mental disorder in relation to violent cognitions, although the literature in this area is scant. Mental illness was not specifically reported on in the papers that were reviewed, although certain personality characteristics were identified as being potentially significant. Nevertheless, this highlights a need for more research in the areas of non-sexual violent cognition and offending and the influence of mental illness and personality.

Finally, this review attempted to elucidate whether there may be differences between scripts and fantasies as related to violent cognition. However, limited reference to violent scripts amongst the set of papers reviewed made it difficult to draw firm conclusions about the possible different routes to offending for these cognitions.

CHAPTER THREE

METHOD: STUDY DESIGN, CONDUCT AND THEMATIC ANALYSIS

3.1 INTRODUCTION

The purpose of the present study is to explore the violent thoughts and fantasies (VTF) of a Mentally Disordered Offender (MDO) group. In the early stages of developing this research project into violent thoughts and fantasies the literature was initially consulted to help frame the aims of the research; develop initial research questions and consider appropriate methodology. Some may argue that consulting the literature prior to conducting qualitative research can create bias by narrowing the field of analytic vision (as in some forms of Grounded Theory; Glaser & Strauss, 1999), while others suggest that it can promote awareness and/or sensitivity to specific areas (Tuckett, 2005). Given the dearth of literature on this topic it was felt necessary and appropriate to consult the literature prior to study development, to help design the methodology and develop preliminary aims for the research. The study was driven by a theoretical interest in VTF and a desire to address particular questions relating to VTF within mentally disordered offender groups and accordingly, a 'top-down' theoretical approach was taken. Qualitative research methodology is advantageous when there is little or no existing literature (Doyle, 1996) and as such it is suitable for an exploratory study such as that described here. Howitt and Cramer (2011) advocate the use of qualitative methodology when attempting to explore phenomena of interest in its natural setting, which in the current study is within the context of experiencing VTF as a mentally disordered offender.

While quantitative approaches can be viewed as the more favourable design in research, given the focus on measurement, manipulation and control of variables

and subsequent improved objectivity of research findings, this approach was considered inappropriate for the current study for several reasons. Firstly, the predominant focus of this research was to explore a currently under-explored research topic and while quantitative methods go some way towards achieving this, the manner in which data are collected becomes limited and narrowly focused, which is in contrast to what is required from this research at this stage. Secondly, the objectives of the current study are to increase understanding about the experience of VTF as opposed to attempting to measure or manipulate these phenomena in some way.

While it is argued that qualitative methodology lacks objectivity, replication and generalisability, it is important to consider these so-called 'limitations' against the potential quality of knowledge that may be developed from the research with these variables in mind. For example, the cognitive nature of violent thoughts and fantasies encourages reliance on self-report data, which could be argued to pose a threat to validity. Despite this, self-report can be seen to be intrinsic to the data collection process, yet this is also determined by the philosophical underpinnings that govern the research. Self-report features as an important process and within the context of qualitative research it can be acknowledged and explored as a variable worthy of enquiry, rather than something that is acknowledged and controlled for in quantitative research. Furthermore, methods to improve the scientific rigor of qualitative methodology are available and some are included within the current study.

3.2 RESEARCH OBJECTIVES AND QUESTIONS

The primary objective of the current research project is to explore the nature, function and quality of VTF amongst a sample of mentally disordered offenders. In doing so, the secondary objective is to offer some clarity on the role of violent thoughts and fantasies in violent offending, as this may have implications for clinical practice.

The research questions are therefore:

1. What are violent thoughts and fantasies according to mentally disordered offenders? *What is the nature and quality of violent thoughts and fantasies as experienced by mentally disordered offenders?*
2. Why do mentally disordered offenders experience violent thoughts and fantasies; *what is the functional utility or purpose of these experiences?*
3. Is severity of mental disorder related to the function of VTF?
4. Is there a role for VTF in violent behavior?
    a. What are the implications of this for clinical practice?

The current study comprised one large qualitative study and the data from the study were analysed using two different methods of qualitative analysis. Thematic analysis (Braun & Clarke, 2006) was selected to initially analyse the interview data and explore research question 1; to assess what violent thoughts and fantasies are, according to mentally disordered offenders. A functional analysis was then performed on the same data with a view to answer question 2; explore why mentally disordered offenders experience violent thoughts and fantasies. The functional analysis was also used to assess whether functions differed depending on severity of mental disorder (question 3). The outcomes of both of these methods of analysis were considered collectively to address question 4 and discuss whether there is a role for VTF in violent behavior and what implications this may have for practice.

This chapter will now proceed to describe the *research action; the methods* used to collect data for the current empirical study. This includes a description of the sample recruited to the study, materials used to collect data and procedures involved in collating data for analysis. Furthermore, this chapter describes the process of thematic analysis (Braun & Clarke, 2006), which was the first method of qualitative analysis performed on the data. Details of the functional analysis applied to the data are presented in chapter 8.

3.3 PLANNING AND DESIGNING THE STUDY

Clinical and academic staff from Rampton Hospital were involved in the initial stages of planning the research and were able to offer useful guidance on the practicalities of conducting research within the high secure hospital. The research protocol was presented to the Peaks Academic & Research Unit (PARU) who provided scientific review (external to the University), which is crucial to developing an ethically sound and robust research project. This process of consultation and review also formed the first stage of the ethical approvals process.

The present author was also keen to include nursing staff in the development of the research to promote better working relationships between researchers and clinicians. The present author met with the Ward Manager from each of the 19 wards that were to be approached for data collection, to provide information about the proposed study, discuss potential challenges and contingency procedures. For example, one aspect of this project that required careful consideration was in relation to the boundaries of confidentiality, especially in relation to the nature of the sensitive data that were to be collected. More specifically, when talking about VTF there was a need to be aware of when information shared as part of the research process may suggest risk, as this would violate one of the conditions of confidentiality and would result in a handover of risk-related information to a senior member of clinical staff. To illustrate, this involved discussing how statements such as “I’ve been thinking about hitting him with a pool cue” vs. “I saw myself picking up the pool cue and hitting him with it”, could be managed within the context of this research project. It was agreed that where patients stated intent i.e. “I am going to hit him” then this would be disclosed to the clinical team. Patients were made aware of these guidelines during the informed consent process.

The outcomes of these discussions were incorporated into the research protocol that was submitted for ethical approval. Ethical approval from the NHS was required as the study included vulnerable adults detained within a national

healthcare setting. The study was reviewed and approved by the Northern & Yorkshire National Research Ethics Service (NRES). Local permission was then received from Nottinghamshire Healthcare NHS Trust's Research and Development Department. For an overview of the processes involved in gaining ethical approval for this study please refer to Figure 3.1.

The British Psychological Society's Code of Ethics and Professional Conduct was adhered to throughout the conduct of this study.

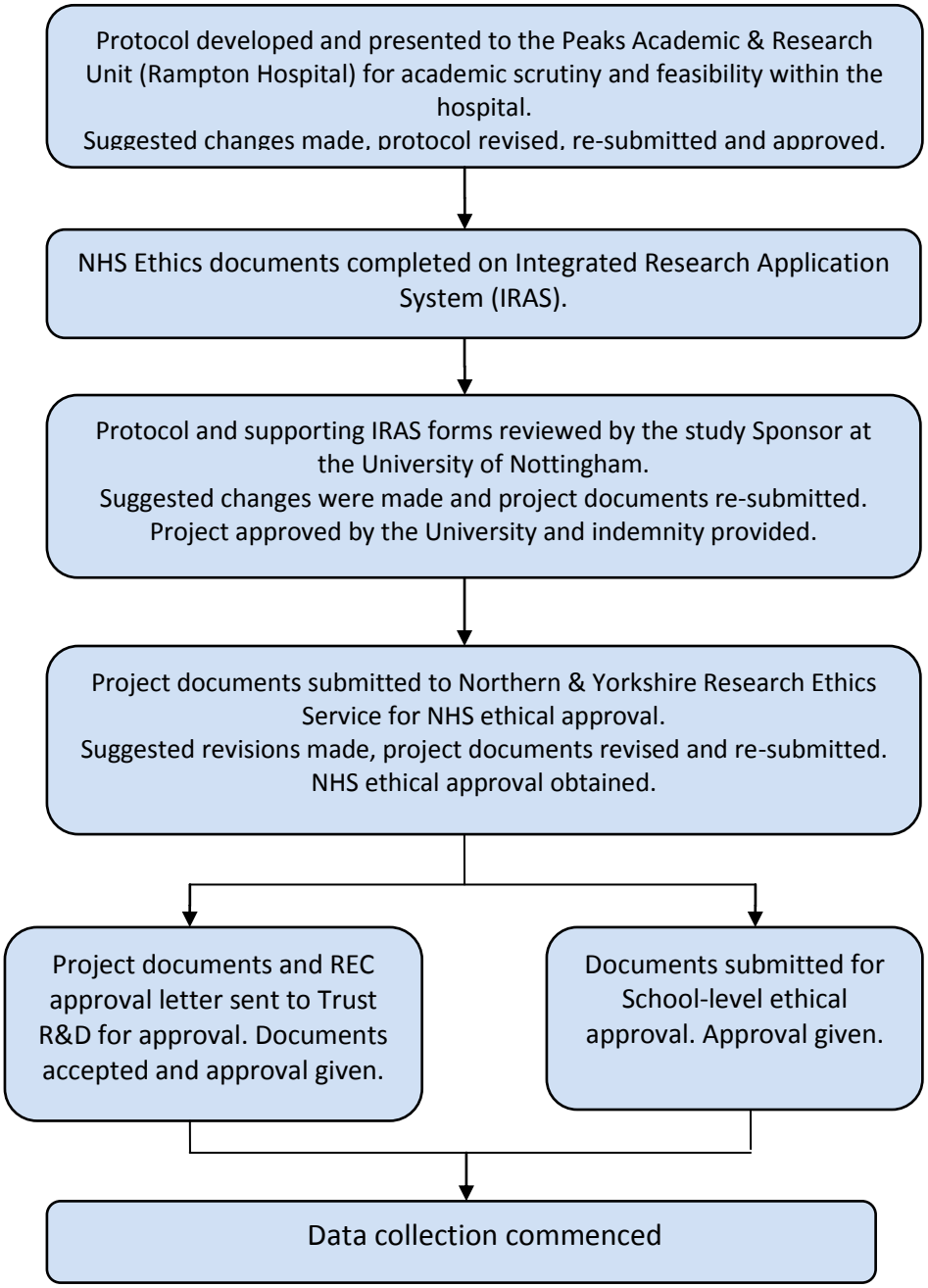

Figure 3.1 Stages involved in gaining ethical approval for a research project exploring violent thoughts and fantasies within a mentally disordered offender group.

3.4 SETTING THE SCENE: DATA COLLECTION AT RAMPTON HOSPITAL

3.4.1 Participants

A purposive sampling method was used to recruit male, mentally disordered offenders. Participants were recruited from three male in-patient services at Rampton Hospital: the Mental Health (MH), Personality Disorder (PD) and Dangerous and Severe Personality Disorder (DSPD) services. Patients from the Learning Disability service were not approached for participation given the complexity of what would be required of participation in the study and the associated ethical challenges in gaining informed consent for participation from this group. Patients from the female service were not approached for participation to ensure homogeneity within the sample and maintain gender specificity for the current study.

Guest, Bunce & Johnson (2006) suggest that a sample size of 12 participants from a homogeneous group is usually sufficient for qualitative research and this was used to estimate the required sample size in the current study. In order to gauge a sample that was representative of the different offender groups across the hospital (violent, sexual, sexually-violent and non-violent, non-sexual offenders) the recruitment process aimed to recruit 12 participants per offender group, yielding an estimated sample of N=48 participants to be achieved.

3.4.1.1 Recruitment

Recruitment and data collection processes were ongoing between 30th August 2011 and 10th January 2012. Recruitment commenced in August 2011 at which time a total of 242 patients were resident across the three services included in the study. A copy of the inclusion and exclusion criteria was provided to each Responsible Clinician (RC) within the MH, PD and DSPD services (see appendix 3-C). Responsible Clinicians were asked to use these criteria to screen patients under their care.

The inclusion criteria were that the patient was an offender (violent/sexual/sexually-violent/non-violent, non-sexual) and that they would be able to provide informed consent to participate in the study. Exclusion criteria stipulated that the patient was aged under 18 years, had a learning disability, or was identified as posing imminent risk to themselves or others. With regards to the last point, this referred to patients in seclusion or those who were nursed separately to other patients, for reasons of maintaining the safety of the patient and others. Some patients within the hospital also had care plans that stipulated that they should be discouraged from sharing their violent fantasies. This was often because, historically, their disclosures of violent fantasies had resulted in increased arousal, which increased their risk of sexualised or aggressive behaviour. Staff had therefore advised that some patients were discouraged from discussing their violent thoughts and fantasies and would therefore be ineligible for the current study. Patients with care plans that reflected these conditions were therefore also regarded within the exclusion criteria. Therefore it is important to consider that the recruited sample is deficient of some individuals who experience VTF.

Whether a client experienced VTF or not was not considered a pre-requite for taking part for three reasons. Firstly, limiting the sample to only those who *claimed* to experience violent thoughts and fantasies may have limited and biased the sample. For example, if the RC was asked to screen for this, the sample becomes limited to only those that the RC *knows* has violent thoughts or fantasies. Some patients may not have expressed these experiences and therefore such pre-screening could have led to some patients being missed. Following on from this is the issue of confidentiality; the RC may have been in breach of patient confidentiality by providing the researcher with such clinical information, without the client having consented for this information to be shared. Thirdly, the concept of what violent thoughts and fantasies are (i.e. how they are conceptualised) varies between individuals and so non-participation on the basis of not experiencing VTF was underplayed. Incidentally, one of the aims of the study was to assess patients' understanding of VTF and how they are construed in this group.

The RC screening process resulted in 177 patients meeting the inclusion criteria who could then be approached for informed consent to participate in the research. As all hospital patients were classed as vulnerable adults under the Mental Capacity Act (2005) it was necessary for the present author to additionally screen each patient and ensure that they had the capacity to provide informed consent to participate in the study. This continuous process started during the informed consent stage (see appendix 3-D and 3-E) and ended when data collection for that patient was complete.

Of the 177 patients who were approached, 50 consented to participate from across the three services (Mental Health Service *n*=17; Personality Disorder Service *n*=14; Dangerous and Severe Personality Disorder Service *n*=19). The recruitment rate was therefore at 28.2%.

Table 3.1

Rates of participant recruitment across the Mental Health (MH), Personality Disorder (PD) and Dangerous and Severe Personality Disorder (DSPD) services at Rampton Hospital.

	MH Service	PD Service	DSPD Service	Total
Population (*n*) August 2011	131	59	52	242
Screened as suitable by Responsible Clinician (*n*)	93	48	36	177
Total recruited sample (% of RC screened)	17 (18.3%)	14 (29.2%)	19 (52.8%)	**50 (28.2%)**

In-between gaining informed consent and data collection however, two patients (out of the 50 patients who had provided informed consent to participate in the study) were withdrawn from the study and were not interviewed; one patient chose to withdraw his consent and another patient lost the capacity to provide informed consent. Both patients were from the Mental Health Service

which reduced the sample recruited from this service from 17 to 15 patients. This rendered the total number of interviews across the whole sample to 48.

Clinical files for all 48 patients were then reviewed in order to begin the data collection process. Offender classification was established by reviewing each participant's offence history, details of which were obtained from each patient's psychology file. While the anticipated sample size of N=48 was reached exactly, the distribution across offender groups was uneven (70.8% violent offenders; 22.9% sexually-violent offenders and 6.3% non-violent sexual offenders) and there were in fact no patients with non-violent or non-sexual crimes, highlighting the severity of offending behaviour and nature of criminality within the sample. A bias towards a higher prevalence of violent offenders means that the findings should also be considered with this in mind.

Non-Consent

Patients who did not provide informed consent to participate were asked to record their reasons for non-participation on a brief reply slip (appendix 3-F). Data relating to non-participation was particularly useful for the current study in attempting to estimate whether a patient's decision not to participate was due to having never experienced VTF or an unwillingness to discuss the experience, which might have contributed to some estimate of prevalence. Out of the 127 patients who did not wish to take part in the study, 27 patients volunteered to provide their reasons for non-participation using 3 pre-defined options. Reasons given for non-participation included a) the patient did not experience violent thoughts or fantasies (*n*=13); b) they experienced violent thoughts or fantasies but did not wish to talk about them (*n*=3); or c) that they didn't want to participate for any other reason (*n*=11). For ethical reasons it was not appropriate to follow up these reasons for non-participation with the patient unless they volunteered this information freely.

3.4.1.2 Final sample description

Forty-eight participants took part in the study. The sample ranged in age from 21 years to 61 years (*M* 38.96; *SD* 10.3) and the length of stay at Rampton Hospital (at the time of their participation in the study) was between 3 months and 18 years (*M* 4.78; *SD* 4.0). The majority of the sample were Caucasian (87.5%) with the remaining 12.5% of the sample made up of patients from Caribbean (*n*=6), African (*n*=2) and mixed race (*n*=1) ethnic groups. Additional demographics for the final sample are provided in Table 3.2.

Table 3.2

Demographics of N=48 patients interviewed about their experiences of violent thoughts and fantasies

Demographics	**Categories**	**Frequency (%)**
Admission Source	Prison	68%
	Medium Secure Unit	4.2%
	Other High Secure Hospital	8.3%
	Young Offenders Institution	4.2%
	Court	2.1%
	Other DSPD service	10.4%
	Other	2.1%
Mental Health Act Section	47/49	54.2%
	47	4.2%
	37/41	27.1%
	41(5)	10.4%
	Notional 37	4.2%
Index Offence Type	Violent (only)	70.8%
	Sexually-Violent	22.9%
	Non-violent, sexual	6.3%
	Non-violent, non-sexual	0%

3.4.2 Materials

3.4.2.1 Semi-structured Interview

This study used a semi-structured interview schedule as the primary data collection tool. As interviews are usually afforded an advantage of being conducted in private, this methodology seemed most appropriate for the sensitive exploration of VTF. The interview schedule was developed to broaden an understanding of VTF as experienced amongst a sample of mentally disordered offenders. Given the absence of literature on this topic the interview questions were framed broadly around different areas of interest, such as the nature and quality of violent thoughts and fantasies (e.g. characteristics and descriptions of these experiences), triggers, associated emotional responses and what purpose or function the experience of entertaining a violent thought or fantasy served for the individual. The flexibility of a semi-structured interview allowed for additional follow-up questions to be asked where the participant's response merited this, for example highlighting an area that seemed important, but which had not already been identified, thus helping to generate unanticipated insights.

Given the absence of an agreed understanding of what is meant by violent thought and violent fantasy (and indeed whether the two constructs are the same or distinct from one another), patients were invited to comment on their understanding of the two concepts during the initial phase of the interview. This discussion was useful in attempting to understand the (different) phenomena and allowed for clarification over which experience the patient was describing as part of the interview. Patients were informed that there was no one way of telling the two constructs apart, and that one of the aims of the research was to explore how VTF were understood by patients to be similar or distinct from each other. This promoted a shared understanding between the researcher and participant about what was understood to be a thought and what was understood to be a fantasy. Both parties were then able to distinguish between which construct was under discussion as part of the interview.

The interview schedule included questions that would help to facilitate an assessment of the functions of violent thoughts and fantasies (to be achieved using a functional analysis method). Daffern, Howells & Ogloff (2007a) suggest a method of assessing the antecedents and consequences of a behaviour of interest, in order to assess the function or purpose of that behaviour. This methodology was employed in the current study and patients were asked about their feelings before, during, and after the experience of a VTF in an attempt to identify the function of the VTF. However, it is acknowledged that there may be a number of different functions operating at any one time and thus this method may not be wholly sensitive to this. In addition, it is recognised that functions vary from situation to situation and therefore it may not have been possible to identify each and every function of VTF within the context of the research interview. Despite this, every attempt was made to assess the functions of VTF where these were reported within the interview. A copy of the interview schedule can be found in appendix 3-G.

3.4.2.2 Screening Questionnaires

As per research question 3 'is severity of mental disorder related to the function of VTF', it was necessary to collect data relating to severity of mental disorder. This would facilitate a better understanding of mental disorder as related to both the experience and function of VTF, as per the overall aims of the empirical study.

It was important to collect screening data relating to mental disorder for all of the patients included in the sample, as mental disorder according to service categorisation does not represent exclusivity in terms of patient diagnosis. Furthermore, there are often high levels of co-morbidity (mental illness and/or personality disorder) between the services within the hospital, which means that patients presenting with co-morbid symptoms can be placed in either service, depending on which of their needs is the greatest and most in need of treatment and/or management. Screening data were also useful for descriptive purposes

when discussing the results in terms of their origins within a mentally disordered offender population. Screening data were collected using two questionnaires: the Personality Disorder Questionnaire, 4th version (PDQ-4; Hyler, 1994) and the Brief Symptom Inventory (BSI; Derogatis, 1993), which screened for severity of personality difficulties and mental illness respectively.

Personality Disorder Questionnaire (PDQ-4; Hyler, 1994)

The Personality Disorder Questionnaire (PDQ–4+) is an internationally recognised clinical assessment which allows for quick and effective screening for personality disorder. It is a 99-item assessment that is completed by answering true or false to each statement. Clinically, the PDQ-4+ has been criticised for being overly diagnostic (e.g. Hyler, Skodol, Kellman, Oldham, & Rosnick, 1990) however, it was considered appropriate for use in this study for the purposes of a screening tool as opposed to a diagnostic instrument. In addition to the 10 types of personality disorder in DSM-IV (American Psychiatric Association, 1994), the measure also includes additional scales for the assessment of passive-aggressive and depressive personality disorders.

The PDQ4+ also provides an overall index of personality disturbance. The PDQ-4 was not used to formally diagnose personality disorder in this study. Instead, the scores were useful in establishing severity of personality disturbance across the sample for descriptive purposes.

Brief Symptom Inventory (BSI; Derogatis, 1993)

The Brief Symptom Inventory (BSI) is a 53-item self-report assessment designed to measure psychological symptoms. This measure was selected for use in this study as a screening tool for severity of symptoms relating to mental illness. Excellent levels of reliability and validity have been established for the assessment (Derogatis, 1993). The assessment comprises 9 sub-scales which reflect 9 primary symptoms dimensions: somatisation (SOM); obsessive-compulsive (O-C); interpersonal sensitivity (I-S); depression (DEP); anxiety (ANX); hostility (HOS);

phobic anxiety (PHOB); paranoid ideation (PAR); psychoticism (PSY). In addition to this the scale provides 3 global indices of distress – General Severity Index (GSI), Positive Symptom Distress Index (PSDI) and the Positive Symptom Total (PST) which collectively illustrate the extent of psychological distress. The GSI is the most sensitive single indicator of a respondent's distress level, combining both frequency of symptoms and intensity of distress. The PST is the total number of symptoms identified as present by the respondent (out of a total of 53). The PSDI is a measure of intensity of distress averaged over all of the positive symptoms identified.

The BSI was not used to formally diagnose mental illness in this study. Instead the scores were useful in establishing severity of mental disturbance across the sample for descriptive purposes. These data, together with scores obtained for severity of personality difficulties are presented in Table 3.3.

Table 3.3

Severity of personality disorder (PDQ-4) and mental distress (BSI) for participants interviewed about their experiences of violent thoughts and fantasies

	MH Service M *(SD)*	PD Service M *(SD)*	DSPD service M *(SD)*	Whole Sample (N=48) M *(SD)*
PDQ-4 Total	29.81 *(16.28)*	40.14 *(18.14)*	35.17 *(14.63)*	34.83 *(16.43)*
BSI – GSI*	49.06 *(10.58)*	50.43 *(11.21)*	52.67 *(7.30)*	50.81 (9.6)
BSI – PST	21.13 *(16.18)*	21.64 *(12.41)*	22.78 *(10.71)*	21.90 (12.97)
BSI – PSDI*	50.87 *(10.89)*	56.07 *(9.68)*	58.83 *(8.03)*	55.38 (9.94)

Note. Abbreviations for BSI global indices of distress – GSI = global severity index; PST = positive symptom total; PDSI = positive symptom distress index.
*T-scores for BSI global indices are presented in the table.

There were no significant differences between scores for the different service groups (MH/PD/DSPD) for either measure. This suggests that the sample could be considered as a whole, as opposed to creating categories based on their placement within the hospital.

3.4.2.3 Case Report Forms

Demographic data were also collated for each patient who provided informed consent to participate in the study. These data were retrieved from patient psychology files, access to which was granted from the Service Director of each service included in the study (MI, PD and DSPD). The data were collected using a pre-defined data collection template (appendix 3-H) and were used to generate a description of the final sample (section 3.4.1.2 above).

3.4.3 Data Collection Procedure

Participants were invited to participate in 2 x 1 hour-long data collection sessions. Participants were asked to complete the BSI and PDQ-4 questionnaires during the first session and participate in a semi-structured interview in the second session, which usually took place 1 week later.

During each data collection session the patient was reminded of his voluntary participation, right to withdraw and was reminded of the confidentiality boundaries that applied to the research session. Data collection sessions usually took place on a 1:1 basis to maximise confidentiality. However, given the risk that some offenders posed this was not always possible and additional staff members sometimes had to be present during the interview. Thirty-nine interviews were conducted individually, 8 interviews were conducted with one member of escorting staff present in the interview room and 1 interview was conducted with two members of staff present in the interview room. Escorting staff were made aware of the aims of the session prior to interview. Staff were asked to maintain the confidentiality of what was said in the interview and were asked to refrain from interjecting, to reduce the influence of an external party within the interview.

All interviews were audio recorded on a Dictaphone. The audio files were transferred to an NHS encrypted computer for secure storage and subsequent transcription. All interviews were transcribed verbatim by the present author. The process of transcription was advantageous in that it increased familiarity with the

data (Riessman, 1993), whilst also allowing an opportunity to reflect on not just *what* was communicated but *how* issues were communicated during the interview. This was useful insofar as it allowed for initial ideas to be generated as part of the early stages of analysis. Following transcription each transcript was checked for accuracy by checking it against a play-back of the interview recording.

The interview transcripts were then imported into NVivo software package (version 9) to facilitate qualitative analysis. Patient data were anonymised and marked with a unique identifier which was known only to the present author. The quantifiable data (obtained from BSI, PDQ-4 and case report forms) were input into IBM SPSS (version 19) in order to collate descriptive statistics for the sample.

3.5 THEMATIC ANALYSIS: EPISTEMOLOGY AND METHODOLOGY

Carter and Little (2007) provide a systematic framework for justifying qualitative research and this framework has been used to structure the remainder of this chapter. Carter & Little highlight the importance of drawing distinction between epistemologies, methodologies and method in qualitative research to allow knowledge to be justified more effectively. The earlier sections of this chapter described the *method* involved in collecting data. The subsequent sections focus on the epistemology and methodologies used to inform the methods that have been described. The current section provides a comprehensive overview of the process of thematic analysis methodology and how it was applied to the data. The process of coding and theme development is discussed alongside a reflexivity statement which describes the researcher's interaction with the data and as such, how the final set of themes was established.

3.5.1 Epistemology

A key aim of the study was to understand patients' understanding of their experiences of VTF, yet it is acknowledged that this is reliant on a subjective account that is grounded in ones' own perception of the experience. Furthermore,

the very nature of the present author's role in the development of the study (e.g. in the use of a top-down theoretical approach to data analysis) meant that their perspective was also existent with study design, which would also influence the subsequent interactions with emerging data. An epistemology which embraced the unique interaction between experience and understanding was therefore selected to justify the methodology.

Epistemology grounds how we can 'know' and is described by Schwandt (2001) as "the study of the nature of knowledge and justification" (p.71). The position taken here is of a contextualist-constructionist epistemology and assumes that the way in which we can 'know', or how knowledge is acquired, is dependent upon the context within which it is conveyed. Contextualism, as the name would suggest, assumes that all knowledge occurs in context and is thus provisional and situation dependent (Jaeger & Rosnow, 1988). Meanings are developed in context and are based on both the interviewee's understanding of the phenomena and the interviewer's subsequent interpretation.

Pidgeon & Henwood (1997) identify four dimensions that may affect the production of knowledge within this philosophical standpoint:

1. Participant's own understandings;
2. Researcher's interpretations
3. Cultural meanings systems which inform both participant's and researcher's interpretations
4. Acts of judging particular interpretations as valid by scientific communities.

Pidgeon & Henwood (1997, p.250)

The contextualist-constructionist framework assumes that both researcher and participant are actively engaged in a process of interpretation and understanding throughout the course of discussion. The data therefore become shaped by those who interact with it and thus it is context-dependent and subjective. Giorgi (1995) argues that as data are developed in context, objectivity cannot be achieved. Objectivity is related to the creation of findings that are

reliable; using methods to produce findings which are consistent, stable and repeatable (Brink, 1991). However, this can be difficult to achieve in social science research given the degree of flexibility in methodology that is afforded in qualitative designs. This makes it even more paramount to make transparent the methodologies used in qualitative research and moreover, ensure that the methodologies are consistent within the epistemological position stated, in order to confidently justify theoretical claims. In the current study this is aided by the use of the Consolidated Criteria for the Reporting of Qualitative Research (COREQ; Tong, Sainsbury and Craig, 2007), to promote accurate responding of qualitative data. Furthermore, section 3.7 also illustrates how measures for validity have been employed in the current study to balance the contextual subjectivity with scientific rigour.

3.5.2 Methodology: Thematic Analysis

Methodology provides the researcher with "an overall strategy for formulating, articulating and analysing their methods" (Carter & Little, 2007, p. 1318) and essentially provides a framework under which methodology-consistent research methods can be justified and applied.

As the research study was designed as one empirical study with two different modes of analysis, as per the research questions identified, it was necessary to select a qualitative methodology that was not empirically grounded in a particular theoretical approach, to allow for flexibility in study design and data collection. In addition, a methodology which was less dependent on the availability of pre-existing theory, which has been identified as the case for the study of VTF and offending, was thought to be advantageous to the current research. Taken together a thematic analysis was selected as the most appropriate methodology as this would allow for the collection of data for functional analysis too.

Braun and Clarke (2006) clarify the utility of thematic analysis and describe a procedure of how to plan and execute a robust thematic analysis and this is the model of thematic analysis that has been employed here. Thematic analysis is most

simply “a methodology for identifying, analysing and reporting patterns (themes) within data” (Braun & Clarke, 2006, p. 79). While thematic analysis is one of the most widely used qualitative approaches it is not widely acknowledged, is poorly demarcated (Boyatzis, 1998) and often thought of as a less rigorous methodology compared to other more branded methods, such as Interpretative Phenomenological Analysis (IPA; Smith & Osborn, 2008) or Grounded Theory (Glazer & Straus, 1967; Charmaz, 2008). Thematic analysis is not wedded to any pre-existing theoretical framework in particular, which means that it offers a flexible approach to data analysis. That said, a theoretical framework should be identified at the outset and adhered to consistently throughout the conduct of the research, as this can help anchor the analytic claims that are made (Braun & Clarke, 2006).

Thematic Analysis is widely used within forensic (Palasink, 2009; Tapp, Warren, Fife-Schaw, Perkins & Moore, 2013) and mixed-methods investigations (e.g. Howitt, 1995; Sheldon & Howitt, 2007), and can allow for social as well as psychological interpretation of the data. It has been selected for use in the current study to develop an increased awareness about the experience of VTF for serious offenders, which will not only help to locate the experience within a research context but may also yield implications for clinical practice. In this study, themes were identified at the semantic (surface) level to allow for themes to be theorised in terms of their broader meanings and implications (Patton, 1990). Here, this approach was used to understand the meaning behind what participants reported about their experience of VTF.

3.5.2.1 Theme Development: The Coding Process

The first stage in the coding process was to become familiar with the data. By the time data analysis began, familiarity had in some way already been achieved through the researcher’s active involvement in collecting the data, transcribing and subsequently checking all transcripts against the audio recordings. Additional time was then spent reading and re-reading transcripts and often listening back to the

audio recordings in order to become more immersed in the data, to facilitate an increased awareness and deeper understanding of the data (Rice & Ezzy, 1999). During the data familiarity stage the researcher began to make some initial notes on interesting features within the data and any repeating or significant patterns. This formed the start of the data analysis and coding process.

The NVivo software package was used to organise data and subsequently helped to facilitate the coding process. Statements of interest were highlighted and recognised as initial 'codes' (known as 'nodes' in NVivo). During the coding process the researcher worked systematically through each transcript, reading each line of text and giving each transcript full and equal attention. Data that appeared to be important or interesting were coded (Daly, Kellehear & Gliksman, 1997). This coding procedure was followed for a few transcripts at a time. The codes that had been identified were then reviewed and sorted into similar code clusters where repetition or similar ideas, that were thought to be theoretically consistent or useful, were emerging in the data. The researcher would then return to coding a few more transcripts using the procedure described above, before returning to re-organise patterns and clusters of codes according to new emerging concepts. This recursive process of coding and reviewing themes allowed the researcher to stay close to the raw data. Once all 48 transcripts had been analysed this way, the clusters of themes were then reviewed and refined using a series of mind-maps, illustrating possible links between themes and sub-themes. The super-ordinate themes and sub-themes were then checked against the raw coded data to ensure that a) they were wholly inclusive of the data that were collected and had not omitted any key ideas; b) the super-ordinate theme and sub-theme names concisely illustrated the data they represented; c) the theme was independent, in the sense that it didn't overlap too closely with other themes, yet; d) remained embedded within the entire data set and collectively contributed to the overall analysis. At this stage, other researchers involved in the study were also asked to review theme names, descriptions and example extracts to ensure that these were consistent and appropriate.

Data appear to have been saturated after approximately 37 interviews had been analysed. However, given the heterogeneity of the sample (mixed violent and sexual offenders from three different services) data analysis continued until all 48 transcripts had been analysed, to ensure the representativeness of the different groups that were approached for participation in the study.

3.5.2.2 Theme Set

The Thematic Analysis methodology lead to the development of four super-ordinate themes from the data: *part of who I am; emotion regulation; aware of the need to be careful; and thinking to doing, to thinking, to doing*. Within each super-ordinate theme are a series of sub-themes that add depth to the overarching super-ordinate theme. A description of each theme is presented in Table 3.4. Each theme is presented and discussed in detail in the results chapters that follow.

While each of the themes are independent from each other and relate to a different aspect of VTF they are all simultaneously inter-related and tell a progressive story about the experience of VTF. The results chapters are therefore presented in a logical way to tell the story of violent thoughts and fantasies starting with origins (covered in chapter four), describing characteristics and functions along the way and ending with an illustration of when VTF may be related to violent offending (chapter seven). The circularity of the final theme also describes how the behavioural acting-out of the fantasy can feed back into violent memories about an offence by replaying what happened and/or imagining alternative endings, which effectively maintains the VTF. The inter-relationships between the super-ordinate and sub-themes are presented in the thematic map illustrated in Figure 3.2.

Once an initial set of themes had been collated the researcher set about evidencing these as part of the write-up process. However, this process featured as part of the analysis as opposed to a consequence of analysis. The process of evidencing themes required further interaction with the data, a process that highlighted alternative ideas on the thematic structure. This suggested that the analysis was incomplete and prompted continued exploration of themes.

Some of the latter stages of this process of theme refinement are presented in the appendix (3-I), which is provided to increase transparency of the thematic analysis process. The relevant appendices (3-I) provide some information on the volume of information that each patient shared within the context of their interview, which is designed to illustrate variability in contribution across the sample. In addition, the relevant appendices section also features a frequency table illustrating the prevalence of themes across the sample, which again provides some indication of the representativeness of patient data within the thematic analysis.

Table 3.4

Themes developed from thematic analysis of patients' experiences of violent thoughts and fantasies.

Super-ordinate Theme	**Subordinate Themes**	**Description**
Part of who I am (chapter 4)	Early experiences; normal versus abnormal	Captures the origins of VTF and how patients make sense of these experiences in terms of their relevance to their identity as an offender or mental health patient. Many patients believe that their experiences of VTF are a consequence of the (negative) experiences they encountered as children and adolescents. As such, the experience was often shrouded in a sense of negativity and viewed as a characteristic abnormality. However this view would simultaneously be offset against the argument that regardless of the socially perceived 'abnormality' of VTF, the experience was still 'normal' for them.
Emotion Regulation (chapter 5)	Power and control; coping mechanism	Describes the functions of VTF as functioning to regulate affect; up-regulating positive affect such as sexual arousal, and down-regulating negative affective states such as anger. VTF were also used as a coping strategy, often referred to as a 'comfort blanket' at times of distress.
Aware of the need to be careful (chapter 6)	Apprehensive anxiety; managing violent thoughts and fantasies; then and now; decision making balance	Describes the anxiety that accompanies the experience of VTF. Patients described feeling the need to carefully manage their reactions, out of fear they may behave in a violent or aggressive way. Theme also incorporates patients' comparisons of how they previously and currently manage VTFs.
Thinking to doing, to thinking, to doing... (chapter 7)	Strategy and planning; out of my hands; thinking compared to doing	The circular relationship between thinking and doing is described in this theme, describing the interaction of VTF and reality; in planning and guiding violent behaviour.

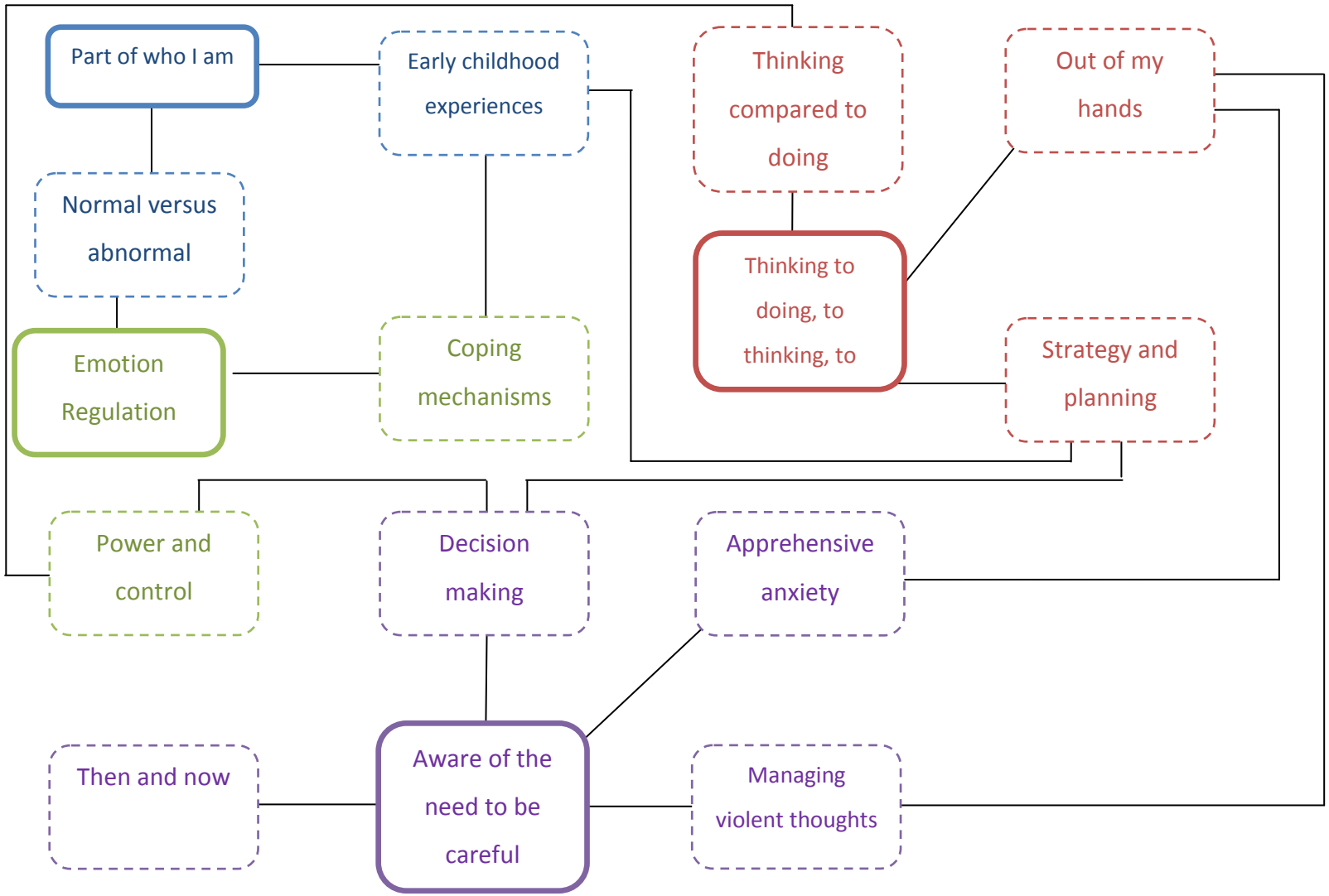

Figure 3.2 Thematic map illustrating inter-relationship of themes developed from a thematic analysis of patients' experiences of violent thoughts and fantasies

3.6 REFLEXIVE STATEMENT

To increase the transparency of this research process it was necessary to develop a reflexive statement in which the researcher could reflect on their role in the conduct of the research, whilst simultaneously highlighting how this involvement may have influenced the study conduct and findings. In this section a reflexive statement is provided. This is followed by a section on validity to illustrate how the quality of this research was assessed.

The origins of interest for this study were borne out of a clinical need to assess the risk that violent thoughts and fantasies posed with regards to future violent behaviour. At the time of study conception I, the present author, was working in a forensic clinical setting, which served as a good starting point for such an investigation. Being a member of staff within the hospital within which the data were collected was advantageous, in that it allowed for prior familiarity with policies and procedures that were to be adhered to within the hospital; from clinical, academic and risk perspectives. In addition, having the input from clinicians and academics within the hospital was also pivotal to the study's design. However, as an existing member of staff in the hospital there was a need to exercise caution in terms of my dual-role as both Research Assistant and PhD Researcher. There was an assumption that my existing role within the hospital may have provided some advantage, in that I was recognised as a member of staff conducting research as opposed to an external researcher. It was therefore assumed that patients may have been more willing to share their experiences with me, given my identity as a member of staff and someone who may have been afforded more trust than an external researcher, especially given the sensitive nature of the study. Conversely, it is important to recognise that some patients may have preferred to discuss these experiences with someone outside of the hospital, who they might assume has lesser influence over their clinical care. Nevertheless, it was important to highlight the distinctions between clinical care and research conduct, yet simultaneously

make clear when the boundaries between the two may need to be crossed, as in the case of a confidentiality breach, for example.

Following on from this it is timely for me to reflect on my personal identity within the research context and comment on how this may have contributed to the development of the data. Burnham's (2011) 'social graces' mnemonic offers a way of making sense of social factors such as gender, race, age and appearance within a social interaction. Being a female researcher, who was also younger than most of the patients that were interviewed, may have had some influence over the recruitment and data collection processes. My gender and age may have appealed to some patients and may have motivated them to participate, while for others this difference may have had some influence over the content and detail that they were willing to share in the interview. For example, some patients may have had difficulty speaking about sexually violent thoughts or fantasies with someone of the opposite sex. In addition, my personal characteristics and demographic factors may also resemble those of patients' past victims, whom they may or may not actively fantasise about, and thus this may have had some effect on the level of detail shared within the interview.

The idea that differences in personal variables may have contributed to a sense of cultural difference and social inequality between parties was also considered. In one interview in particular, I recall a patient subtly highlighting social difference between us, when he referred to his upbringing being complex and challenging and made an assumption that this was different to mine. The patient's assumption of me may have been based on a number of different factors (my identity as a member of staff; young; female; the way I dressed; spoke; and behaved within the context of the research sessions), but in making this assumption he highlighted what he recognised was a difference between us, that was based on his perceptions of the way we were brought up. As a result I wonder whether this patient, and perhaps others who held similar assumptions, may have felt that I wasn't able to fully understand their experiences, as someone who had not been through the same experiences that they had.

Developing trust within the research context was difficult in such a short space of time and with some patients more than others. For example, during one interview a patient abruptly stopped part way through his answer to ask "where does this [information] go?" The limits of confidentiality and data anonymity were clarified but it didn't seem to have much impact on anything extra the patient wanted to add. However, it was thought that this may have been to do with trust issues, with regards to the content of discussion overall, rather than my role as interviewer.

This issue of trust emerged again through the development of the 'then and now' sub-theme, as patients drew distinction between how they *previously* managed violent thoughts (usually occasioning violent action) and how they *currently* manage violent thoughts and fantasies. The very nature of this theme is thought to convey positive change, insight, increased wellness and reduced risk. However, my interpretation of this theme may be based on my preconceptions that patients may have been attempting to present themselves in a more positive light in the interview, again because I was seen as a member of staff and thus someone who, again, they might see as having some influence over their care. In any case one needs to consider the possibility that if patients' contributions relating to the 'then and now' theme were to do with positive self-portrayal, from a research point of view there is a need to question whether this was an accurate representation of their experiences.

The level of information and detail that patients were willing to share was considerably varied. Although, it was noted that it was easier to interview those who were willing to share their experiences in detail; this led to increased discussion about their experiences, which in turn led to a more comprehensive interview. However, at times the quality of information that was shared was far more graphic and the violence more brutal than anticipated. On these occasions I felt torn between wanting to fully explore the sometimes 'gruesome' details in the quest for 'good' data, at the cost of how inappropriate it felt at times to be pursuing some questions in the search for more details.

On the other hand, some patients were less open about their experiences which made it more challenging to engage them in the interview. It is unclear whether this was due to an inability to answer certain questions (because some may have perhaps seemed too complex), or perhaps not wanting to answer certain questions. With regards to the former, in that the questions were too complex, this may have been partly driven by my curiosity in attempting to explore the topic as fully as possible. This may have encouraged the asking of spontaneous follow-up questions, which may not have had a straight-forward answer (e.g. asking "what tips the scales when you might act on a violent thought?"). Not wanting to (fully) answer some questions may have been due to issues of wanting to maintain positive self-portrayal, yet one would wonder why some patients would agree to take part in the study if they weren't willing to share their experiences of VTF. This prompts reflection in terms of what the function of participation was.

Being able to reflect on the dynamics between interviewer and interviewee during the interview process has been advantageous in noticing these issues and being able to work through them in clinical supervision. The present author has, at time of writing, been working as an Assistant Psychologist the same clinical setting and this has facilitated an increased awareness of the operations that underlie VTF. As such, the present author's way of thinking about VTF is grounded in the cognitive model of psychology that is ascribed to, but nevertheless there is an appreciation for different theories and assumptions which may also account for these data, which can be explored through discussion with professional peers in the field.

3.7 ASSESSING THE QUALITY OF THE QUALITATIVE ANALYSIS

3.7.1. Reliability

Reliability relates to the extent to which data is consistent, stable and can be repeated (Brink, 1991). One way in which reliability was maintained was through the control of some interviewer effects; same interview schedule, same interviewer and primary data analyst. However, it is important to recognise that these data

were collected in context and thus it may be difficult to assess their reliability. Several methods of reliability were considered, but these were not found to be appropriate for the current study that is rooted within a contextualist epistemology. For example, multiple-researcher coding and the use of code-books (methods illustrated by Boyatzis, 1998; Crabtree & Miller, 1999) were considered, however, Fielding & Fielding (1986) argue that the use of such methods within the contextualist – constructionist framework would only add value to the current understanding of the experience, as opposed to functioning to converge the findings. Furthermore, Seidel & Kelle (1995) argue that measures designed to improve reliability in qualitative applications are meaningless; consistent coding using a coding template for example, would suggest that the raters have *interpreted* the data in a similar way, rather than this being an example of reliable coding. Finally, the use of a coding template may have restricted the elaboration of context-sensitive data (Manning & Cullum-Swan, 1994), potentially limiting the overall quality of data that were developed. As such, formal measures of reliability were considered but not deemed appropriate for use in the current study.

3.7.2 Validity

Yardley (2009) suggests a number of criteria for enhancing the validity of qualitative research such as triangulation, participant feedback and evidencing a paper-trail to verify themes. Secondary researcher coding for purposes of triangulation was not used, however it was felt important to include other researchers in the analysis process to increase the credibility of the findings; reducing the potential bias caused by just one researcher conducting the analysis. Coding discussions were held between the researcher and their colleagues and these were ongoing as codes and themes were developed, in an attempt to generate a more comprehensive and shared understanding of the findings. This would include discussions about whether the themes were valid and where they were located within a broader clinical psychology context. This method was useful

in that it added value to substantiate the findings, whilst embracing the subjectivity of the themes, in line with the contextualist-constructionist epistemology.

Participant feedback methodology was also not used here as Sandelowski (2002) argues that such member-checking processes can sometimes become the participant's response to new phenomena in the form of the themes that the researcher has developed, thus reducing the utility of this method as a means for assessing validity.

Instead, the method of disconfirming case analysis was used to demonstrate validity for themes identified within the study. Disconfirming case analysis involves searching for data that serves to test the hypothesis or disconfirm the theme or pattern that has been recognised within the data. Disconfirmation case analysis therefore provides an indication as to the limits of the theme and the extent to which it can be generalised (Booth, Carroll, Ilott, Low, Cooper 2013; Pope and Mays, 1995). Each theme developed as part of the thematic analysis was scrutinised for disconfirming cases and evidence of this is discussed within each chapter where appropriate.

Yardley (2009) suggests that a paper trail can help to improve the subjective status of the findings. The paper trail presented in appendix 3-I additionally illustrates how certain decisions were made[6], to increase transparency with reference to how themes were developed and to demonstrate credibility of the findings overall (Koch, 1994). In addition, the frequencies of each sub-theme are noted in parentheses next to each sub-theme heading in the following results chapters, to illustrate the relative prevalence of the themes across the data. Data which illustrate the variability in contributions from participants and theme frequencies are also reported within appendix 3-I.

[6] This is available electronically as part of the NVivo software that was used to collect the data. Some of the later stages of the analysis were transferred to paper for ease of developing themes. Mind-maps are also available in appendix 3-I.

Finally, to demonstrate the quality of the qualitative analysis the COREQ checklist (Tong et al., 2007) was used to assess the quality of the research detailed within this thesis. The COREQ is a 32-item checklist that aims to encourage the reporting of qualitative research conduct. For example, some items enquire about the researcher's experience and training, what coding strategies were used and overall theme representativeness and clarity. The full checklist as applied to this research study can be found in appendix 3-J.

CHAPTER FOUR

THEME 1: PART OF WHO I AM

INTRODUCTION

The *Part of Who I Am* theme captures the origins of violent thoughts and fantasies (VTF) and how patients make sense of these experiences in terms of their identity as an offender or mental health patient. The theme name is so termed to boldly convey ownership over the experience of violent thinking, whilst simultaneously highlighting the ascribed importance that violent thinking has to one's identity. Many patients spoke of how they attribute their experience of VTF as a consequence of how they were brought up; the experiences they encountered as children and adolescents such as being brought up to use violence and/or being a victim of violence during childhood. As such, the experience of violent thinking was usually portrayed as an abnormal experience but one which patients claimed was normal or regular for them, because of who they are - their identity as a mentally disordered offender.

This theme illustrates the origins of VTF and describes how these experiences are grounded within one's identity. As such, it provides a useful introduction to the results section and for the subsequent themes that will be described hereafter. In this chapter the theme of 'part of who I am' is illustrated in detail, alongside the two sub-themes: 'early experiences' and 'normal versus abnormal'. A discussion of the theme is also presented at the end of the chapter, within the context of existing literature and psychological theory.

4.1 EARLY CHILDHOOD EXPERIENCES (15)

Patients usually described their childhood experiences as difficult and/or problematic. Often patients reported that their VTF started when they were of school-age (e.g. between 5-7 years old) and that furthermore, the timings of these experiences occurred concurrently with when they began to behave in a violent way. Many patients spoke about traumatic experiences that they had experienced whilst growing up and often this was their reasoning for why they felt they experienced violent thoughts and fantasies today. Some patients often referred to events that occurred when they were very young (infants) in speaking about why they believed they had violent thoughts and fantasies. Within this there was a sense of blame; patients blamed their parents or other childhood caregivers for why they had developed into the person they were; their identity as an offender and inherent within this, why they experienced violent thoughts and fantasies.

> *"I think because of the way I was raised, you know by my mum and dad. I think they were quite violent people generally anyway and I think they raised us in a kind of – I think with me they made me into a psychopath by the way they kind of bullied and harassed us as young kids. I just feel like they were very big on corporal punishment, you know, smacking and hitting a lot and I just feel like it, it became a way of life from an early age". [R25]*

A violent lifestyle was common for many individuals within the group, with many patients describing how they learned that violence was an acceptable or common part of life from an early age. This included being encouraged towards violent sports and hobbies as children and being taught to solve interpersonal problems with violence, which is further reinforced by being around people who use violence, such as family, peer groups and significant others.

> *"I've learned from a young age, from all my peers, my family and that, to solve a problem you've got to be violent. So if there's any kind of domestic problems, any money problems the way to solve it is through violence. So when I get that feeling, I feel obliged... So it comes like nature to me, you know". [R24]*

Patients spoke about how violence was normal for them, highlighting how it was a defining feature of their childhood that now contributes to who they are and their identity as someone who is different to others.

> *"I believed violence was the way of life. Suppose it's just a- It's not just about family life, it's about school, it's about the way you're raised, it's about people around you, you're community. My days were a bit different to somebody who was raised in a perfect background. Violence was just the way of life. And I learnt to become violent when I was younger". [R16]*

Many patients spoke about their experiences of having witnessed domestic violence and/or being exposed to violence themselves.

> *"I was brought up in erm an environment that included sexual violence. Erm… and I witnessed at three year old, my dad trying to rape my mum. And I remember- The reason that I remember this is coz I, it was the first time I swore at anybody. And I remember the urge that I had to run over and …. But I was three year old. So it were a bit difficult that one". [R37]*

Often patients were able to describe their past abusive experiences quite vividly and sometimes expressed that they experienced flashbacks of abuse or traumatic memories. Furthermore, memories of being abused in childhood were sometimes triggered by current conflicts.

> *"When I was getting abused by my step-dad I er, I was rummaging around the house and I found he had a shotgun and I just thought about getting the shells, loading the shot gun and shooting him- you know what I mean. But I searched the house all over looking for bullet shells for it but I couldn't find any... I think about it all the time. I thought about the shotgun every time I was abused and when someone upsets us... It's usually when someone upsets us, makes me feel defective stuff like that". [R08]*

In the extract above the patient describes how, when he is made to feel defective by others, this experience reminds him of when he felt this way as a child in relation to the abuse that he was experiencing. Furthermore, current situational triggers also re-trigger the violent thoughts that he held as a child (10 years old at the time). This not only highlights the entrenched nature of some violent thoughts but also suggests that there may be common thematic triggers for violent thoughts both historically and in the present day.

Those individuals who were victimised as children, through abuse for example, also described revenge fantasies where they imagined taking revenge on their childhood abusers. Revenge fantasies were rooted in the past but were often currently held by the individual, indicating that they were often long-standing and had been maintained over a number of years. Thinking about revenge is discussed in more detail as part of the 'coping mechanism' sub-theme in chapter 5, however it is important to recognise these experiences here within the context of how patients described these revenge fantasies as being related to their early experiences, which consequently affect who they are and why they feel they have violent thoughts and fantasies.

> *"Er, I think it's, with someone with my background... and with what's happened to me is – it would be natural to have violent thoughts of- or fantasies if you like, about er harming people that have done wrong to me". [R17]*

The experience of revenge fantasies appeared to be normalised in light of the individual's experiences; it was acceptable for some patients to experience violent thoughts and fantasies because of what had happened to them in the past. Of particular relevance is the level of investment and dependence on a revenge fantasy. The following extract highlights the strength of the fantasy as providing the motivation or encouragement to get out of the prison or mental health care system. While this may have also served functions related to action (described in

chapter seven) it nevertheless highlights the longevity of the fantasy, which the individual may have been reliant on whilst detained within the prison or healthcare system.

> *"...and I ended up with broken bones and all sorts of things. I managed to get out and I always promised myself that you know, anyone that was- could do that, I would have to kill. From that moment onwards, I think I kept it going for a long time. So when I've been banged up in different institutions, I've always had that thought and that's what always-, for a long time, spurred me to er, to want to get out. Erm, now I think that it's not the case. I don't want to get out anymore, coz I don't want to do that sort of thing anyway. I don't want to live my life like that, I don't want to go out there and carry that sort of thing out, I don't want to do anymore. But I carried it around with me for 30 years … it was a nice thought, well in my mind it was, obviously it's not a nice thought to have at all, but for me it was helpful in the sense, kind of like, and that". [R06]*

The content of the violent fantasy, which in this case is to imagine revenge, is paired with a sense of dichotomy, perhaps with regards to the social and/or moral perception of violent thinking. This dichotomy is discussed further in the normal versus abnormal sub-theme.

4.2 NORMAL VERSUS ABNORMAL (10)

An argument about relative normality or abnormality of violent thinking runs through the 'part of who I am' theme, with the experience described as having both positive and negative qualities respectively. In the first instance some patients spoke about how fantasies were normal experiences; experienced by all and were functional in different ways. Some patients had opposing views and argued that the experience of violent thinking was normal for them specifically, because of their

childhood experiences (as discussed) and/or their identity as a mentally disordered offender.

> *"I am not saying it's OK to have violent thoughts, but I think people with personality disorders are always going to have some kind of thought". [R01]*
>
> *"I am a naturally violent person, do you know what I mean, so these thing will come in my head all the time". [R10]*

Within the seemingly normal side of violent thinking was also an underlying assumption of negativity and abnormality where patients would simultaneously acknowledge the socially or morally abnormal side of violent thinking.

> *"it's not right is it... it's evil". [R19]*

The way the offenders made sense of their experiences of violent thinking however (as either abnormal or normal), appeared to be tied in to the thought or fantasy's perceived importance and/or utility, and the functional purpose of the fantasy was the over-riding most important thing and this seemed inherent within the individual's identity. The statement below highlights how violent thoughts and fantasies are acknowledged to be socially and/or morally unacceptable, but at the same time reflects how this patient refutes this because of what VTF stand for, for him, as they form part of who he is.

> *"This environment says to you that having a violent thought is wrong, having a violent thought is dangerous, having a violent thought is unacceptable therefore we must stop having violent thoughts. And in order for you to stop me from having violent thoughts you must remove all aspects of my mind, because that's who I am, that's how I think". [R02]*

In summary, violent thoughts and fantasies appear to have origins in patients' childhood experiences and they help them to make sense of their

experiences. The more successful the fantasy is at meeting these needs, the more it appears to become integral to the individual's self-identity, which may increase dependence and assigned importance.

> *"I think… I think coz they've been with me for a lot of- a long time of my life, I think that coz they're a big part of me erm… I think in some ways- I would still say it's still quite strange to sort of say it but I think they are important to me because they are part of my make-up, they are part of me. Erm…. so that's what- they're still important to me". [R39]*

4.3 DISCUSSION OF THEME

This theme highlights the long-standing experience of VTF amongst patients within the sample. Many patients described how their violent thoughts and fantasies were grounded in their childhood experiences. These experiences included being victimised both inside (abuse/neglect) and outside (e.g. bullying) the home. The impact of victimisation on a child's development is particularly well documented (Cassidy, 2009; Ogloff, Cutajar, Mann & Mullen, 2012; Reckdenwald, Mancini & Beauregard, 2013; Wolke, Copeland, Angold & Costello, 2013), however the focus here is the impact that victimisation can have on children's cognitions about violence and specifically how this may contribute to the development of violent thoughts or fantasies.

Accordingly, it may be timely to consider the relevance of attachment theory as relevant to early experiences and the development of violent thoughts. It is widely recognised that early childhood experiences are key determinants for attachment relationships during childhood and for behavioural patterns that extend into later life (e.g. Collins & Reed, 1994; Rich, 2006; Young, Klosko and Weisharr, 2003). The rich literature on attachment highlights a number of means by which attachment patterns can be categorised into clinically useful categories. One of the most prominent methods is Ainsworth's (1979) Strange Situation classification

system that identifies infants as having secure, insecure-avoidant or insecure-ambivalent attachment patterns. While the majority of children could be classified into either of these 3 types, a small minority of children displayed behaviours that could not be recognised using this system. Such behaviours included appearing confused, disorientated and/or engaging in unusual behaviours (e.g. rocking, freezing and head-banging), whilst simultaneously displaying inconsistent behavioural responses towards their caregiver. Main & Solomon (1990) therefore added a fourth category of insecure attachment to classify children who displayed these behaviours as having a *disorganised attachment* style. Children with disorganised attachment styles were characteristically disorganised, a pattern thought to result from frightening, severely neglectful or abusive care. Disorganised attachments are often recognised in children whose carers have been physically and/or sexually abusive, victims of domestic violence and who have severe mental health problems (Howe, 2006).

Furthermore, a disorganised attachment style in childhood, as with any other insecure attachment style, is thought to be associated with an increased risk of mental health problems in adulthood (e.g. MacBeth, Gumley, Schwannauer & Fisher, 2011; Mahedy 2012; Schimmenti & Bifulco, 2015). The disorganised attachment style specifically, is thought to more closely have implications for the development of borderline personality disorder (Liotti, 2014). Furthermore, a large proportion of offenders are thought to have disorganised attachments and a recent review by Savage (2014) highlights link between disorganised attachment and violent behaviour.

There is some indication, amongst the data collected as part of this study, that the environments that these patients were brought up in were not particularly wholesome, however there is not enough detail to specify particular relationships and attachment patterns. From the data that are available however we can speculate that for some patients the home environment was not particularly helpful. For example, some patients described witnessing and being exposed to domestic violence, others reported being abused by caregivers both physically and

emotionally. It would not be appropriate to make assumptions about specific attachment styles and their relationship to violent thinking and/or violent behaviour based on the limited data that are available, yet consistent and reliable evidence from a number of researchers in this area do recognise the prevalence of insecure attachments amongst those with mental health problems and/or criminal histories, highlighting the potential relevance of attachment to the current research.

Insecure attachments have been found to be associated with problematic behaviours in childhood and adolescence (Elliot and Cornell, 2009; Lyons-Ruth, 1996; Vando, Rhule-Louise, McMahon, & Spieker, 2008) which may also extend into adulthood (e.g. Baker & Beech, 2004; Bowlby, 1973). Bowlby (1973) postulated that

> children who fail to form bonds or connect with their caregivers develop inner working models of others as unworthy of trust, empathy and concern, which can lead the way to a broad range of callous traits characteristic of cold-hearted offenders (cited in Saltaris, 2002, p.740).

There is a widely recognised association between attachment and later offending. A recent meta-analytic review by Ogilvie, Newman, Todd & Peck (2014) found that violent offenders were less secure in their attachments than non-offending controls. Furthermore, Oglive and colleagues identified that there was an association between insecure attachment, mental health problems and criminality and that violent offenders, compared to non-violent offenders, were more insecure in their attachment styles. A number of theories attempt to theorise the association between insecure attachment and offending, for example Marcus & Kramer (2001) suggest three routes to offending which include disruptive behaviour as a means of eliciting care and attention, reactive aggression towards others bourne out of an extrapolation of the child's internal working model as others as uncaring or abusive and low pro-social orientation and resistance to the kind of social experience that could correct these difficulties. Fonagy (2003) suggests that aggression is innate but that it is unlearned through the course of healthy development; secure

attachments facilitate the development of control over one's innate aggressiveness, but where these attachments are absent, this process of unlearning becomes disrupted. From the data that is available from this study it might be sensible to suggest that part of this 'unlearning' that Fonagy (2003) describes may have been disrupted through the course of challenging environmental circumstances during childhood.

Alternatively, an integrated social-cognitive theory may offer some explanation to the findings. Similar to attachment theory, the social-cognitive theory also assumes that early experiences such as exposure to violence and/or physical abuse may lead to a perception of the world as an unkind, unsafe or hostile place. Some of the patients with this experience may have come to learn, through the observation of others' behaviours, that violence is a means of resolving conflict (Huges & Hasbrouck, 1996; Lochman & Dodge, 1994) which, over time can be internalised, habituated and subsequently strengthened. Violence therefore may become recognised as a method of being able to survive in the world and this may explain the development of violent thoughts or violent fantasies from an early age.

Despite the seeming abnormality of origins, patients report how VTF have functional utility in that they can be helpful with certain issues in sustaining a sense of self. For example, in one of the extracts provided above the patient makes reference to how he "kept it going for a long time" [R06] suggesting that he was active in this process of maintaining the fantasy. The statement in context referred to how the fantasy was sustaining him for when he was released, therefore suggesting that it was sustaining in some way. Actively sustaining the fantasy for the duration of the time that the patient was institutionalised may have met an otherwise unmet need; *imagining* revenge given his inability to enact revenge (due to the constraints of being detained in a secure setting) may have therefore functioned as a substitute for revenge. One might then consider whether this similar for other offenders and whether fantasising provides a way of achieving something in-vivo that can't be achieved in real life. If the violent fantasy provides and effectively sustains an individual's needs, one could assume that this promotes

dependence on the fantasy, thereby encouraging it to become a more integral part of a person's identity. These functions identified may collectively contribute to why violent thoughts and fantasies have continued into adulthood and how, over time, the patient has become more dependent on them. The reinforcing quality of the VTF therefore becomes more integrated with the individual's identity and a more integral part of their personality.

CHAPTER FIVE

THEME 2: EMOTION REGULATION

INTRODUCTION

The *Emotion Regulation* theme illustrates how violent thoughts and fantasies were used to regulate emotional states. Broadly, the use of violent thoughts and fantasies (VTF) could be divided into two main groups; those used to up-regulate positive affect (such as feelings of power or control) or down-regulate negative affect (such as anger). Despite this theme being the smallest super-ordinate theme within the analysis (prevalent across 20 transcripts) it highlights a number of functions of violent thinking which may be useful in assessing the relevance of VTF to this population. A detailed description of the emotion regulation themes, including a focus on the two sub-themes 'power and control', and 'coping mechanism' are presented in this chapter. As part of this chapter we are also able to offer some clarification over what is understood as a violent thought and how this is different to a violent fantasy, based on the way these two experiences were described by patients in terms of their differing affect regulation qualities. The chapter will conclude with a discussion of the findings from this chapter, their relevance to other themes and links with the wider scientific literature on affect regulation within mentally disordered offender groups.

5.1 POWER AND CONTROL (9)

Patients' use of violent fantasy to gain a sense of power and/or control was clear from the content, characteristics and function of violent fantasy. Patients would largely describe feeling in control of their fantasies; control of their occurrence, the duration of engagement, and content. Violent fantasy content

included severe and intentional harm being inflicted on another and included bludgeoning, strangulation, burning and the use of weapons to harm and/or cause fatal injury towards other people. The weapons that were used in fantasies included cross-bows, axes, swords and guns, and also included some weapons that are more readily available to patients within the secure setting such as pool cues, scissors and cutlery. There were also themes of sexual violence including rape, sexual degradation and sexualised torture.

It is useful to highlight the positive and powerful portrayal of the self within each patient's own fantasy. Within these fantasies the aggressor would be portrayed as a powerful character, a better person (than they currently perceive themselves to be) including someone they would like to be.

> *"Makes me feel as if like I was a hero, that nobody can stop me in battle". [R48]*

On most occasions it was the patient themselves who was the aggressor within their fantasies. Imagining other people being violent was also represented within the context of fantasies, although this was less frequently observed.

> *"I sometimes see myself- I stand back and see myself committing the offence rather than- its similar to that really. Other people might be involved in that offence for example, so erm.. Because I'm- The particular fantasies that became a problem for me where I imagined myself making a film, for example.... Erm, I might be the filmer for example, so I might be filming somebody else committing a rape for example, erm or somebody stabbing somebody with something, doing something like that.... For example I might have made a fantasy out of a story about meeting somebody over the internet, erm that wants to commit a similar offence and we get together like a group. I mean I know in reality*

it does happen, people do get together and do things like that. I think as a fantasy it was similar, it was still the same sort of thing. So two or three people act together and I might be filming a particular offence they're committing against somebody". [R39]

Often patients would even describe unreal or hypothetical situations in which they imagined themselves engaging in unrealistic violence that they would not ordinarily be capable of. This highlights how fantasies are fictional; not based in reality and can be limitless in content and whatsoever the creator desired.

"If it's a fantasy it'll be me attacking someone, using a more elaborate fashion than I can actually physically do. So for instance, I have a fantasy where I take on a room full of people, sort of flying kicks and you know, things which I can't particularly do. But erm, quite brutal in some cases.... fantasies are completely outrageous. It may involve me twirling through the air with a samurai sword, bouncing off walls and matrix style. It's unrealistic". [R18]

This adds emphasis to the 'self-created' nature of violent fantasy; fantasies can be whatever the individual wants them to be and serve whatever function the individual needs the fantasy to serve.

A comprehensive storyline was also sometimes embedded within the fantasy, which included wishful and ideal features or characteristics. In the following example the patient describes a fantasy that details what his plans were for his index offence. This example is particularly helpful as it illustrates the level of thought, detail and planning that had gone into the fantasy – a story within a story. Also, the content of the fantasy includes the patient as the offender but also depicts himself as the rescuer; the one who isn't really behind the crime and actually wants to help the victim.

"I knew that I was going to kidnap somebody. Obviously search them and then cuff them and put them in the boot of the car. Drive to wherever it was that you'd drive to and then do a strip search and then an internal search looking for bugs, that had been put under the skin or internally as a erm GPS tracker. I knew it wasn't there. That was kind of part of the story. And then take them somewhere to hold them and try and get money out of them. And if they didn't do as I told them to, I was gonna- well possibly gonna do it anyway- and cutting the face the breasts, burning of the genitals and sexual degradation. Erm…. And it…. the whole kind of thing was to kind of……. The story I was going to tell her was that a friend of mine had got involved in with erm…. drugs and was in trouble and I was trying to help her. And I'd got in contact with this chap, basically to see if I was Kosher so to speak - in his eyes - he wanted me to kill this lady, but I didn't want to kill her. So, I was basically, I was taking her I was going to find someone to kind of give her a new identity and sort it out and all that sort of thing. Obviously for that I need money. And that's how I get the money and then I would take her to a train station in- under the pretence that she's meeting with this other chap and then just walk away. And then she'd realise that I was lying- or she'd even know already or would realise that was a lie." [R31]

The level of clarity, detail and conviction within these fantasies suggests that they are well thought out and may well have been developed for a number of years, which is consistent with the origins of violent thoughts and fantasies being in childhood, as discussed in chapter four.

Within the offender's fantasies the offender himself was in a position of dominance and/or control, for example, as the aggressor or perpetrator of violent/ sexually violent crime. This might indicate that the fantasies provided a sense of

power or control from an imaginary situation in which they could dominate or be masterful of others. In addition, the feelings of power and control that would accompany and/or be derived from the fantasy would often encourage repeated engagement with the fantasy. Violent fantasies could occur pre, during or post-offence. For the latter, patients would also blend memories of real events with their self-created fantasies (described in more detail within chapter 7).

Revenge fantasies (many of which were described to have origins in childhood – see chapter 4) would also allow patients to gain a sense of pseudo power and control following incidents of abuse during childhood. Some patients spoke about how their revenge fantasies, targeted towards their childhood abusers, offered a means of dealing with the trauma they experienced as children or young people, and as one described provided 'closure' on these past experiences.

> *"If somebody's been abused then, you know, er, because there is no closure in, you know, what happened to them. Then you, you know, you fantasise about getting revenge if you like, you know. But it's not to say that you're going to do it. But, you know, it's about dealing with erm,.. trauma. That's it". [R10]*

Within the revenge fantasies in particular, there was sometimes a desire to ensure that the victim within their fantasy knew who their aggressor was; the patient whose fantasy it was. This might bring with it a more intense state of deliberate and intentional revenge, for example:

> *"I'd want them to know it was me". [R06]*

5.2 COPING MECHANISM (11)

Difficulties identifying and regulating emotions is a challenge some individuals experience. In the current sample this includes those diagnosed with personality disorder or severe personality difficulties, which are characterised by affective dysregulation (e.g. Sarkar & Adshead, 2006). The coping mechanism sub-theme illustrates a role for violent fantasy to regulate negative affective states.

The experience of engaging in a violent thought or fantasy was often characterised as comforting and was sometimes referred to as a 'comfort blanket'. The findings from the analysis suggest that this sub-theme may be related to protecting and/or sustaining the self through a violent fantasy, as fantasies are portrayed as providing a form of internal assurance to the individual.

> *"It gives me sort of like a comfort to know, you know, that I could do something like that". [R11]*

Patients reported that the fantasy itself was often enough to make them feel better, by means of providing assurance to them that they would be able to carry out what they had imagined. The feelings of powerfulness that ensue are often positively reinforcing and may encourage repeat engagement with the fantasy, which may lead to dependence on fantasy as a source of comfort or pseudo-power.

Some patients also described using the fantasy as an in-vivo platform in which a sense of comfort could be achieved.

> *"You're going through it in your mind what you'd like to do and then it almost feels that satisfying enough to a degree that you can just switch it off and it gives you a bit of comfort.... It's sort of like having a comfort blanket if you like. You know you can't do anything about it but at least it gives you some comfort, you know". [R17]*

Furthermore, gaining this sense of satisfaction from violent fantasy was often reported to be sufficient enough to dispel negative affect, which some patients reported would reduce their need to have to act out the fantasy in reality, as the fantasy would provide an equivalent or appropriate level of emotional outcome. In this sense violent fantasies functioned as an outlet for emotional states; a way of venting frustrations internally which was often described as a way of coping with anger, frustration or stress.

> *"I think the violent thoughts in a way are a coping mechanism, it's a coping strategy. Because in having that violent thought you're releasing that frustration internally. The internal frustration, you know. It's like you've got- A lot of physical violence originates in here [gestures to head] and I think if you can deal with it at that point, it doesn't come out anywhere else". [R38]*

Following disconfirmation analyses it was also considered that for some patients however, thinking about violence for an extended period of time was enough to motivate them to offend. Whilst the current theme describes VTF as functioning to help individuals cope with their VTF, and thus, arguably inhibits action, the following extract illustrates how, for one individual, VTF motivated him to offend by providing permission.

> *"Like the exposures, I used to fantasise and fantasise and fantasise about this particular staff and in the end it just knocked the wall down and gave me permission to do it...if that makes sense". [R20]*

This highlights the variation in function for different fantasies and for different individuals. In addition this emphasises a need to be responsive to frequent fantasising and the function it serves; when is it effective in regulating affect and when is it likely to promote a violent response.

Internal expression of negative affect did not always involve violent imagery and patients would often report that simply imagining themselves being aggressive or hostile towards another person (e.g. swearing or making threats of violence) would also allow them to feel like they had dealt with the situation.

> *"I mean sometimes I'd even end up saying while she was causing arguments with me that I would, "yeah I am gonna kill you and cut your body up and put it in a box". And that was my way of sometimes dealing with the stress I was under. I'd just like, sort of fantasising- half fantasising about what I could do to end the stress she was giving me." [R25]*

Despite the seemingly comforting nature of violent fantasy there was recognition that this was an unusual experience and that it may sometimes be perceived by others as odd or bizarre due to the assumed social or moral discrepancy or dissonance. This is also similar to the normal versus abnormal theme described in chapter 4.2.

> *"I was going through my mind about how I could kill somebody … and the processes of that. I've done that for a very long time and it er… It sounds- this might sound a bit strange, but it's soothing. Do you know what I mean? Obviously carrying it out's not soothing but the thought process of it- coz I'm so used to it, it's something that occupies my mind". [R30]*

In addition it could also be argued that the fantasy may be soothing or comforting to the individual because it's familiar to them, which would suggest that it may be long-standing as opposed to a spontaneous or momentary experience and perhaps something which has served the necessary function effectively in the past.

5.3 DISCUSSION OF THEME

This chapter describes how violent thoughts and fantasies function to regulate emotional states. Fantasies were described as being more self-selected and controllable activities in which violence was imagined in detail. Consequently fantasies were longer-lasting and were described as enjoyable and something that the individual got pleasure from. Thus, it seemed there was a greater expression of violent *fantasy* within the power and control sub-theme. Patients' application of thoughts on the other hand often appeared in response to environmental stressors such as feeling threatened or bullied. This might explain why thoughts were more often described as momentary; brief in duration and characteristically spontaneous. The thoughts were often more grounded in reality compared to fantasies, which would fit with the notion that thoughts were also found to be less elaborate and more focused on violent actions that were readily available in the immediate environment. The spontaneous and relatively brief duration of a violent thought was also described as sufficient in helping the individual to cope with the precipitating situation and dispel anger. This might suggest that, despite its brief duration, the thought was powerful enough to help the individual deal with the perceived provocation in that instant. This is not to say that these are two mutually exclusive categories. The experience of violent thoughts and fantasies can be interchangeable and not always limited to one particular function. What is proposed here is that duration, detail and importantly function may allow us to separate out what is meant by thought and what is meant by fantasy.

Some patients described how their revenge fantasies afforded an opportunity to deal with historical childhood abuse and/or traumatic events they may have experienced (see chapter four). However, the extent to which fantasies were effective in serving this function is unclear given the fantasies were still present and active. It could be argued that the fantasies provide an ongoing process of *attempting* to gain closure on traumatic events from the past. This would provide support for the long-standing nature of fantasy and would also make sense given

these events were so traumatic that it was not something that could be solved quickly. The finding that fantasies were described as being useful in helping patients to deal with formative traumatic events has nevertheless highlighted a potentially important function. When thoughts or fantasies are effective at serving the function of providing a sense of control, dealing with stress or anger or helping the individual to cope with their emotions then it is argued that this may negate the need to act on the VTF. A catharsis viewpoint (e.g. Bushman & Baumeister, 1998) would posit that the thought or fantasy reduces the anger and thereby brings about emotional regulation. Moreover, if the emotion which drives aggression is alleviated, it could be argued that the risk of action is also reduced.

On the other hand there were a few patients who described that the more they imagined violence the more likely they were to act on it. This could be explained in terms of the script-rehearsal theory as proposed by Huessman (1998). This theory suggests that when there is continued engagement with, or rehearsal of a violent thought, it becomes more deeply encoded in memory, more easily accessible in a threatening situation. This theory was used by Grisso, Davis, Vesselinov, Appelbaum, & Monahan (2000) to explain a higher prevalence of violent behaviours amongst mentally ill patients who disclosed having violent thoughts (see chapter two for a review).

The functions of violent thoughts and fantasies become increasingly important within a sample of offenders for whom personality difficulties and mental illness can exaggerate their risk of violence (see McMurran & Howard, 2009). Of note, the overarching emotional regulation theme may be so significant within the analysis because this is something that people with personality difficulties or those diagnosed with personality disorder have difficulties with; recognising and managing emotions. As discussed throughout this chapter it may be that the violent thought or fantasy provides the individual with a need. For example, a need for power and control which may have been lost though a traumatic childhood (Lachman & Lachman, 1995), or indeed may be linked with sadistic personality, which is characterised by a need to control. The fantasies of

power and control that were so detailed, elaborate and not based in reality also suggest extravagance, perhaps related to over-compensation for low self worth or indeed linked with narcissism. Pathological narcissism is characterised by "protection and sustenance of a grandiose and inflated but ultimately fragile and unstable self" (Logan, 2009 p.89). It could be argued therefore, that fantasies which portray the self (as the aggressor) as very strong, powerful and superior may, on the surface, suggest narcissistic personality traits. Conversely, it might be that the individual wishes to over-compensate for the discrepancy between actual and ideal self.

The theoretical underpinnings of the research highlight the importance of data collected in context and thus it may be timely to reflect on whether sharing VTF within the context of the interview also afforded an opportunity to convey a sense of power and control. It is likely that the sub-theme power and control may well have been borne out of an offender's need to gain a sense of power and control by sharing these omnipotent VTF with the researcher; and whether some secondary reinforcement was gained through the sharing of these experiences. On the whole however, sexually violent and sadistic thoughts and fantasies were not frequently reported. This may have been due to a number of reasons including reduced overall prevalence of these experiences compared to non-sexually violent thoughts or perhaps difficulties sharing these experiences in interview. With regards to the latter, this may have been due to contextual factors such as feeling shame or embarrassment and perhaps the effect of sharing these experiences with the researcher themselves.

Finally, it is important to recognise the context within which this theme was developed. Patients detained at Rampton Hospital are restricted in their interactions with others (e.g. relationships, behaving violently/ taking revenge). If the fantasy allows them an opportunity to experience such events or situations that they could not ordinarily access, it would suggest that they may become more dependent on the fantasy in providing them with what they need, with the

individual becomes increasingly dependent on the VTF through the process of VTF functioning to regulate affect.

In summary, violent thoughts and fantasies serve functions related to emotion regulation in mentally disordered offenders. This includes using violent fantasy to up-regulate positive affect or down-regulate negative affect. Using fantasy to regulate emotions may be particularly important for those individuals who have difficulty recognising and managing emotions (or emotional responses), such as those diagnosed with personality disorder. There is a high level of importance assigned to the thought or fantasy experience, which may be due to high levels of investment or dependence on fantasy as a patient's only means of in-vivo contact with the outside world whilst they are incarcerated. The findings from this chapter highlight a number of clinical implications which may be useful for practice. This includes initially assessing the function of the fantasy. Where VTF are used for affect regulation the individual should be supported to consider alternative means by which affect regulation can be achieved as their presence may also motivate an offender to act. This has implications for risk management and therefore should be considered within the context of offender management and treatment.

CHAPTER SIX

THEME 3: AWARE OF THE NEED TO BE CAREFUL

INTRODUCTION

This theme describes a state of awareness in which individuals make sense of their vulnerability of risk to either self or others. The way in which individuals process external cues within their environment can lead to a state of anxiety in which they worry about being a victim of violence and/or behaving in a way that would make them the aggressor in a particular situation. For the latter, patients describe how they attempt to manage their violent thoughts and fantasies in order to minimise their risk of acting on their violent thoughts and becoming an aggressor. Within this chapter the theme of 'aware of the need to be careful' is described in detail alongside four sub-themes: *apprehensive anxiety*, *decision making balance*, *managing violent thoughts and fantasies,* and *then and now*. The findings are discussed briefly in relation to existing literature and psychological theory and links to other themes within the analysis are also highlighted.

6.1 APPREHENSIVE ANXIETY (11)

Violent thoughts and fantasies (VTF) were described as characteristically negative and unwanted experiences. While patients often recognised the functionally useful side of fantasising (e.g. makes them feel better, as described in chapter five) the characteristics of VTF were often described in a negative way and were labeled as 'annoying', 'scary' and generally troublesome. Many patients described how they would prefer not to experience VTF and that they were largely intrusive experiences that provoked anxiety.

"I try and stop them, coz they're not nice. Erm… they put me in a very negative mood and I don't like being in that place, it's not a nice place to be". [R30]

There was a greater feeling of unease regarding violent thoughts over violent fantasies, which may be because the former are based in reality, which increased the potential risk, making the experience of a violent thought more distressing.

"The violent thoughts particularly were really bad. It was- I could be sitting there and I'd have the overwhelming urge to jump on the person sort of next to me and attack them. That was really intrusive, it really just changes sort of- how you interact with people. Now it's- they're there, you get them, they go. It's not as scary". [R18]

When a threat or stressor is perceived in the environment the individual is prompted to make sense of this. This largely involves processing of the situation; making sense of what has happened and how they are feeling, which in turn leads to an informed decision about an outcome. When an individual perceives risk to themselves (through the interpretation of others' behaviour) this may fuel a sense of vulnerability towards violence where they may see themselves as at risk of harm.

The role of mental illness is considered to be significant here as this has some influence over the way in which people make sense of things, including when they perceive themselves as a target for violence or harm. Specifically, within this research it became apparent that some environmental stressors were described to be real experiences by the person who experienced them but upon verification of these assumptions they sometimes appeared to reflect persecutory and delusional beliefs.

Perceived vulnerability might trigger a violent thought in which one imagines violence that functions to regulate the negative emotional response

brought on by the trigger (see chapter 5). If the process of emotional regulation is unsuccessful it may encourage a need to want to defend or protect oneself from risk of violence, which is discussed further the sub-theme *decision making balance*. Pre-empting violence *towards the self* and *from the self* appears to be surrounded by feelings of anxiety grounded in the awareness that he may behave violently, which he may be motivated to avoid.

> *"But there's times when I've- something's happened and I've just got to get away from here- the wife and kids in case I hurt them or, you know what I mean. It-… nothing's going to happen, but you think it's going to happen". [R40]*

> *"I've been assaulted 4 times and I've never reacted, I've walked away. But my fear is, is that sometimes you can only take so much, do you know what I mean, then you result to something you don't want to do". [R41]*

Often this state of anxiety could resemble being hyper-vigilant to perceived threats in the immediate environment. Being a patient within a high secure hospital was often fraught with concern about the characteristics and temperament of other patients they were surrounded by, in that they were also offenders with mental illness and/or personality disorder. Sometimes patients would normalise their hyper-vigilance or make sense of their hyper-vigilance in terms of their detention within Rampton Hospital.

> *"You become constantly vigilant then you see, so that's when you can misinterpret things. If someone gives you a funny look you think, 'oh dear', or 'how comes they give us a funny look, I ain't got no problems with him, I don't think'…. and then it gives you room to start making assumptions and thinking about things that aren't*

necessarily what it could be. And then later on you might bump into him and he says, 'oh, I was going to come down and see you earlier and I was going to come and ask you about something, I was going to come and see if you could do this or do that' and it could be totally innocuous. But because you're a bit heightened and you over-read things – or I did, I'd over-read things, and I became paranoid". [R07]

Being aware of the type of person they are surrounded by increases feelings of vulnerability to harm and may maintain the cycle of hyper-vigilance towards threat. Often patients would describe that this cycle was ever-increasing, which made it more difficult to control acting on. There was some suggestion that the power of the violent thought would become so intense that it might exceed their ability to control it, which might then culminate in violent action. The idea that this control could be lost was something that caused anxiety.

"It's very stressful. I know I am going to end up assaulting someone, I just don't know when". [R18]

It was generally agreed that the overall experience of VTF was distressing enough to be worthy of management or control. This motivated the individual to reduce the associated anxiety in an attempt to reduce the likelihood of violence occurring.

6.2 MANAGING VIOLENT THOUGHTS AND FANTASIES (15)

Early recognition of the state of anxiety was often functional, insofar as it prompted an awareness of the need to be careful; referring to proceeding with caution in terms of how to manage the violent thought or fantasy. This was particularly important in the thought's infancy to inhibit progression or escalation to the point at which it may have become too difficult to control. This is where

patients described a process of managing VTF so that they could find ways of coping or dealing with them which lessened the power of the fantasy and in doing so, reduced the risk that it might lead to violent action.

The initial step in managing violent thoughts was to identify them, appraise risk of action and try to control them accordingly. This process of making sense of the situation was relatively quick, which patients viewed as necessary in terms of minimising their risk of violence as swiftly as possible.

> *"But the thing is I very quickly realised where I was and I was kind of like 'oh shit!' I need to get out of here quick! Do you know what I mean? Because they'd really pressed the wrong button. They pressed the button of the childhood abuse, the childhood, are you with me, so therefore erm, I needed to find a way of removing myself from the abused child to the adult, are you with me? And I needed to get out of there very quickly, so I very quickly just turned away and walked away. I just got out of there quickly and went to my room, shut the door." [R04]*

Many patients talked about accepting the situation and walking away so that they could have time to reflect before reacting. However, it is difficult to ascertain how accurate and consistent this pattern of behaviour was across the sample. Patients who walked away from the provoking situation asserted that they had had dealt with it and thus they didn't feel the need to behave violently. These patients therefore recognised this as a protective factor.

> *"I think that maybe you'd have the fantasies yeah because they protect you from acting out there and then". [R03]*

> *"I just sit there and think about erm, you know, why I'm feeling the way that I am? And having to try and like unscramble the thoughts*

in my head so I can make sense of it all. But at the same time what I'm doing is, I mean, I say to myself is I'm not only trying to make myself feel safe, I'm trying to protect the others around me as well. That's the reason why I do it". [R41]

Patients also used distraction techniques to reduce the risk of acting on a violent thought. This was achieved by engaging in activities that would enable them to shift the focus from a stressful or provoking situation and simultaneously provide an opportunity to deal with the emotion that might otherwise drive the violent behaviour.

"If one of my CAT [Cognitive Analytic Therapy] cycles was triggered then I am quick tempered… so therefore I am quick tempered to think about maybe erm maybe wanting to punch somebody, but I don't mean –I don't want to do it. So therefore I'll go an do somat' else, I'll go play scrabble, or I'll go, I'll go, I'll go do a cross word, I'll go do something to dissipate my emotions immediately. Because I don't really want to do it anyway, it's not something I'd like to do, I can't do it. You can't go round hitting people, it's not appropriate". [R04]

It could be argued that the violent thought was in itself a distraction from the action, and functioned to regulate affect (see chapter five), although some patients would describe needing to distract themselves from the violent thought itself, as it was unpleasant and likely to increase their risk of violence if it wasn't managed appropriately. Some methods of distraction involved going to the gym or completing coursework for educational programmes (e.g. Open University Degrees).

Alternatively, in an attempt to manage the VTF some patients described feeling compelled to act out the VTF in the hope that this would stem the VTF and eliminate or terminate the experience.

> *"To be honest with you, up until a certain point, I don't intend to carry any of them out. It just gets a bit too much for me. It's like er…. Having something in your head that's just pounding and pounding and pounding away and you just try to live with it and try to get it to subside. Erm and then I just think, you know, I go for it. Just to get rid of it. And I also have a belief that once I've done it I won't have those thoughts anymore." [R30]*

Based on the patient's description of his experience and the violent behavior which ensued, this was his attempt at 'managing' the violent thoughts, which places it within the current theme; the function of the behavior was to manage the thought, a consequence of which was the occurrence of violent behavior. Some patients also described a need to manage the expression of VTF in what they believed to be a more adaptive way, such as directing the violence towards themselves in acts of deliberate self harm, with some indication that they would even prefer to take it out on themselves rather than hurt someone else.

> *"I have a thing where I used to run around naked outside. That's weird innit! But I did. And I'd have-... I used to have a thing where- I like mud, OK. Really slippy sort of nice textured mud, not gritty mud. And I'd get naked and kneel in it and masturbate to hard core images.... Now that's weird. But the thing is, all these things I was doing to keep me away from committing an offence, you see." [R27]*

"Because I couldn't take it out on her and I tried to take it out on myself by cutting myself and all stuff like that, and taking loads of my prescribed medication that I was on at the time.... But I was impulsive so I would need something to take away the anger that I felt, and for me it was the fire that took away the need for me to take it out on her." [R07]

Alternative behaviours, such as those provided in the examples above, may be examples of Offence Paralleling Behaviours (OPBs; e.g. Daffern et al., 2007b). Offence Paralleling Behaviours are described as:

> A behavioural sequence incorporating overt behaviours (that may be muted by environmental factors), appraisals, expectations, beliefs, affects, goals and behavioural scripts, all of which may be influenced by the patient's mental disorder, that is functionally similar to behavioural sequences involved in previous criminal acts (Daffern et al., 2007b, p. 267).

Accordingly, it could be argued that violent fantasising may also be identified as an offence paralleling behaviour (OPB) in that it isn't an overt or directly observable experience. Although many patients described VTF as a protective mechanism (in that they allowed for in-vivo rehearsal of the fantasy instead of action), it is also likely that this process of rehearsal could be reinforcing (e.g. in line with script theory; Huesmann, 1988; 1998) and thus may be an important consideration for violent offending.

One final way that patients would attempt manage their VTF was to share their VTFs with others to decrease the burden associated with them. Patients reported that they often made their disclosures to staff in an attempt to get help and support with these negative experiences. However, patients often felt that the level of support that they required was not achieved. In the extract below, the

patient describes approaching his Community Psychiatric Nurse (CPN) for support with his fantasies yet he didn't feel that this was achieved and consequently used this as his rationale for needing to manage them himself, in whatever way he deemed necessary.

> *"Yeah, coz that's what it [trialling the fantasy in reality] was for, is to dull the feelings and get them out of my head for a bit. What eventually happened is just before I went to London I actually spoke to my CPN about it [violent thoughts] and as far as I'm concerned I got fucked off. Coz I'd had enough of the thoughts. So it was getting to the point where I'd had enough. I didn't want them anymore. So it was like well, I'm not going to get help…. erm, I don't want them, so the only option left is to do it. And obviously, stupidly, I went and did it, like a plonker". [R31]*

6.3 DECISION MAKING BALANCE (18)

The decision making balance sub-theme was one of the strongest sub-themes in the analysis and was observed across 18 transcripts. This sub-theme describes the decision making process in which the individual makes sense of the threat or stressor and considers their behavioural response, including a decision as to whether or not they will respond in a violent or aggressive way. As the sub-theme name suggests, the decision is a carefully balanced process in which the costs for violent behaviour are weighted against the benefits. There are a few elements to consider within this process, such as the perceived acceptability of their intended behaviours weighted against the likely consequences of their actions.

Normative beliefs about violence were identified within this theme. These guide one's awareness of what they deem to be acceptable and unacceptable, which subsequently informs their judgment and attribution of external events. For

example, in the extract below a patient describes how a violation of his masculine values could contribute to his decision to behave in a violent way.

> *"If I feel hard-done by I feel like I've got to protect my masculine values like, yeah, say if somebody breaks one of my roles as a bloke, like hitting a woman or a kid or pinches your car or something, I feel obliged, I've to go stand up for myself, yeah". [R24]*

It seemed highly important for patients to stand by their beliefs in order to maintain a certain image of themselves. This would ensure that their reputation was upheld and that they were not seen to be someone who was weak, as this might also make them into a target.

> *"I think a lot of it was to do with criminal code of conduct so to speak and erm. I dunno. I suppose in my line of work at the time – for want of saying er, you know if people do things like that against you, they have to be paid-back kind of like and that. Otherwise you're seen as a very weak person and people will take advantage of you and so you have to pay these people back and like and that". [R06]*

However, these decisions would often be weighed against the consequences of behaving in a violent way and generally, patients spoke about making decisions as to whether this type of behaviour would be worth engaging in.

> *"And I can't afford, you know, all of a sudden I've got so much to lose and I just want to get out and enjoy life, enjoy my life with my nieces, my nephews and my sister. And it's just not worth losing all that over a couple of seconds- of something that you might enjoy*

for a couple of seconds- and then you have to pay the price for". [R06]

"I ended up killing him. He drove me to it.... Wish I didn't have to go to such lengths because I knew I'd get caught, but it had to be done". [R46]

The decision making balance therefore involves the perception of a problem that the individual decides they need to solve. In the extract below a patient describes how a challenging social situation could be resolved with an argument or with something more sinister, further highlighting the process of decision making whilst simultaneously highlighting progression in severity of methods used to resolve the problem.

"If there's a perceived injustice, be it by staff or by another prisoner then to save loosing face, you have to deal with it, in matters, you know, that are available or deemed suitable at the time. It could be an argument. It could just end at an argument. Or it could become a bit more cloak and dagger, cloak and dagger sort of style". [R07]

6.4 THEN AND NOW (12)

This sub-theme describes how patients are able to reflect on previous experiences of VTF; how they were previously managed and how they used to result in violent behaviours. It was largely conveyed that previous experiences of VTF had contributed to violent behaviours and this in turn had facilitated an increased awareness of the risk associated with VTF and moreover, a need to recognise and manage them effectively. As such, reflecting on previous experiences often appeared to function as a learning opportunity. Patients compared their past

and present management of VTF, usually concluding that they were *now* more able to control the behavioural expression of VTF.

> *"If somebody winds me up you know, and they're generally being a pain in the arse, I just think to myself, you know, they're an idiot, it's not worth worrying about, you know. I am not going to get myself wound up over something like that. Even though its annoy- it annoys you, it's just not worth the hassle, it's just not worth it. And that's the way I think now. Whereas before it wouldn't be, I wouldn't think through the situation, you know. I would be more impulsive, it would be more about me and not about them, how it's impacted on me- I wouldn't even how it's impacted on them. So then it'd be.. then I would start to live out a fantasy of what I would want to do or what am I going to do, but now it's, it's not really like that".[R17]*

It was frequently observed that patients presently felt that they were more aware and in control of their violent thoughts and fantasies and that they were subsequently more able to manage them effectively.

> *"I don't allow them to take over my head like I used to". [R10]*

This could be through choice as suggested in the example above, or as a result of the skills and/or treatment they have received since being in Hospital. Many patients spoke about how they found certain medications helpful at reducing the frequency of violent thoughts or increasing their tolerance and ability to manage them more effectively. It was frequently observed that patients who were able to make *then and now* reflections usually portrayed their current management of violent thoughts in a more positive and favourable light.

6.5 DISCUSSION OF FINDINGS

Overall, the experience of VTF was described to be negative experiences because of their recognised association with risk. Patients identified the troublesome nature of violent thoughts and fantasies and described their various attempts at managing these experiences in order to reduce or eliminate potential risk of violence. An ability to recognise and manage VTF however, effectively highlights a controllable side to these experiences and importantly suggests that there is a choice to be made about a) whether or not to manage and b) how to manage them.

Such decisions are likely to based on the way in which social cues are interpreted and are dependent on social – cognitive information processing skills. In the first instance, scripts related to violence or aggression may be activated in a threatening situation triggering a need for the individual to consider possible behavioural responses. This activates a series of scripts, which are each evaluated and the most appropriate script retrieved for activation in that situation. Crick & Dodge (1994) and Dodge (1980) would argue that deficits at any stage in the information processing model can increase the likelihood of violent behaviour. However, this theme appears to demonstrate that it may not be a deficit per se, but perhaps a bias in information processing which might contribute to the selection of certain behavioural scripts over others. Biases in cognitive processing have been widely identified within the offender literature but what is of particular relevance to this study is the fact that offenders can make decisions about whether or not to engage in violence.

Patients described implementing a range of techniques in an attempt to manage the experience and expression of VTF. However, these techniques were sometimes unhelpful, for example not getting the support they felt was needed and/or engaging in offence paralleling behaviours. Consequently, some patients appeared to displace the drive behind the fantasy or behind the violent action onto other problematic behaviours such as self-harm (for a review see Klonsky, 2007),

which may also be identified as a way of shifting the focus onto the individual himself. Alternatively, behaviours such as viewing and masturbating to pornography that are recognised as offence paralleling behaviours may also be potential treatment targets.

On the other hand, some patients who were receiving treatment for their violent thoughts and fantasies often spoke positively about the treatment they had received. Medication for example was associated with less intrusive violent thoughts, which one patient stated reduced the anxiety behind his violent thoughts and therefore enabled him to reside amongst his peers without the worry of acting on a violent thought. Talking therapies were not specifically mentioned, however some patients made reference to understanding their violent thoughts and fantasies in a psychological way e.g. making reference to activation of CAT cycles being triggered and schemas being activated, suggesting that there is some awareness of how violent thoughts are manifest within psychopathology. Furthermore, this highlights how violent thoughts and fantasies may be discussed within the context of psychological therapy sessions and that support for these experiences may be received here.

However, there were some patients who said that talking about their violent thoughts and fantasies didn't get them the help they needed. This may be due to a number of factors ranging from the nature and function of the experience (in context), the person they sought support from and how this was subsequently managed. Accordingly there may be a number of potential implications for practice. On the whole however, it seems appropriate to suggest that individualised care plans which are developed in collaboration between staff and patient that stipulate how violent thoughts and/or fantasies can be supported, may be useful to both the client and supporting staff.

Finally, the *then and now* sub-theme highlights the patient's ability to reflect on their previous experiences of managing VTF and is described as a kind of learning experience. It was generally conveyed that patients felt like they were 'now' more in control of, and able to manage, their VTF; preventing behavioural

expression in what they ascribed to be a problematic manner. However, the accuracy of these claims is debatable and may be biased through attempts at positive self-portrayal. While it is not disputed that some patients may be more able to manage VTF at the present time, there remains a need to consider issues of social desirability, and/or lack of insight into these experiences.

In summary, this chapter illustrates the theme of 'aware of the need to be careful' and provides some suggestion that mentally disordered offenders are able to make decisions about how to respond to aggressive or hostile social situations. However, this decision appears to depend on many factors including cognitive biases and distorted beliefs in relation to the self and others. Patients have described an awareness of the need to carefully manage their thoughts given their appraisal that some thoughts are associated with risk of action. However, the extent to which the strategies that patients used to manage these risks is unclear, given some techniques include offence paralleling behaviours. Nevertheless, this theme highlights patients' abilities to recognise risk and encouragingly, engage in attempts to reduce this risk.

CHAPTER SEVEN

THEME 4: THINKING TO DOING, TO THINKING, TO DOING…

INTRODUCTION

The theme of *thinking to doing, to thinking, to doing* that is described in this chapter represents a progression from the theme described in the previous chapter and illustrates the escalation of violent thoughts and fantasies (VTF) to offending. This chapter describes the transactional process between thinking (violent thoughts and fantasies) and doing (violent behaviour) and captures the presence of VTF displayed in reality where they usually take the form of violent behaviours. While VTF have been identified as being used to guide or plan offences, there is also evidence to suggest that the observed violent behaviour is only a small part of what the offender has actually planned in their VTF. Simultaneously, a reverse relationship (doing to thinking) is also illustrated in which violent behaviours are also thought to directly influence patients' VTF, as aspects of reality and the memory of the offence itself become integrated into their VTF. As such it is proposed that the relationship between thinking and doing is circular and ongoing with the two feeding into one another.

There are three sub-themes within the super-ordinate theme. *Strategy and planning* describes the function of the VTF as an aid to planning a violent assault, *out of my hands* describes the patient's attribution of why the violent offence occurred and finally *thinking to doing* illustrates patient's reflections on their violent behaviour, including alternative outcomes and subsequent renewal of VTF in some cases. Each sub-theme will be discussed in turn and following this a brief discussion will place the current findings into context, with reference to the broader thematic structure and relevant literature.

7.1 STRATEGY AND PLANNING (22)

This sub-theme captures the function of VTF as a means of developing a strategy and plan for violent action. When thinking about responding to provocation or when thinking about revenge, the perceived severity of harm that the individual was exposed to is used to determine the severity of their response.

> *"I'll think about all different ways of being violent and then I'll normally choose what's worst or what I think is fair". [R35]*

> *"I would creep around the garden and kill their pets to get back at people. Sometimes I would wonder what would happen if I stuck glass in their face. The harm is proportional. The worse they make you feel, the worse you have to make them feel". [R08]*

In putting a plan together as to how one might behave there is also a consideration of available resources used to commit the crime. This sometimes involves detailed consideration of whether the plan is feasible and its likely success. When using a fantasy to plan an offence, consideration is given to available resources, personal strengths and effectiveness. Personal strengths within the context of violent fantasy have some links with the desirable and wishful elements of fantasy, as illustrated in chapter five within the discussion about violent fantasies. Methods of harm that have historically proved successful become prioritised as illustrated in the following extract.

> *"Yeah, I think that's like a technique I've had to use even when I've got into fights. It's something that I always kind of go for because I find that I can put a good strangle hold on someone, you know, if I had to. So I've, been able to you know, fight my way out of things with strangle holds basically. So yeah, that's something I've kind of*

put at the top of my priority list when it comes to action. I always think strangle, you know, get around the back and strangle them". [R25]

In addition, it is clear to see how a successful method can be reinforced for use on subsequent occasions. This might include revising a fantasy or plan to ensure that it is effective.

"The kind of core of the fantasy was very similar. The basis was the same but the way I did it changed because I knew what I did, didn't work, so 'instead of that I can do that', 'instead of that I can do that' sort of thing. And it was kind of in a sense replaying it for when I went home". [R31]

Consider the extract below in which an individual with obsessive-compulsive disorder (OCD) meticulously plans his offence. The fantasies he uses to plan his violent attacks are usually highly detailed to procure the best possible chance of success.

"I want to make sure that I get- I give myself the best chance to carry out what I intend to carry out.... When I say meticulous detail I'm looking for erm, a pattern to the other persons behaviour. Erm.. I'm looking for what staff are on and where they are and where they might be when I… er… you know, try to perform a- such a task. All different, you know, situations and how they might react. Just so, just so I have the best picture possible for, for er… not just for my own personal scenario but for, you know like if, if, you can never account for, for everything. Something, something always goes wrong somewhere along the line and you then have to pre-empt that in thoughts". [R30]

In the strategy and planning sub-theme it is suggested that VTF could be used to guide behaviour and that as such, fantasy-driven violence may be well thought out, deliberate and under the conscious control of the individual. This sub-theme illustrates how violent behaviour can be goal-oriented with the offender choosing to behave violently.

7.2 OUT OF MY HANDS (6)

This sub-theme illustrates the way in which patients account for their fantasy driven violent behaviours after the violence has occurred. While the plans may be well thought out, and the behaviour intentional, this sub-theme captures patients' attributions of how the offence occurred in that it was out of their hands. As the theme name suggests, patients' appear to describe a loss of control over their violent behaviour or alternatively, describe their violence as the fault of an external party and not their own; patients would report that they didn't *want* to act violently, but that instead they felt *driven* to behave in such ways.

In some ways elements of this sub-theme overlap with the 'managing violent thoughts' sub-theme (chapter 6.2) where patients describe feeling compelled to act out their violent thoughts in an attempt to get rid of the thoughts. However, the current sub-theme relates more specifically to patients' loss of control over their behaviour, as opposed to choosing to engage in violence in order to achieve a particular goal e.g. goal is to minimise or reduce VTF.

> *"I could always control them until a certain point. And I kind of expected others to intervene. Because on the first occasion- no on the second occasion I informed people that that was my intention, that's what I was going to do. And by doing that I kind of relieved myself of any guilt or anything like that. It's their fault then, in my mind. I know it's not but whatever I do then it's their fault because they haven't intervened". [R30]*

In the extract above the patient describes unsuccessful attempts at seeking help for his VTF; he had asked for help and had not received it and that therefore his actions were no longer his responsibility. While this suggests some awareness of what was going to happen (i.e. foresight that he was going to behave violently) it also indicates some relinquishing of responsibility for his offence.

Some patients described how the drive or force behind the fantasy, which drove the offending behaviour, exceeded their ability to inhibit or prevent action and that this culminated in the violent act. In the brief dialogue below the patient describes 'over-feeding' a fantasy to the point at which he may lose control and 'let go' which would then culminate in the violent action. This is something he worries about which also links in with the *aware of the need to be careful* theme illustrated previously in chapter six.

> ***Patient**: "I'll still feed a fantasy, I'll still use a fantasy to get a buzz so I can feel the fantasies. So its round in circles. You shouldn't do that. And I'll feed it too much, so..."*
> ***Interviewer**: "Because if you feed it too much-"*
> ***Patient:** "I could explode. It's a worry actually, I'll let go." [R21]*

This suggests a loss of control over the behavioural expression of the fantasy. Some patients appeared to externally personify the fantasy itself saying for example "it got the better of me" (as in the extract below), which suggests that the fantasy took over or that the fantasy exceeded their ability to inhibit their actions.

> *"There have been a couple of occasions in the last few years where it's got the better of me and I've gone mad a bit and punched a wardrobe or thrown my fan at the wall or something like that. Erm, tellingly no violence against a person". [R37]*

"You get a small burst of violent thoughts, you know, they're not as loud and big as what they used to be, you know what I mean, its just, it's got a wee squeaky voice and you know, and then it doesn't get the better of me" [R14].

In the extract below the patient describes a sense of giving in to the fantasies, thus allowing them to manifest the violent behaviour that he planned to commit before committing suicide.

"Once I decided to kill myself then the fantasies took over coz that was all I had left now. One act of what I viewed as pleasure, before I kill myself". [R43]

Through the process of externally attributing cause of the violent behaviour to another party, the patient may be able to relinquish some responsibility for the offence that they have committed. There is a question of controllability here with many references to patients losing the ability to control their fantasies, which culminates in violent action, or perhaps that the fantasy in some way becomes more powerful for them to inhibit any longer, which they then give into. The question of whether this occurs by choice or not will be discussed in the main discussion section of the thesis.

7.3 THINKING COMPARED TO DOING (19)

This theme captures patients' reflections on their violent thoughts and violent behaviours and captures their afterthoughts on these experiences. The reflections include offenders' views on how the fantasy compared to carrying out the violent action in reality. There were often unforeseeable challenges that got in the way of the fantasy being carried out as they had planned, despite careful planning. As such, there was often a discrepancy between how the offender *imagined* the fantasy would occur in reality and how it *actually* happened.

In the extract below the patient describes acting out part of a fantasy in reality and how he couldn't act out the whole thing as imagined due to unforeseen challenges.

> *"So I'm thinking about my daughter- step daughter and I drank half a bottle of brandy and I went into her room and I kissed her and she woke up screaming and her mum came in. That's as far as it went. Do you know what I mean. But the thing is, in my head, it went a lot further. Do you know what I mean. And I'd got it all planned in my head, I just wasn't capable- physically- because of the amount I'd drunk of doing anything". [R27]*

As such it often seemed as though the plan was only partially acted out because of practicalities in his environment that prevented him from doing what he had planned to carry out in the fantasy, but that nevertheless the fantasy was ready in its entirety to guide the behaviour.

In the following extract the patient also describes entertaining a fantasy that extended what actually happened in reality. However, in this case he is also able to blend aspects of his previous offence into his current fantasy. For example, in the extract below the patient describes changing the face of his victim in his fantasy to faces of other staff he finds attractive.

> *"I indecently assaulted her, but sometimes I fantasise about having sex with her. You know, erm. And then sometimes I might even like put a different face to that- on that staff who I've like fantasised about here". [R20]*

This may be an example of fantasy re-modelling where the fantasy can be adapted to meet the offenders (changing) needs. The re-modelling of a fantasy highlights the interaction between fantasy and reality in creating something that the offender desires, as per the characteristics of a fantasy. Regardless, there appears to be

some maintenance of the fantasy and this maintenance may be related to the function the fantasy serves. In the above extract for example, the fantasy may function as a source of sexual arousal and the individual can re-model the targets in his fantasy to staff members he finds attractive. In doing so the individual can ensure that the fantasy continues to be sexually arousing.

When comparing the fantasy to the offence, patients often expressed afterthoughts about the violent assault that included contemplating alternative endings and thinking about ways in which the violent assault they committed might have been avoided. Many patients spoke about experiencing memories of their past violent behaviours and that these were shrouded in feelings of guilt, shame and sometimes remorse. For these reasons patients reported that they didn't actively engage in violent thinking and would attempt to avoid or suppress memories of violent crime and subsequently aim to reduce the negative feelings that accompanied them. In the example below the patient is talking about his memories of his sexually-violent assault and how he would rather not have to acknowledge his past behaviours.

> *"I mean I still do from time to time, but in the early days yeah, because you have to go through therapy and obviously you have to talk about what you've done so. That were pretty horrendous. And it's not very- not nice to know that you've, that you've hurt somebody else. Because again up until that point, I'd never hurt nobody in my life so. Yeah, its pretty- it's not something that you want to acknowledge. You'd rather run away from it than acknowledge it, but eventually you have to acknowledge and that you have done it. So yeah". [R09]*

Sometimes patients' reflections on their offences encompassed both negative and positive feelings. For example, remorse for the offence paired with intense feelings of awe and power through having achieved their fantasy in reality.

"It's not pleasure but sometimes I just feel well that was quite a feat, you know like a great feat even though it was an evil feat and it was like a bad deed I regret, but it was, from a martial artist kind of perspective I just felt like well I achieved what I aimed to do, you know... it was something I was quite surprised that I managed really.... It was something I'm not really proud of but at the same time I have to accept I did it. So I like to- sometimes just go through it just to accept that why I did it. I mean I find myself obviously trying to justify and rationalise to myself how it all came about and how I could have maybe avoided it ending up like that. But the fact that I have done it and I did do it, you know it just its, like I say, like some kind of shock or awe of myself". [R25]

As illustrated in the extract above the patient remembers his offence and expresses conflicting feelings about the offence itself and how he feels about it now on reflection.

The super-ordinate theme presented in this chapter not only covers the progression from thought to action but also describes the interaction between the fantasy within a mental space and the fantasy within reality. Behaviour and VTF are intrinsically linked as one can guide the other and this is most obviously illustrated within the strategy and planning sub-theme where VTF functions to guide behaviour in reality. Reality however can also feed back into the fantasy, which can contribute to re-modelling or updating of the fantasy in light of events that occur within the environment, for example having to revise a plan or adapt behaviour in a way that is effective. The relationship between thinking and doing is therefore considered to be circular rather than linear and this is conveyed within the current theme name 'thinking to doing, to thinking, to doing'.

7.4 DISCUSSION OF THEME

This chapter has highlighted a circular relationship between thinking and doing and thus identified a function of VTF to guide and plan violent offences. This has significant clinical implications in that a disclosure of VTF could indeed be indicative of action. However, a disclosure of VTF is not necessarily problematic as verbalising the experience allows others to become aware of the VTF. Self-reporting VTF is significant as this process allows risk to be estimated. There is a need to consider different explanations as to why people choose to self-disclose their VTF however, and furthermore identify the function that disclosing or sharing VTF may serve. As illustrated in the examples provided, a disclosure of VTF appears to function as a means of accessing support from clinical staff. However, patients also reported that they would do this to achieve other outcomes such as eliminating their own sense of guilt for when they did act violently. The functions of disclosure will be discussed in more detail in the subsequent discussion chapter.

There is evidence to suggest that some fantasies that are developed can be adapted, improved, or revised through the individual's interaction with their internal and external environment. Within a similar vein one might suggest that the fantasy could be updated or changed so that it continues to meet the evolving needs of the individual, e.g. as a source of sexual arousal or means of achieving a pseudo sense of power or control. It seems therefore that so long as the fantasy effectively serves the function that the offender needs, there may not be a need for it to be changed. That said, changing fantasy may indicate changing needs of the offender which may have implications for clinical practice and the way in which help and support can be identified and offered.

The 'out of my hands' sub-theme was the least frequently occurring theme in the analysis and was observed across just 6 transcripts. Despite this, it provides useful information relating to attribution biases for violent behaviour as driven by violent thoughts and fantasies. The decision to act on a violent thought or fantasy is a choice that the individual must make and as illustrated in the previous chapter these decisions are usually grounded in a complex belief system, integrating information from schemas, scripts as well as normative beliefs about the

appropriateness of violent behaviour. Minimising or de-personalising fantasy or offending i.e. *"getting rid of them sexual thoughts business"* [R09] may be the offender's way of diminishing the significance of their fantasies or wanting to distance themselves from the negative attributions that VTF have. Simultaneously, drawing distance between themselves and their violent actions may also be a way of externally attributing the blame for their behaviours onto someone or something else because they have difficulties accepting the affective consequences of their actions (Barringa & Gibbs, 1996; Gibbs, 1993). In addition, such attributions may also represent cognitive distortions in which violent behaviours are minimised or justified. Other similar strategies are described by Walters (2009) and include *mollification* (externalising blame for the negative consequences of a criminal act) and *cut-off* (rapid elimination of common deterrents to crime) which are observed here as possibly contributing to the way in which offenders make sense of the link between VTF and behaviour.

There is an issue of controllability as one considers the deliberate and intentional side of VTF related violence (strategy and planning) versus the seemingly non-controllable or non-intentional/deliberate side of VTF related violence. Here it may be timely to consider the role of impulsivity as a likely factor facilitating the progression from thought to action. This finding is not surprising given the nature of the sample, which includes personality disordered offenders, who are characterised by high levels of impulsivity (Howard, 2009; Miller, Flory, Lynam & Leukefeld, 2003). For some violent offenders it may be the case that violent behaviours were not planned, but that the scripts for violence were merely more accessible (Huesmann, 1998) and when activated resulted in violent action. This would provide an argument for an impulsive, yet unplanned violent attack that may provide support for the idea that the violent incident was out of their control and happened suddenly, without forward or active planning.

On the other hand it is worth considering that for some offenders planning a violent attack may be characteristic of psychopathy. As Vitale & Newman (2009) point out, psychopaths commit reactive crimes as well as those which are

instrumental and goal oriented, the latter involving a degree of strategy and planning. In addition, planning a violent attack may also be related to stimulating feelings of power and control and omnipotence, as described in chapter five (section 5.1).

This chapter has illustrated the progressive links between VTF and violent behaviour, which has crucial clinical implications in terms of assessing and managing the risk of violence that is often assumed to accompany VTF. The findings from this chapter highlight that these assumptions of a link between fantasy and offending may be true and thus highlight how VTF can be used to plan and guide offences. The way in which the individual interacts with their environment can provide material for the VTF and the processes by which these experiences are made sense of can contribute to the occurrence of violent behaviour. With respect to the final finding and third sub-theme of *thinking compared to doing* it is important to highlight the patient's ability to reflect on their experiences of VTF and violent behaviour in a pro-social way. Some patients spoke about feelings of remorse and regret yet also about moving forwards and coming to accept their past behaviours. This may be illustrative of development and change and has some links with the then and now theme described in chapter six (section 6.4), yet within the context of this theme it is also related to the maintenance of the violent thought or fantasy related behaviour cycle.

CHAPTER EIGHT

FUNCTIONAL ANALYSIS: METHODOLOGY AND ANALYSIS

INTRODUCTION

One of the aims of the current project was to explore the reasons why mentally disordered offenders experience violent thoughts and fantasies (VTF) and identify what function or purpose these experiences serve for the individual. Over the course of this research a number of functions of VTF have been identified. These include motivating offending behaviour (chapters two and seven) and regulating affect (chapter five), for example. However, as part of a desire to undertake a more comprehensive assessment of the various functions of violent thoughts and fantasies it was necessary to use a methodology that was more sensitive to the assessment of functions. Using a specified methodology such as Functional Analysis also helps to increase the transparency of the way in which functions were identified from the data.

A Functional Analysis, following methodology proposed by Daffern, Howells & Ogloff (2007a), was performed on the same set of interview data set that was collected as part of the main empirical study described in this thesis. As such, this chapter presents a re-analysis of the same data with a view to address a different objective. Here, the aim of the analysis is to elucidate the functions of violent thoughts and fantasies. Understanding why offenders experience VTF may highlight areas for clinical intervention but also help in the risk assessment and management of these experiences.

The objectives for this study were to:

1. Develop a checklist for the identification of functions of violent thoughts and fantasies within a mentally disordered offender group;

2. Apply the checklist to data to explore the prevalence of different functions within a sample of mentally disordered offenders;
3. Explore whether severity of personality disorder and psychiatric symptoms are related to functions of fantasy.

This chapter begins with a description of the Functional Analysis method and its applicability to the current study before moving to describe the development of a checklist for the functions of violent thoughts and fantasy. The checklist that was developed was applied to the interview data collected for this study and the outcomes of this are also presented and discussed.

8.1 FUNCTIONAL ANALYSIS

Functional Analysis is a technique used in clinical and research settings that offers a method of assessing behaviours. More specifically, functional analytic methods aim to assess the purpose or functions of certain behaviours; why certain behaviours might occur and/or how they may be maintained (Haynes & O'Brien, 1990; Holden, 2002). In clinical settings functional analysis methods largely take the form of an idiographic assessment approach in which a clinician can make an assessment of a behaviour of interest. For example, clinical case formulation processes often include an assessment of why patients present with certain behaviours; what might trigger these behaviours (precipitating factors) and what is maintaining their occurrence (perpetuating factors). Assessing the antecedents, consequences and of course the behaviour itself, can therefore help to generate hypotheses about what function the behaviour serves (Daffern, Howells & Ogloff, 2007a). The strengths of functional analysis lie in its flexible approach to behavioural analysis and complementary use alongside a thematic analysis, an approach which is sometimes used in clinical work (e.g. Jones, 2010). Identifying the functions of problematic behaviour i.e. offence-related behaviours can help to identify treatment targets and thus contribute to recommendations for therapeutic

interventions that may be necessary to help manage and/or treat the behaviour in question. This is considered a priority for forensic patients (e.g. Sturmey, 2010; Sturmey & McMurran, 2011).

Functional analysis methods are widely used in clinical forensic settings (e.g. Jones, 2010; Sturmey, 2010) however, functional analytic studies are not widely published due to the idiographic application of the method (Daffern, 2011), which can limit the available literature and evidence for this method of analysis. Daffern (2011) suggests that the paucity of evidence may also be due to a lack of reliable and valid ways of developing and testing a functional analysis and thus encourages the conduct of research which may overcome these challenges.

8.2 FUNCTIONAL ANALYSIS: THE DEVELOPMENT OF A FUNCTIONS CHECKLIST

8.2.1 Review of the Literature in the Search for Functions of Violent Thoughts and Fantasies

A useful starting point in the development of a functions checklist was to revisit the literature in the area. The systematic review yielded several functions relating to VTF and these functions were therefore identified deductively. Violent thoughts and fantasies were found to function as a coping strategy (Beauregard, Stone, Prolux & Michaud, 2008), substitute for action (Burgess, Hartman, Ressler, Douglas & McCormack, 1986; Prentky et al., 1989), increase feelings of power or control (Knoll, 2010; MacCulloch, Gray & Watt, 2000), provide sustenance and reassurance to self (Burgess et al., 1986; Knoll, 2010), provide emotional and/or sadistic gratification (Burgess et al., 1986; Hazelwood & Warren, 2000; Knoll, 2010; MacCulloch, Snowden, Wood & Mills, 1983; MacCulloch, et al., 2000; Prentky et al., 1989), function to guide behaviour (Burgess et al., 1986; Deu, 1998; Grisso, Davis, Vesselinov, Appelbaum, & Monahan 2000; Hazelwood & Warren, 2000; Knoll, 2010; MacCulloch et al., 1983; MacCulloch, et al., 2000; Prentky et al., 1989) and provide justification for offending (Burgess et al., 1986). A hand-search of additional

literature was also completed to ensure a thorough search. The process of hand-searching the literature lead to the inclusion of additional functions of violent thoughts and fantasies such as 'for excitement', 'to feel safe', 'to alleviate boredom', 'sensation seeking' and 'dealing with provocation' which were obtained from a conference paper delivered by Sheldon & Patel (2009). Finally, two additional functions observed within a comprehensive review by Maniglio (2010) on deviant sexual fantasy and sexual homicide included violent fantasy as a means of achieving dominance and control and providing an outlet for unexpressed emotional states.

Other functions were also inductively generated from the thematic analysis presented. These included affect regulation (chapter five), facilitating decision making and managing anxiety (chapter six) and providing an opportunity to plan and relive offences (chapter seven).

The search process yielded a number of different functions, some of which appeared to be thematically similar. The functions were reviewed and were broadly condensed into smaller categories, each intended to reflect a distinct functional category.

8.2.2 Reliability and Validity Checks

The face validity of the preliminary list of functions that were identified was assessed through consultation with clinicians within Rampton High Secure Hospital. Five clinicians (3 Consultant Psychiatrists, 2 Nurse Consultants and 1 Forensic Psychologist) and one academic member of staff who was independent to the research team, independently provided feedback on the face validity of the checklist. This was facilitated by a discussion of the different functions; which functions were recognised in clinical practice, how they were recognised (e.g. though patient disclosure) and what the implications of this were. Following consultation and further discussion a final set of functions of violent thoughts and fantasies was identified and these are presented in Table 8.1.

Table 8.1

Checklist of Functions of Violent Thoughts and Fantasies within Male, Mentally Disordered Offender Groups.

Function	Description and examples
Gain positive affect	VTF to increase positive feelings. Positive intrapersonal process e.g. wishful or grandiose cognitions; may function to increase feelings of powerfulness or control; may function to provide reassurance to self-esteem, enhance or sustain it.
Reduce negative affect	VTF used to self-soothe, includes using VTF to feel safe, escape or function as a coping strategy or outlet. Negative intrapersonal function to restore emotional equilibrium following a negative arousal state e.g. anger.
To deal with provocation	VTF may facilitate problem solving and decision making in a social situation. This might include thinking about a violent response but without acting violently; the thought or fantasy may substitute action in this case.
Sensation Seeking	Use of VTF for stimulation purposes. They may be actively selected for arousal; not necessarily sexual but may include sexual arousal and sadistic gratification e.g. observing victim's distress. May also be used to create or intensify an existing arousal state.
To guide violent behaviour	Use of VTF to plan or guide violent behaviour e.g. planning steps involved in a violent behaviour.

8.3 METHOD: APPLICATION OF THE CHECKLIST

The interview data that were available from the main study (described across chapters 3-7) were then subject to secondary data analysis for the purposes of conducting a functional analysis. The functions checklist (appendix 8-A) was applied to all 48 interview transcripts, coding for whether a function was identified as present or not present. The interview questions that concerned the functional analysis (i.e. asking about antecedents and consequences to VTF) were referred to

as part of the coding process, however it was necessary to review each transcript in full to ensure a comprehensive data collection process.

Each transcript was coded for whether the function was present or not present. A second rater independently rated 10 transcripts (20%) that were selected at random. The second rater was asked to familiarise themselves with the descriptions of functional categories provided in the table. They were then asked to read through each transcript in full and use the checklist to record whether any of the functions were present. To minimise bias, the second rater was blind to patient classifications (e.g. which service the patient was from) and groupings (whether they were a violent/sexually violent offender). Inter-rater reliability was calculated using the joint probability of agreement method. This was achieved by dividing the frequency of agreed codings (complete agreements for function present) by total codings (sum of codings for function present). This was calculated as percentage agreement and at 80% agreement this was suggestive of good levels of inter-rater reliability for the functions checklist.

8.3.1 The Functions of Violent Thoughts and Fantasies

The initial findings illustrate that the most commonly identified function of violent thoughts and fantasies within the whole sampled population (N=48) is *to deal with provocation* and use of violent thoughts and fantasies *to guide violent behaviours*. The least frequently observed functions were *sensation seeking and reducing negative affect*. The frequency of the functions identified within the sample as a whole are presented in Table 8.2.

Table 8.2
Prevalence of Functions of Violent Thoughts and Fantasies within a sample of Mentally Disordered Offenders (N=48).

Function	**Frequency of Function 'present'**
Gain positive affect	17
Reduce negative affect	16
To deal with provocation	25
Sensation Seeking	16
To guide behaviour	25

When applied to the data collected as part of this study, the checklist allowed for initial review of the different functions of violent thoughts and fantasies across the sample. Some functions were more prevalent than others. The low prevalence of using fantasy for sensation seeking was a surprising finding given that sensation seeking is one of the key characteristics of individuals with personality disorder, and approximately 2/3 of the sample included in the study were diagnosed with personality disorder, based simply on their placement in the hospital. In chapter 7 it was evident that a number of patients reported feelings of anxiety or distress when they experienced VTF. Therefore, there may only be a few patients for whom fantasising serves this function and thus there is generally a lower prevalence of this function within the sample.

Alternatively, it is also worth considering that sensation seeking behaviours that are commonly observed amongst people with personality disorder or psychopathy (Howard, 2009; Porter & Woodworth, 2006; Whiteside & Lynam, 2001) may not be the same as using fantasy as a sensation seeking activity. Moreover, the extent to which using fantasy as a sensation seeking process is synonymous with sensation seeking behaviours is somewhat unclear and would warrant further investigation.

Dealing with provocation was one of the most frequently occurring functions and this finding provides some support for the theme described in chapter seven that relates to having an awareness of risk relating to violent thoughts and fantasies, which drives a need to deal with these experiences effectively. If this function is effective one might expect a reduction in the number of aggressive/violent incidents that usually occur in a situation of provocation or interpersonal conflict. However, it was beyond the scope of the current study to explore this.

Using VTF to guide behaviour was another frequently occurring function of VTF. While this might have been illustrative of more patients identifying with this function, it is also important to consider the possibility that a higher frequency of this function might also be a consequence of the direct questions that were asked about violent fantasies in relation to offending, as part of the interview schedule. The relative bias towards questions that specifically asked about offending may have encouraged patients to discuss their experiences of this more than any other function where direct questions were not asked. This may have lead to increased dialogue from which functions relating to planning or guiding action may have been identified, resulting in increased frequency for this function.

8.3.2 Clinical Psychopathology and function of violent thoughts and fantasies

In line with the objectives of this exploratory study a series of between-group comparisons were made to assess whether there were clinical differences between individuals who identified with a particular function and those who did not. Between-group comparisons were performed using severity of personality disorder and severity of psychiatric symptoms as independent variables and function present or absent as the dependent variable. The severity of personality disorder was obtained from each patient's total score on the Personality Disorder Questionnaire (PDQ-4; Hyler, 1994) and the severity of psychiatric symptoms was obtained using the Global Severity Index (GSI standardised t-score) from the Brief Symptom Inventory (BSI; Derogatis, 1993). For each function, patients were divided

into two groups – those who had the function present and those who did not. The groups were then compared on personality disorder severity (using PDQ-4) and psychiatric symptoms (BSI GSI scale).

Histograms for PDQ-4 total scores and GSI scores were inspected individually. The data did not appear to be normally distributed. As the sample was relatively small non-paramertic tests were used to compare the groups.

The hypotheses and null hypotheses for this aspect of the study were:

H_i 1: There is a difference in PDQ-4 score between the two groups

Null $H_{i1:}$ There is no difference in PDQ-4 score between the two groups

H_i 2: There is a difference in GSI score between the two groups

Null $H_{i\,2:}$ There is no difference in GSI score between the two groups

The outcomes of the Mann Whitney test are presented in Table 8.2 below alongside the descriptive data for the independent variables.

Table 8.3

Differences in clinical psychopathology for function present versus not present

Function		**PDQ-4 Score**		**BSI GSI Score**	
		Present	**Not Present**	**Present**	**Not Present**
Gain positive affect (*n*=17 present)	Mdn	42	28*	56	49*
Reduce negative affect (*n*=16 present)	Mdn	32	32	52	48
To deal with provocation (*n*=25 present)	Mdn	32	32	50	51
Sensation Seeking (*n*=36 present)	Mdn	32	32	50	50
To guide behaviour (*n*=25 present)	Mdn	36	24*	52	47

*significant difference between group at $p<0.05$

For the functions *to reduce negative affect*, *to deal with provocation*, and *sensation seeking* there were no significant differences between participants scores on either the PDQ-4 or BSI GSI measures, and therefore the null hypothesis that personality severity and psychiatric symptom severity are not significantly different between individuals that identify with these functions and those that do not, is accepted.

However, three significant differences were observed. There was a greater severity of personality disorder amongst the group of patients who used violent thoughts or fantasies to gain positive affect (Mdn = 42) compared to those that did not use VTF in this way (Mdn = 28). This finding was significant and has a medium effect size (Rosenthal, 1991) $U=160$, $z=-2.23$, $p<0.5$, $r=-.03$.

Similarly, there was a greater severity of psychiatric symptoms for patients who used violent thoughts or fantasies to gain positive affect (Mdn = 56) compared to those that did not use this VTF in this way (Mdn = 49). This finding was significant and has a medium-large effect size (Rosenthal, 1991) U=133.5, z=-2.81, p<0.5, r=-.04. Finally, there was a greater severity of personality disorder amongst the group of patients who used violent thoughts or fantasies to guide behaviour (Mdn = 36) compared to those who did not use VTF in this way (Mdn = 24). This finding was significant and had a medium effect size (Rosenthal, 1991). U=186.5, z=-2.08, p<0.5, r=-.03. The group of patients for whom this function was identified have significantly higher levels of personality disorder than those who do not use this function. This finding may be considered alongside what is known about personality disordered individuals and violent offending (e.g. McMurran & Howard, 2009). In particular, if highly personality disordered offenders use this function in the commission of their offences then it may represent a treatment target alongside other risk management programmes for personality disordered offenders.

However, VTF serve dynamic processes and are therefore likely to change from situation to situation. Violent thoughts and fantasies may occur in the context of an interaction of different circumstances, individual characteristics and predispositions, which may even include some clinical psychopathology. As such, functions of VTF are likely to change from situation to situation and therefore perhaps resemble states as opposed to traits. The between-group analyses which were conducted therefore would have been reliant on data assessed within the context of the interview which means that the functions identified are solely based on those that were reported or identified at one time-point. This highlights several limitations; firstly that the data are based on self-report which is reliant on the individual's ability to articulate their experiences in a way in which facilitates assessment of function by the assessor. Secondly, the functions of VTF may be responsive to an individual's needs at any one time. As such, the data which have been collated may represent only a fraction of what is actually experienced.

This has important implications for future research on the functions of VTF. An assessment of the functions of VTF is important as this may highlight clinical issues that may be supported through intervention. The functions checklist that has been developed here may be a useful starting point for assessing such experiences. Future research could test the framework and expand it for use in other clinical settings.

8.4 THE UTILITY OF THE CHECKLIST

This chapter reports on the development of a checklist designed to recognise the various functions of violent thoughts and fantasies. The checklist may have some use in clinical settings and may facilitate an assessment of the functions of violent thoughts and fantasies for a mentally disordered offender group. While existing dimensional assessments of fantasy exist, having a more comprehensive understanding of *why* offenders use violent thoughts and fantasies may help to inform suitable interventions so that these experiences can be managed appropriately. For example, Grisso Davis, Vesselinov, Appelbaum, & Monahan (2000) report on the development of a screening tool to assess violent thoughts and fantasies amongst a clinical sample. While the Schedule of Imagined Violence (SIV) tool aims to assess a breadth of characteristics for VTF it is arguably limited in the quality of information that it generates. For example, the tool attempts to gauge the frequency, recency and chronicity of the experience in a structured way using a fixed, multiple-choice response format. While this information may be useful to an assessor in terms of gaining a broad understanding of the individual's experience, it is not sensitive to what these experiences represent for the individual. Instead, it is proposed that an assessment of function may be used alongside a measure such as the SIV to gain a more comprehensive assessment of VTF.

8.4.1 Limitations

As the checklist was developed on a set of data derived from interviews with mentally disordered offenders, the range of functions identified may not be applicable to another clinical group and further research may be necessary to improve the checklist's use across different settings. In the first instance, it may be useful for future research to apply the checklist to similar clinical forensic populations and this might serve to improve the reliability and validity of the checklist. In addition, the option for 'other function not otherwise specified' was not available on the current checklist, which might have resulted in some functions being forced into another category or missed altogether. As such, future research that uses the checklist may wish to consider including an 'other' category.

Secondly, it should be noted that functions are dynamic processes and may vary from situation to situation. The functions identified as part of the interview are therefore limited by the context in which the data were collected; as functions were assessed during one interview it is unlikely that the whole range of functions that VTF serve for any one person would all have been captured. However, in practice this may be overcome by frequently assessing functions of VTF at regular time points; being responsive to the VTF as and when they occur may facilitate an understanding of antecedents and consequences, and ultimately the function of the VTF as part of the assessment process. However, this may be reliant on staff availability to perform assessments at required time-points. To lessen the burden on staff, an alternative approach might be for patients to keep diaries in which they self-monitor and record their experiences. Routine assessment might lead to the development of a set of functions which routinely occur for a particular individual and these may then form the basis of a care or management plan in which the patient can receive the help or support that is needed. Continuous monitoring might also be used to develop (existing) clinical case formulations and thus may also contribute to an overall understanding of the patient's clinical and risk presentation. As such the functions checklist developed herein may provide a useful

starting point for the assessment of VTF amongst mentally disordered offenders, but further work may be necessary to increase its applicability in other settings.

8.4.2 Practical considerations

A number of observations were made about the way in which patients responded to questions about the functions of violent thoughts and fantasies. For example, in trying to ascertain functions of VTF, questions were asked as to the proximal antecedents and consequences of the VTF. Specifically, this involved questioning the patient about how they were feeling before, during and after the experience. Many patients found it difficult to articulate how they were feeling, for example reporting that they felt *"nothing" [R22]* or "*felt like I didn't have anywhere else to go" [R25]* or *"felt like I needed time away from the table, because I had a fork in my hand" [R01]*. Some patients may have found it difficult to recognise and/or articulate their emotions, which is characteristic of a condition known as alexithymia that is common in personality disordered individuals (McMurran & Jinks, 2012; Nicolo et al., 2011) and may offer an explanation for this. This may have implications for future assessment of functions of VTF, especially if functional analyses are reliant on patients' abilities to articulate their experiences.

Secondly, it was noted that many patients reported that they felt 'better' after the experience of VTF had passed or gone away. This provides support for the *aware of the need to be careful* theme described in chapter 6, in terms of patients disliking the experience of VTF and therefore reporting that they felt *'relieved' [R32]* or *'a bit better' [R22] because* it had gone away. This might suggest that the VTF experience was distressing or upsetting in some way and that some patients reported affect regulation after the experience had ended. However, on these occasions it was sometimes difficult to establish the type of experience the patient was describing e.g. violent fantasy, intrusive thought or rumination. For example, some patients made reference to the experience of VTF as scary and that furthermore, the uncontrollable nature of VTF is what made them scary. Based on

these descriptions, there is some suggestion here that these experiences of VTF may have resembled intrusive thoughts.

By their very nature, intrusive thoughts are involuntary experiences and occur spontaneously in consciousness (Berntsen, 2009; Mace, 2007). Intrusive thoughts are often observed within the context of post-traumatic stress disorder (PTSD) or depression, yet there is increasing evidence to suggest that some violent offenders may develop PTSD (Kruppa, Hickey & Hubbard, 1995; Spitzer et al., 2001) and thus may experience similar symptoms (Evans, Ehlers, Mezey & Clark, 2007). Gray et al., (2003) even found evidence to suggest that committing violent crimes may even contribute to some mentally disordered offenders developing PTSD. Within the sample studied, which comprised serious violent and/or sexually violent offenders, it is fair to assume that intrusive thoughts and memories (including those of perpetrated crimes) may have been observed amongst this research into violent thoughts and fantasies. This further highlights the need for clinicians to be able to distinguish between related cognitive constructs as they may require different management/treatment approaches. Furthermore, it is important to recognise that mentally disordered offenders are a heterogeneous sample and individualised assessment should therefore always be at the forefront of practice, hence why a single case or idiographic approach may be advantageous to this area.

Finally, it was noted in more direct discussions regarding the purpose of VTF that patients felt they experienced VTF for reasons concerning self-image or protection e.g. *"If somebody didn't pay a drugs debt or something like that I used to think oh well I've got to do this to them so that people don't try and take advantage of your kind nature" [R24].* This is not identified as a function of VTF but instead is illustrative of the potential function of a *disclosure* of VTF e.g. threatening or voicing intention to harm someone, or a function of the violent behaviour itself. With regards to the latter this may highlight a role for VTF in the occurrence of violent behaviour, as previously discussed in chapter 7. Clinicians may therefore need to be sensitive to the function of the disclosure i.e. the context within which the patient is disclosing their experiences and what their motivation may be for sharing.

CHAPTER NINE

DISCUSSION OF THE OVERALL FINDINGS

INTRODUCTION

This research project was designed as an exploratory study into the violent thoughts and fantasies (VTF) of a mentally disordered offender population. The research comprises a systematic review of the literature on violent (including sexually-violent) cognitions and their relationship with offending, a thematic analysis to explore the nature and experience of VTF and a functional analysis to identify the functions that these experiences might serve. This chapter attempts to integrate the findings from the project as a whole and synthesise key conclusions that may inform future clinical and research practice.

9.1 THOUGHTS, FANTASIES AND OTHER RELATED PHENOMENA

Chapter one provided a description of several key terms that were used in the literature to reflect different cognitions related to offending. Such cognitions included fantasies, criminal attitudes, cognitive distortions, scripts and schemas. It was evident that a number of different terms operated under the umbrella term of *cognition* and so some attempt was made to clearly delineate what some of these were, with particular emphasis on thoughts and fantasies as per the cognitions selected for exploration as part of the research.

The outcomes of the systematic review highlighted that the term *fantasy* was used most often, with only two papers making reference to *scripts*. Beauregard, Stone, Prolux, & Michaud (2008) suggested that early experiences of trauma and abuse may have contributed to the development of *scripts* related to sexual violence but they also reported that sexually-violent *fantasies* were related

to offending. While Beauregard et al., did not offer any additional supporting argument to distinguish between the two products it was assumed that perhaps there may be differences between the two. From what could be gathered from the literature review, fantasies were described in the context of providing something to the offender e.g. affect regulation. Scripts on the other hand were used more directly to reflect the process of learned behaviours (e.g. Beauregard, Stone, Prolux, & Michaud, 2008) or in relation to cognitive rehearsal (Grisso, Davis, Vesselinov, Appelbaum, & Monahan 2000; Huesmann, 1988; 1998). However, it seems that both fantasy and script may overlap. In particular, the procedural nodes of a script may also be associated with fantasies, where fantasies detail how one might behave. If procedural nodes interact with the fantasy this might explain the thinking to doing patterns that were described in chapter 8. In addition, Ward & Hudson (2000) suggest that repeated use of fantasy may lead to the creation of a behavioural blue-print, which might also be recognised as a behavioral script. Therefore it seems sensible to conclude that fantasies and scripts are separate but related constructs. The research did not attempt to explore this relationship further and so this assumption is proposed tentatively. Nevertheless, it may be useful to use this assumption as a starting point for future studies that explore cognitions that may be related.

The terms thoughts and fantasies were used throughout the thematic analysis section. As part of the interview process participants were invited to describe thought and fantasy and how they are both construed, before talking about their experience of either one or both of these phenomena. Some of these data are reflected on in chapter six where fantasies were commonly reported to be associated with power and control and were often described as generally being longer and more detailed than thoughts, for example. Therefore, while there was some exploration of how thoughts and fantasies differ, the methodology and procedure of analysis did not afford an opportunity to collate these data for direct comparison. Whilst some broad distinctions could be observed within the thematic analysis, the evidence for this would not be sufficient to provide a robust argument

for distinction. It therefore seems sensible to accept the assumptions that were made in chapter one, in that in that thoughts and fantasies are two separate phenomena with the latter recognised as more complex.

Other phenomena that were identified throughout the course of the interview included intrusive thoughts, as identified by patients' descriptions of these experiences as somewhat disturbing, unwanted and unpleasant experiences that motivated some form of distraction or suppression. Although, it is unclear whether some of these experiences were actual intrusive thoughts i.e. those that are often experienced as part of Post Traumatic Stress Disorder (PTSD) (e.g. Evans, Ehlers, Mezey & Clark, 2007; Kruppa, Hickey & Hubbard, 1995; Spitzer et al., 2001) or indeed whether they were examples of rumination given the similarities between these constructs. In any case, the presence of intrusive thoughts is not surprising given that these are sometimes found amongst individuals with mental illness and/or those who are violent offenders (e.g. Evans et al., 2007). Moreover, Evans, Ehlers, Mezey & Clark (2007) identified a higher prevalence of intrusive memories amongst those participants who had a history of psychiatric disorders and violent offences and that furthermore, 46% of their sample of violent offenders reported intrusive memories of the crime they committed. Intrusive thoughts are phenomena that are symptomatic of PTSD. The prevalence of PTSD within the sample was not recorded, however given the severity of abuse, trauma and victimization that patients often described (chapter four) it might be sensible to speculate that some patients may have been experiencing intrusive thoughts that were related to PTSD, although this cannot be known. Some patients also described flashbacks, which are also significant within PTSD.

While the study process has not yielded any substantial data to suggest revisions to any of the descriptions of violent cognitions discussed in chapter one it has demonstrated, in some detail, the nature of violent thoughts and fantasies for a group of mentally disordered offenders.

A summary of the key cognitions are presented below in Table 9.1.

Table 9.1

Descriptions and definitions of key cognitions; content, structures and processes

Cognitions	Description or Definition
Schemas	Overarching knowledge structures stored in memory within which cognitive content is stored and connected with other content. Schemas represent substantial knowledge about any given concept, its attributes and relationship to other concepts (Huesmann, 1988).
Scripts	Scripts contain both procedural and declarative information about any given event or situation, that facilitate a prediction about the behavioural sequence and likely outcomes, including how one might respond (Huesmann, 1988).
Normative Beliefs	Structures that cluster beliefs about the typicality and appropriateness of aggressive behaviour.
Thoughts	Cognition that may reflect an attitude, belief or appraisal.
Fantasies	Elaborated thought for example, "an elaborate set or sequence of cognitions (such as thoughts, images, feelings and internal dialogue)" (Maniglio, 2010 p.295). Fantasies are argued to be deliberate and controlled (Bartels, 2014) that also involve some active creativity (e.g. Crepault & Couture, 1980) and appear to be more complex phenomena than thought, which may mean that these are longer lasting experiences.
Rumination	A passive process that involves repetitively thinking about causes, consequences and symptoms of one's negative affect (Nolen-Hoeksema, 1991). Rumination appears to be involuntary (Wells, 1997) and uncontrollable (Smith & Alloy, 2009) and often co-occurs with negative mood.

Social Cognition	Series of related cognitions that collectively inform how people perceive themselves and how they perceive their relationship with other people; how they interpret social behaviours and choose appropriate behavioural responses (Gannon, 2009; Gannon, Ward, Beech & Fisher, 2007). Social cognition integrates different aspects of cognition and as Huesmann (1998) suggests, social cognition could be characterised as a *mediating* process which integrates cognitive products, schema and scripts in the processing of social information.
Intrusive thoughts	Intrusive images are involuntary and occur spontaneously in consciousness (Berntsen, 2009; Mace, 2007). These phenomena appear to be repetitive, uncontrollable and distressing (Brewin, Gregory, Lipton & Burgess, 2010).
Cognitive Distortion	A thought or belief through which offending is rationalised, minimised or justified.

9.2 VIOLENT THOUGHTS, FANTASIES AND BEHAVIOUR

The findings from the study appear to be consistent with a Social - Cognitive – Information Processing Model (SCIPM; Crick & Dodge, 1994; Dodge, 1980) with regards to explaining the role of violent thoughts and fantasies in offending behaviour. The SCIPM (Crick & Dodge, 1994; Dodge, 1980) recognises the individual as an active construer of information; making sense of events within their environment and using these perceptions and interpretations to inform how they might subsequently behave. The SCIPM (Crick & Dodge, 1994; Dodge, 1980) has 6 stages: encoding, interpretation, goal formation, response selection, evaluation of scripts and enactment and the findings from the systematic review and thematic

analysis may be applied to various stages of this model in helping to understanding the cognitive processes that underlie violent behaviour.

Information from the social environment is initially attended to and encoded. There may be biases in this process as people with delusions or mental illness may be selective in their attention to different stimuli (e.g. Garety and Freeman, 1999; Garety, Hemsley & Wessely, 1991; Garety, Kuipers and Fowler, 2001; Kinderman & Bentall, 1997). While this was not recognised within one of the *themes* for the research, delusions and processing biases were recognised as part of the research process in the context of some interviews with patients.

The second stage of the model is interpretation. From the data that has been reviewed as part of the systematic review and thematic analysis it seems that early childhood experiences contribute to the development of scripts or normative beliefs about violence. Moreover, it is precisely these structures that help to govern interpretations. Within chapter four, some patients described violent thoughts as normal and as pertinent to their identity as an offender. It seems therefore that such interpretations may normalise the experience of violent thoughts. Moreover, Hughes & Hasbrouck (1996) suggest that individuals who grow up in a violent environment may be more likely to perceive hostility within social situations, which is in line with the views of the world that they have developed. Yoon, Hughes, Cavell & Thompson (2000) also point out that more aggressive individuals selectively attend to aggressive cues in their environment, following which there is a tendency to make more hostile or aggressive attributions about the trigger or stressor in that environment. As such, this process can be cyclical and enduring.

Goal formation is the third stage in the model and it is here where individuals go through a process of reviewing their goals for a potential solution, which might then inform the selection of a behavioural response that is in line with this goal. Following this is the evaluation of potential scripts for selection. These processes may be observed within the themes described in chapter six which reviewed the theme of *aware of the need to be careful*. This theme was the largest theme identified in the analysis with 56 observations of this theme (including sub-

themes) occurring across 48 transcripts. The theme not only illustrates how social information can be encoded and interpreted (e.g. as part of the *apprehensive anxiety* sub-theme) but also provides an example of how this can facilitate a process of decision making about violent behaviour (e.g. as part of the *decision making balance* sub-theme). For example, this might include an assessment of the individual's perceived self-efficacy to carry out the violence as imagined. Here, patients describe problem-solving processes in which they weigh up the likely success of a potential violent response. As such, there are elements of this theme which may also be applicable to the 5th stage of the SCIPM model which is evaluation of scripts. Finally, the theme presented in chapter seven which reflects the cyclical process between violent thoughts and fantasies and violent behaviour appears to relate to stage 6 of the model which is about behavioural enactment.

Therefore, this model may be relevant to consult when considering an assessment of violent thoughts and fantasies and their relationship with possible offending behaviour. However, Sestir & Bartholow (2007) suggest that deficits in information processing at any one of these stages may increase the likelihood of violent action. From the findings it seems more likely that biases, as opposed to deficits, would present an increased risk. For example, patients were generally able to demonstrate a process of decision making with regards to behaving in a violent way. This demonstrates some ability to problem-solve social situations and consider behavioural options. As such, treatment recommendations may be geared towards encouraging offenders to increase their repertoire of skills in this domain.

Another aim of this research was to explore the functions of violent thoughts and fantasies. The functional analysis that was conducted enabled a review of the types of functions that violent thoughts and fantasies serve for the mentally disordered offender. Some of these functions appeared to be directly unrelated to offending, yet they were still recognised as phenomena that were potentially relevant to risk for a number of reasons. For example, some patients described sustaining functions of violent thoughts and fantasies (e.g. sustaining self-esteem or sexual arousal) which may be associated with a higher risk of action (as

discussed in chapter two). This leads on to discuss the final research question; whether there is a role for VTF in the occurrence of violent behaviour. The findings from the systematic review (chapter two) have highlighted that there is a role for violent thoughts and fantasies in violent offending and that moreover, violent cognitions span the pre- during- and post- offence stages. Finally, the outcomes of the thematic analysis (in particular, chapter seven) and functional analysis (in particular, the function to guide behaviour) more clearly highlights the role of violent cognitions in offending. Violent thoughts and fantasies should therefore be considered as risk factors for violent offending and are therefore identified as treatment priorities. However, it should be noted that other factors may contribute to increasing risk, such as rehearsal of a violent thought or script or frequent engagement with a fantasy, which might also function to strengthen its association with behavioural nodes, thereby increasing the potential for violent action. Further discussion of this is provided in the concluding section which details the main clinical implications arising from this study.

9.5 LIMITATIONS

One of the limitations of this research was the reliance on self-report. While this was necessary as part of the qualitative design, the research may have benefitted from the inclusion of additional measures relating to violent cognition. Such assessments may have provided some method of triangulation by which the reliability of the qualitative data might have been increased.

Another limitation of this study is that the sample of patients who took part may not be representative of the mentally disordered population within the hospital. The data reflect contributions from just 20% of the targeted population who volunteered to be interviewed about their violent thoughts and fantasies and so the results may not be generalised to the remaining 80% of patients within the three targeted services who did not participate in the study.

Firstly, there were some patients who self-reported that they experienced violent thoughts and fantasies but were unwilling to discuss them within the context of the research. It was noted that 3 patients used the non-consent form to record this as their reason for not participating in the current study, while a further 11 used the non-consent form to indicate that they didn't want to take part 'for any other reason'. While these reasons for non-participation remain unknown it could be assumed that some patients may have believed that sharing their violent thoughts and fantasies would result in adverse outcomes, hence their decision to avoid participating in the current study. Such outcomes might relate to increased restrictions being placed on these patients by staff in order to minimise risk of future incident, given the association between violent thinking and violent behaviour in this context.

Secondly, some patients may have been excluded from participation by their Responsible Clinician early in the screening stage. Specifically, some patients had care plans that stipulated that they were not to openly share their violent thoughts and fantasies and staff had advised that this was to reduce risk, as some patients became very aroused when they discussed these experiences. The unfortunate exclusion of this sub-sample of patients however has several implications as the study is deficient of data from patients known to experience violent thoughts and fantasies, but most importantly patients for whom VTF are known to be particularly problematic, given the associated risk. It is unfortunate that these individuals could not be included in the study and it is the very association that VTF has with risk that epitomises this research. The findings that have been derived from the data gathered as part of this study should therefore be interpreted in context in that the findings are derived from a sample of patients who are perhaps less strongly aroused by their violent thoughts and fantasies, or indeed, those who are able to manage the expression of their VTF in a more inhibited or controlled way.

It is consequently worth pausing to briefly reflect on those participants that did volunteer to be interviewed. Given the stigma that may surround discussion of such sensitive topics it is important to think about each participant's motivations

for taking part; what function the interview might have served for the participant (e.g. if they had anything to gain from talking about their VTF) and whether this had any influence over the data (e.g. specific content) that they shared. Following on from this are issues of socially desirable responding. A measure of social desirability was not included in this study, but might have been useful to control for positive self-portrayal.

9.6 CONCLUSIONS AND IMPLICATIONS

In spite of the limitations outlined, this study has offered a unique insight into the violent thoughts and fantasies of a mentally disordered offender group. Qualitative methodology has contributed to the generation of a breadth of data which has not only advanced the current understanding of these experiences for this group, but has also provided a foundation for further research in this area.

Taken together, the outcomes of the systematic review (chapter two) and the *part of who I am* theme (described in chapter four) indicate that some individuals will be predisposed to developing cognitions related to violence. Early experiences appear to contribute to a schematic framework in which beliefs, attitudes and thoughts about violent behaviours are organised.

Violent fantasies were recognised to serve a number of functions such as emotional regulation and there was some evidence to suggest that fantasies may have also been used in the lead-up to offending, which might indicate some premeditation or planning. However, it was also recognised that violent thoughts and fantasies served a number of other functions for violent offenders including regulating affect and providing stimulation through sensation seeking. The functions collectively seemed to share one common characteristic that appeared to be related to sustaining the self in some way; through self-soothing (down-regulating affect) or creation of grandiose views of the self (gaining positive affect), for example. However, such sustaining functions may lead to continued use of the fantasy and dependence on it. If fantasies are to be associated with scripts (as

argued in chapter one) then it might be sensible to suggest that rehearsal of fantasy (through repeated activation), might also contribute to a stronger relationship with the script that the fantasy is associated with. In the case of violent or aggressive fantasies therefore, repeated use of the fantasy might simultaneously increase risk of behavioural script activation, in line with Huesmann's script rehearsal theory (Huesmann, 1988; 1998). As such, clinical recommendations are directed towards the management of these experiences.

9.6.1 Clinical and Research Recommendations

Violent thoughts and fantasies were often described as distressing and problematic. Furthermore, patients described attempts at managing these experiences using suppression and distraction methods, which appear to have inconsistent, unpredictable and potentially risk-related outcomes. Consequently, it seems appropriate to suggest that some support should be made available to support offenders in the management of their VTF. This might initially be guided by an assessment of an individual's VTF, to gain a better understanding of how these are experienced and this might also include an assessment of the functions of VTF to better understand antecedents to these experiences. The assessment needs to be thorough and may include a range of different measures that assess different types of violent cognition. For example, the use of a dimensional assessment such as the Schedule of Imagined Violence (SIV; Grisso et al., 2000) alongside other measures such as the EXPAGG-M (Archer & Haigh, 1997a) could facilitate a more comprehensive assessment of violent cognition.

A functional analysis of VTF may also help clinicians to get a better understanding of these experiences to identify an appropriate method of support. In addition to standardised and self-report measures, other methods of assessment and monitoring might include the use of the use of diary cards for patients to record their experiences of VTF. Diary cards might also provide an opportunity for multiple and repeated assessment of VTF which might help to identify functions of VTF at different time points. Assessment of VTF should crucially be used to help

determine when VTF are related to violent behaviours and the conditions under which this may occur so that risk-preventative measures can be put in place.

Following a comprehensive assessment, clinicians should be encouraged to formulate a client's VTF to inform subsequent treatment and management plans. Clinicians should be encouraged to work with patients to increase their repertoire of skills for managing known antecedents (e.g. provocation from others or anger), or strengthening the use of existing strategies that are productive. Such skills might include improving emotional awareness and ways of self-regulating, or developing skills relating to social problem solving in relation to considering alternatives to acting on VTF, for example.

Interventions should be geared towards helping the individual to achieve a similar affective outcome without the use of a VTF as the findings from this thesis highlight recognised associations between VTF and violence, which include violence originating from both impulsive and long-standing VTF. Consequently, it is important to maximise alternative strategies that avoid violent thoughts or fantasies, in order to minimise risk. Such strategies and management plans might be discussed and developed in collaboration with patients as part of an individualised care plan (Collie, Vess & Murdoch, 2007). This might involve a discussion about what support the patient would find helpful i.e. distraction activities that are helpful.

From a clinical standpoint it may be worth evaluating some of the clinical recommendations identified here. This may involve evaluating the effectiveness of the functions checklist developed in this study (chapter nine), and/or assessing the utility of functional analysis methods which are aided by diary-cards and self-monitoring methods in the assessment and management of VTF. This may be piloted within an institutional setting to assess whether any of the recommendations have been clinically beneficial. The checklist of functions developed as part of this project may provide an aid to the assessment of function, yet future research may be guided to extend this for use with other samples and to perform more assessments of its validity and application. Future research on VTF

should aim to use a series of assessments that measure different aspects of violent offenders' cognition; multiple methods of measurement will facilitate a more comprehensive and multi-dimensional assessment of VTF. This may also go some way towards improving awareness of the cognitions that are related to offending and the processes by which these cognitions operate in relation to offending. Given the relative paucity of research on non-sexual violent cognitions and offending, future research may also be guided in this direction. This should include the study of mental health samples, both offending and non-offending, to increase understanding of violent cognitions as related to dimensions of mental health.

CHAPTER TEN

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CHAPTER ELEVEN

APPENDICES

1-A List of disseminated works: conference presentations and peer reviewed publications

Conference Presentations

Patel, G. (2011, June). Violent thoughts and fantasies in violent offender groups. Poster session presented at the Annual Conference of the Division of Forensic Psychology, Portsmouth, UK.

Patel, G. (2012, June). Violent thoughts and fantasies in a mentally disordered offender group: A thematic analysis. Paper session presented at the Annual Conference of the Division of Forensic Psychology, Cardiff, UK.

The findings of the studies presented within this thesis were also presented to staff at Rampton Hospital in January 2014. All patients who took part in the research will also be provided with an informative leaflet highlighting the key findings from the research.

2-A Systematic Review: Example Search Strategy

Example search strategy. Executed in PsycInfo via Ovid SP on 11th August 2014.

1. violen*.ab,ti.
2. aggress*.ab,ti.
3. sadis*.ab,ti.
4. "sexual* violen*".ab,ti.
5. murder*.ab,ti.
6. homicid*.ab,ti.
7. kill*.ab,ti.
8. Violence/
9. 1 or 2 or 3 or 4 or 5 or 6 or 7 or 8
10. cogniti*.ab,ti.
11. thought*.ab,ti.
12. fantas*.ab,ti.
13. imag*.ab,ti.
14. script*.ab,ti.
15. daydream*.ab,ti.
16. 10 or 11 or 12 or 13 or 14 or 15
17. 9 and 16
18. offend*.ab,ti.
19. assault*.ab,ti.
20. offen#e.ab,ti.
21. crime*.ab,ti.
22. behavio#r*.ab,ti.
23. “mentally ill”
24. Psychiatric
25. Hospital*
26. Prisoner
27. ((violen* or aggress* or sadis* or "sexual* violen*" or murder* or homicid* or kill*).ab,ti. or Violence/) adj2 behavio#r*.ab,ti.
28. 18 or 19 or 20 or 21 or 23 or 24 or 25 or 26
29. 9 and 16 and 28
30. 30
31. limit 30 to (full text and english language and yr="1950 - 2014")

2-B Summary of Selected Studies

Summary of Included Papers

Papers identified from electronic searches that appeared to be relevant (N=28)

1. Adachi, P. J. C., & Willoughby, T. (2011). The effect of violent video games on aggression: Is it more than just the violence? *Aggression and Violent Behavior*, *16*(1), 55–62.
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Thirty-six papers screened by two independent reviewers resulting in the inclusion of 13 papers (denoted by *) and exclusion of 23 papers that did not meet the inclusion criteria.

3-A Institute of Work, Health & Organisations Ethical Approval Letter (for main study)

Institute of Work, Health & Organisations
http://www.nottingham.ac.uk/iwho

The University of Nottingham
UNITED KINGDOM · CHINA · MALAYSIA

Gita Patel

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13/05/2011

Dear Gita

I-WHO Ethics Committee Review

Thank you for submitting your proposal on "Triggers of Violence: An exploration into violent thoughts and their relationship to behaviour". This proposal has now been reviewed by I-WHO's Ethics Committee to the extent that it is described in your submission.

I am happy to tell you that the Committee has found no problems with your proposal. If there are any significant changes or developments in the methods, treatment of data or debriefing of participants, then you are obliged to seek further ethical approval for these changes.

We would remind all researchers of their ethical responsibilities to research participants. The Codes of Practice setting out these responsibilities have been published by the British Psychological Society. If you have any concerns whatsoever during the conduct of your research then you should consult those Codes of Practice and contact the Ethics Committee.

You should also take note of issues relating to safety. Some information can be found in the Safety Office pages of the University web site. Particularly relevant may be:

The *Safety Handbook*, which deal with working away from the University.
http://www.nottingham.ac.uk/safety/
Safety circulars: Fieldwork P5/99A on
http://www.nottingham.ac.uk/safety/publications/circulars/fieldwk.html
Overseas travel/work P4/97A on http://www.nottingham.ac.uk/safety/publications/circulars/overseas.html
Risk assessment on http://www.nottingham.ac.uk/safety/publications/circulars/risk-assessment.html

Responsibility for compliance with the University Data Protection Policy and Guidance lies with all researchers.

Ethics Committee approval does not alter, replace or remove those responsibilities, nor does it certify that they have been met.

We would remind all researchers of their responsibilities:

- to provide feedback to participants and participant organisations whenever appropriate, and
- to publish research for which ethical approval is given in appropriate academic and professional journals.

Yours sincerely

Professor Nadina Lincoln
Chair IWHO Ethics Committee

3-B NHS Ethical Approval Letter

positive

Nottinghamshire Healthcare NHS
NHS Trust
Positive about mental health and learning disability

Research Management and Governance
Institute of Mental Health
2nd Floor, Duncan MacMillan House
Porchester Road
Nottingham

E-mail: emma.pearson@nottshc.nhs.uk
Direct Line: ext 10661 / 10663

Tel: 0115 969 1300

Local Ref: FOR/13/06/11

Date: 13th June 2011

Miss Gita Patel
PGR: Institute of Work, Health and Organisation
International House, Jubilee Campus
University of Nottingham
Nottingham
NG8 1BB

Dear Miss Patel

I am writing to confirm that NHS permission for research has been granted for the following study.

Title: An exploration of violent thoughts and fantasies in high risk violent and sexual offender groups
Rec ID: 11/NE/0110

Sites that have been given NHS permission: Rampton Hospital

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

Document	Version
IRAS	3.1
Protocol	1.0 05/04/11
Participant Information Sheet	1.0 05/04/11
Consent Form	2.0 02/06/11
Reply Slip	2.0 02/06/11
Peer Review	04/03/11
1.0 05/04/11	
CV's	Sheldon, Patel, Browne

Start Date: 13th June 2011 **End Date:** 30th Sept 2011

Outline:
The aim of the study is to explore violent fantasies in offender groups, paying particular attention to the functions of these fantasies and when violent fantasy might be a risk factor for future violent behaviour to test the common assumption that violent thoughts are in some way predictive of violent behaviour and that this is exaggerated in offender or mentally disordered groups.

Participants with the DSPD, PD and mental health services will be invited to complete a number of questionnaires and undertake an interview, it is expected that this will last 2 hours.

3-B NHS Ethical Approval Letter

Honorary contracts/letters of access have been requested from the Trust HR department for the following members of your research team:

Name	Expiry Date
Gita Patel	7th October 2011

Approval is dependent on a number of conditions, which are listed at the end of this letter.

Please note that Nottingham Healthcare NHS Trust is required to monitor research to ensure compliance with the Research Governance Framework and other legal and regulatory requirements. This is achieved by random audit of research and requesting the completion of a brief progress report every 6 months.

You can now proceed with your study in accordance with the agreed protocol. Please keep this letter with you during the course of your research to confirm that you have Directorate and RMG Department approval, to gain access to the areas where your research is taking place.

If you or others have concerns please contact the RMG department on 0115 9691300 ext 10661 or by email to emma.pearson@nottshc.nhs.uk

We wish you well with your work.

Yours sincerely

Dr Peter Miller
Medical Director
Nottinghamshire Healthcare NHS Trust

Cc:
Chief Investigator and Academic Supervisor: Professor Kevin Browne
Academic Supervisor: Professor Kevin Howells
Local Collaborator: Dr Kerry Sheldon
Sponsor: Paul Cartledge

Conditions of Trust approval are as follows.

1. All members of the research team should familiarise themselves with all relevant policies and procedures, including the Trust policy GG/CG/04 – staff conducting, hosting or collaborating in research (note, currently being revised).

2. The Chief Investigator, and all other members of the research team, should comply with any regulations applicable to the study, including, but not limited to: The NHS Research Governance Framework for Health and Social Care (2005), The Declaration of Helsinki (2000), The UK Medicines for Human Use (Clinical Trials) Regulations (2004), ICH Good Clinical Practice guidelines (1997), The Human Tissue Act (2004), The Data Protection Act (1998), The Mental Capacity Act (2005).

3. The Chief Investigator should ensure that all members of the research team are suitably qualified and experienced, and adequately supervised. This should include training in informed consent procedures and GCP, where necessary.

Dear Dr ……..

Re: Research Project: Violent thoughts in Violent Offender Groups

I am seeking your permission to approach some of your patients with a view to their participating in a research project which is being conducted as a collaborative effort between the Peaks Academic and Research Unit (PARU) and The University of Nottingham. The study has been reviewed by the Northern & Yorkshire Research Ethics Committee and the NHCT Research Management and Governance Department. The project is being completed as part of a PhD that I am undertaking at the University.

The project aims to investigate violent thoughts and fantasies and their relationship to behaviour in a sample of offenders. Additionally, I wish to investigate whether the link between violent thoughts and behaviour is mediated by anger. I have enclosed a copy of the information sheet that I will be distributing to patients, for your information. Participants will be asked to spend up to 2 separate 1 hour sessions with the Researcher to complete a few questionnaires and an interview. Shorter research sessions will be facilitated for patients who will struggle with concentration.

Due to the nature of some of the questions asked at interview e.g. “do you ever think about past violent offences” and “how do your violent thoughts make you feel”, we are requesting that all participants nominate a member of nursing staff whom they can speak to for support.

Interviews with patients will be tape recorded for transcription purposes. Consent for this will be taken from the patient as they consent to participate in the study. If you have any objections to audio recording of interviews then please let me know.

After each data collection session the Researcher will provide a verbal handover to the Nurse in Charge of the ward, describing the patient’s presentation and co-operation

throughout the session. An additional note will be entered into RIO and an SIR completed should a confidential disclosure be made.

All patients with violent/sexually/non-violent/non-sexual offences are eligible to participate in this study. In addition, the inclusion and exclusion criteria are listed below. I would very much appreciate it if you would provide me with a list of patients under your care that I might approach to participate in this project.

I would also like to ask that you let any patient that you identify for the study, know that a Researcher will be coming to see them in the near future about taking part in a research project.

Inclusion / Exclusion Criteria

Inclusion Criteria

- Violent offender with no history of sexual offences **or** is a non-violent, non-sexual offender (will form groups A and B respectively for Study 1).
- **OR** the Participant is a violent and sexual offender (has convictions for both in offending history) **or** is a non-violent sex offender (will form groups C and D respectively for Study 2).
- Is inpatient at Rampton Hospital
- Has been resident within the Institution for at least 7 days
- For Rampton patients only, patients have to have been identified by their RC.
- Participants have to provide Researcher with informed consent to

Exclusion Criteria

- Patient has a learning disability
- Participant is female.
- Participant is aged under 18 years.
- Patients who have care plans which stipulate that they are not allowed to talk about their violent thoughts/fantasies
- Patients who are identified as posing imminent danger to themselves or others.

If you have any further questions about this project please do not hesitate to get in touch with either myself or one of my supervisors.

Many thanks in anticipation,

Miss Gita Patel

PhD Student, I-WHO, University of Nottingham.

Contact: lwxgp@nottingham.ac.uk / gita.patel@nottshc.nhs.uk / Tel: 01777 880121)

PhD Supervisors:

Professor Kevin Browne

First Supervisor, I-WHO, University of Nottingham

Contact: Kevin.browne@nottingham.ac.uk / Tel: 0115 832 2210

Professor Kevin Howells

Second Supervisor, IMH, University of Nottingham

Contact: Kevie.howells@gmail.com

Nottinghamshire Healthcare NHS
NHS Trust

The University of Nottingham

Positive about mental health and learning disability

Patient Information Sheet:

Draft Version 1, Final Version 1.0, 5th April 2011

Rampton Hospital Sample

Title of Study: **An exploration of violent thoughts and fantasies in high risk violent and sexual offender groups.**

Name of Researcher: Miss Gita Patel

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. One of our team will go through the information sheet with you and answer any questions you have. Talk to others about the study if you wish. Ask us if there is anything that is not clear.

What is the purpose of this study?

This project is taking place because at the moment very little is known about violent fantasies and what, if any, impact they have on violent behaviour. It is hoped that your participation in this project will help us to learn more about what role these factors play in triggering violent behaviour.

Why have I been invited?

We are looking to include patients from within Rampton Hospital who have offended either violently or sexually in the past.
You have been identified by your Responsible Clinician as someone who might be suitable to take part. They have given me permission to approach you so that I can tell you more about the study and see if you would like to be involved in it.

Do I have to take part?

It is up to you to decide whether or not to take part. This project is being carried out for research purposes and will not influence the care that you receive. 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 to take part you are still free to withdraw at any time and without giving a reason. This would not affect your legal rights.

What will happen to me if I decide to take part?

Consent

First of all, you will need to fill out the reply slip attached to the end of this information sheet. Completing this does not mean that you have to take part. Your participation is completely voluntary and you can change your mind about participating at any time, without giving reason.
Once you have agreed to be contacted to arrange a suitable time and date for the researcher to meet with you, you will be asked to sign a consent form prior to the research commencing.

Questionnaires & Interview

If you were to take part in this project we would require only 2 hours of your time. For most people taking part the tasks can usually be done over 2 sessions (each 1 hour long), but if you prefer they could be done over 3-4 shorter sessions.
During the sessions you will be asked to complete some questionnaires and answer some questions for example "do you ever think about being violent?"

To make sure I capture all the information you tell me during the interview, I would like to tape record the interview session. The recording will be written up (transcribed) by the researcher doing the interview – Gita Patel - to maintain your privacy and confidentiality. Once the information from the tape has been fully typed up, the audio recording will stored securely and will be anonymised. Your name will not appear on the typed-up interview (transcript) so that no body will know what you have said except the person interviewing you. If something you say particularly interests me I may want to include exactly what you say (direct quote) in my thesis or in any articles that come out from this work. Where this happens I will never make any reference to you so no-body will know that the quote had come from you.

File Information

We also require information from your psychology files. For example, demographic information which includes things like how old you are, where you came to Rampton from, and what your section and diagnoses are. I would also like to collect some information about any previous offences you might have, for

example, how many violent offences you have. This information will usually be looked at by Gita Patel, (the same person who you will see for Interview) and will be kept securely with other data that you share with us.

What are the possible disadvantages and risks of taking part?

Answering questions about your thoughts and emotions before any violent offending that may have occurred in the past, may bring back some unpleasant memories. You do not have to answer every question.

What are the benefits of taking part?

We cannot promise the study will help you but the information we get from this study will be useful to professionals by allowing them to be more aware of what violent fantasies are and how they may or may not be related to behaviour.

Taking part in the study may also give you some insights into the ways you typically think, feel and act.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. If Gita is unable to help you, her University Supervisor Professor Kevin Browne who is overseeing the study can also be contacted using the details provided at the end of this sheet. Alternatively you can always speak to your Responsible Clinician should you not want or be able to contact Gita Patel or Kevin

Browne. If you remain unhappy and wish to complain formally, you can do this by contacting NHS Complaints. Details can be obtained from your hospital.

Will my taking part in the study be kept confidential?

Confidentiality is very important for this project. What you say in the interview will not be discussed with anybody else unless you disclose information that you intend to, or know of others who intend to:

- harm yourself or others
- commit a crime or report a previously undisclosed crime
- harm a child
- put the security of the hospital at risk.

This is in line with Trust policy.

The information you provide will be input into a secure computer database protected by a password, which only the research team will have access to. Your name will not appear on this database or on any documents that you have completed (e.g. questionnaires) to maximise anonymity. All paper data like questionnaires and the typed up interview will be stored securely in a lockable cabinet within Rampton Hospital.

In line with regulations from the University of Nottingham, all study data will be transferred to the University for archiving for a period of up to 7 years. A copy of these data will also be stored within the Nottinghamshire Health Trust Archives. Your name will not appear on any of these data. Any data taken out of the hospital will not

have your name or personally identifiable information on it and will be anonymised so that your identity is protected.

What will happen if I don't want to carry on with the study?

Your participation is voluntary and you are free to withdraw at any time, without giving any reason, and without your legal rights being affected. If you withdraw then the information collected so far cannot be erased and that this information may still be used in the project analysis.

What will happen to the results of the research study?

A summary of the results of the project will be available once the study is over. Gita Patel will send a simple summary of overall results from the project to everybody who has taken part in it.

Who is organising the research?

The project is jointly organised by the University of Nottingham and Rampton Hospital. The project is being conducted by Gita Patel, a Research Psychologist.

Who has reviewed the study?

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. The study has also been reviewed by the NHCT Research Management and Governance Department and has been reviewed and given favourable opinion by the Northern and Yorkshire Research Ethics Committee.

Further information and contact details:

Gita Patel
Peaks Academic & Research Unit (PARU)
Clair Chilvers Centre
Rampton Hospital
Retford
DN22 0JR
Tel: 01777 880121/ Internal Ext: 6121

Professor Kevin Browne
Institute of Work, Health & Organisations
Jubilee Campus
University of Nottingham
Nottingham
NG8 1BB
Tel: 0115 823 2210

Thank you for taking the time to read this information.

Nottinghamshire Healthcare NHS
NHS Trust
Positive about integrated healthcare

CONSENT FORM
Final version 2.0: 2nd June 2011

Title of Study: Violent thoughts and fantasies

REC ref:

Name of Researcher: Gita Patel

Name of Participant:

Please initial box

1. I confirm that I have read and understand the information sheet version number 1 dated 28th April 2011 for the above study and have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without my medical care or legal rights being affected. I understand that should I withdraw then the information collected so far cannot be erased and that this information may still be used in the project analysis. ☐

3. I understand that relevant sections of my medical notes and data collected in the study may be looked at by authorised individuals from the University of Nottingham, the research group and regulatory authorities where it is relevant to my taking part in this study. I give permission for these individuals to have access to these records and to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential. ☐

4. I understand that the interview will be recorded and that anonymous direct quotes from the interview may be used in the study reports. ☐

5. I understand that should I state that I intend to harm myself, harm others, report a previously undisclosed or future crime, or inform the Researcher about harm to a child or anything that may put the security of the hospital at risk, then this information will be handed over to the Nurse in Charge of the ward on the day the breach is made. I understand that a confidential note will also be entered into my clinical notes and an incident form may be completed. ☐

6. I agree to take part in the above study. ☐

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____

The University of Nottingham

Nottinghamshire Healthcare NHS Trust

Positive about mental health and learning disability

Reply Slip B

Giving an answer to this next question is purely optional.

Would you be able to provide a reason for not taking part in this study?

(Please tick one of the boxes below).

Is it because…….

- I do not have violent fantasies ☐
- I might have violent fantasies but do not wish to talk about them ☐
- Other reason (you do not have to state what this is) ☐

Many thanks for taking the time to complete this. Please return your form to Gita Patel.

The University of Nottingham

Semi-Structured Interview Schedule

Have you ever imagined physically harming another person?

Is this a violent thought or a violent fantasy?

Could you tell me how you think violent thoughts are different to violent fantasies?
[clarify distinction]
Do you have [opposite]? *If no, then we talk about X, if yes, talk about one first then I will ask some questions about the other if that's OK.*

OK, using your most recent violent fantasy could you describe in as much detail as you can, what happens in it.

a) Is [the action] something that you have experienced personally?
b) Why do you think you imagined [the action] over other violent acts?

Are your thoughts/fantasies controllable or uncontrollable or both? Please describe.

What do you think triggered your most recent violent thought/fantasy?
Probe for what was going on in the environment that may have triggered the fantasy or how they were feeling.
How did you feel when as you were imagining it?
What about when the fantasy had ended?

Do your fantasies stay the same or do they change? *E.g. people in them, content, severity of harm etc..*

3-G Interview Schedule (for main study)

Have you ever imagined someone else harming another person? Could you describe what happened there? What was happening right before you had this thought *(probe for environment stimuli)*. How did you feel as you were imagining [what was happening] and how did you feel when the fantasy had ended?

Is the content positive / negative / both? In what way? *Content negative, affect positive etc? Make feel good? Disturbing/upsetting? Make you feel guilty?*

Could you describe the overall experience of a violent fantasy – intensity, emotions, physiological arousal?

Under what circumstances do you experience these fantasies? *List.*

How important is it to you that you have these violent thoughts/fantasies?

Could you rate this on a scale where 10 is extremely important and 1 is not important at all.

- Please explain why you have selected this number?

Can you remember your earliest violent fantasy and how old you might have been when you had it?

- early childhood 0-6 years
- schoolchild 7-11 years
- adolescent teenager 12-17 years
- young adult 18-22 years/ adult 23+ years.

Think about the last time you were angry.

First of all, how did you know you were angry?

3-G Interview Schedule (for main study)

How do you tend to react when angry?

Did you have any violent fantasies?

Are your fantasies different in any way when you're angry compared to when you're not angry? How?

How long after the event that made you angry will you continue to think about it?

Could you describe the content of your thoughts at this time? *E.g. Is it replaying what happened? What you would do differently?*

Do you control this length of time that you spend time [ruminating]?

Is it helpful to think this way?

Thank you and any questions for me?

Nottinghamshire Healthcare NHS
NHS Trust

Positive about mental health and learning disability

Case Report Form:

File Data Collection Proforma

Participant ID_____

Prisoner or Patient *(circle as appropriate)*

DOB_____

Start date of current incarceration_____

Nationality _____

Ethnicity _____

Sentence length_____

Life Sentence? Y / N *(circle as appropriate)*

Life tariff (if appropriate) _____

Admit Source *(tick one that applies)*

- ☐ Prison
- ☐ Medium Secure Unit
- ☐ Other high secure hospital
- ☐ YOI

☐ Court

☐ Other DSPD service*

If applicable to DSPD patients

☐ Other (please state)_____

MHA Section *(tick one that applies)*

☐ 47/49 Home office Transfer

☐ 47 Home office Transfer

☐ 37/41 Hospital Order with Restrictions

☐ 41(5)

☐ No MHA section

☐ Data unavailable/unknown

Psychiatric contacts prior to incarceration? Y / N *(circle appropriate)*

Details_____

_____

Substance Misuse History? Y / N *(circle appropriate)*

Index Offence (state)_____

Category (tick 1 that applies)

☐ Violent offender (violent only offence)

☐ Non-violent offender (non-violent, non-sexual offence)

☐ Violent sexual offender (violent and sexual offence)

☐ Non-violent sexual offender (sexual offence only)

Details (e.g. victim known/unknown/evidence of planning/)

_____

_____

_____

_____

Offence History

Category (tick all that apply)

☐ Violent offender (violent only offences)

☐ Non-violent offender (non-violent, non-sexual offences)

☐ Violent sexual offender (violent and sexual offences)

☐ Non-violent sexual offender (sexual offences only)

Details (e.g. victim known/unknown/evidence of planning/)

_____

_____

_____

_____

Paper-Trail for Thematic Analysis

Copies of memos, physical mind-maps and NVivo Theme ‘Trees’

Table illustrating patient contributions during interview, as evidenced by transcript word counts.

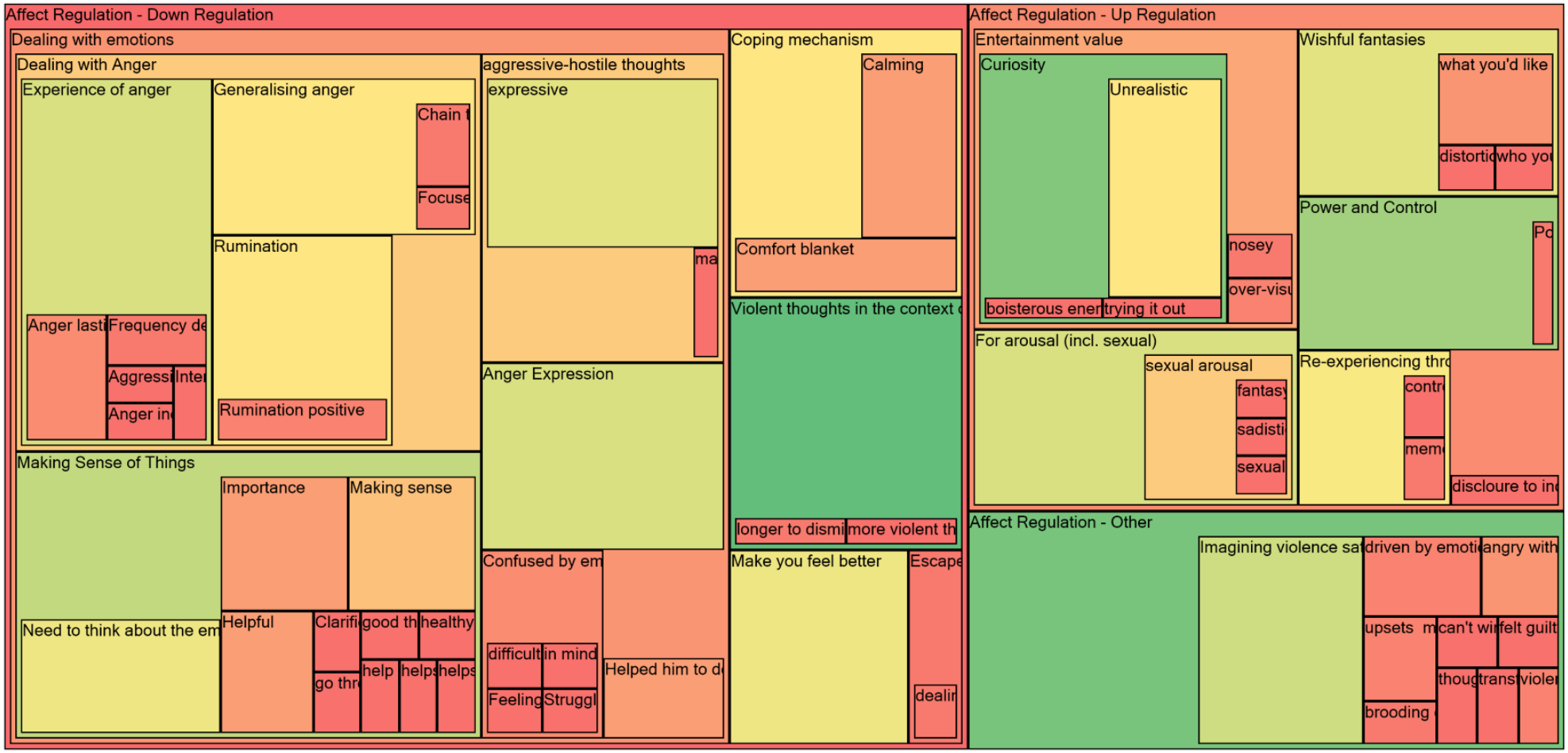
Participant number	Word count	Participant number	Word count
R01	7494	R25	5836
R02	6604	R26	2102
R03	3574	R27	13,026
R04	4156	R30	5828
R05	3544	R31	8166
R06	8399	R32	3720
R07	6660	R33	5108
R08	1082	R34	902
R09	7257	R35	3441
R10	2775	R36	1675
R11	2834	R37	3891
R12	1997	R38	6989
R13	917	R39	7435
R14	6240	R40	2681
R15	1937	R41	4760
R16	3223	R42	4367
R17	4215	R43	3076
R18	5159	R44	836
R19	848	R45	2599
R20	5451	R46	2005
R21	2378	R48	3782
R22	2394	R49	2336
R23	5871	R50	4078
R24	4857	R51	2412

Table illustrating theme frequency across the sample

3-I

Theme	Frequency (present within transcript)
Early Experiences	15
Normal versus Abnormal	10
Power and Control	9
Coping Mechanism	11
Apprehensive Anxiety	11
Managing Violent Thoughts and Fantasies	15
Then and Now	12
Decision Making Balance	18
Strategy and Planning	22
Out of my Hands	6
Thinking compared to Doing	19

Nodes compared by number of items coded



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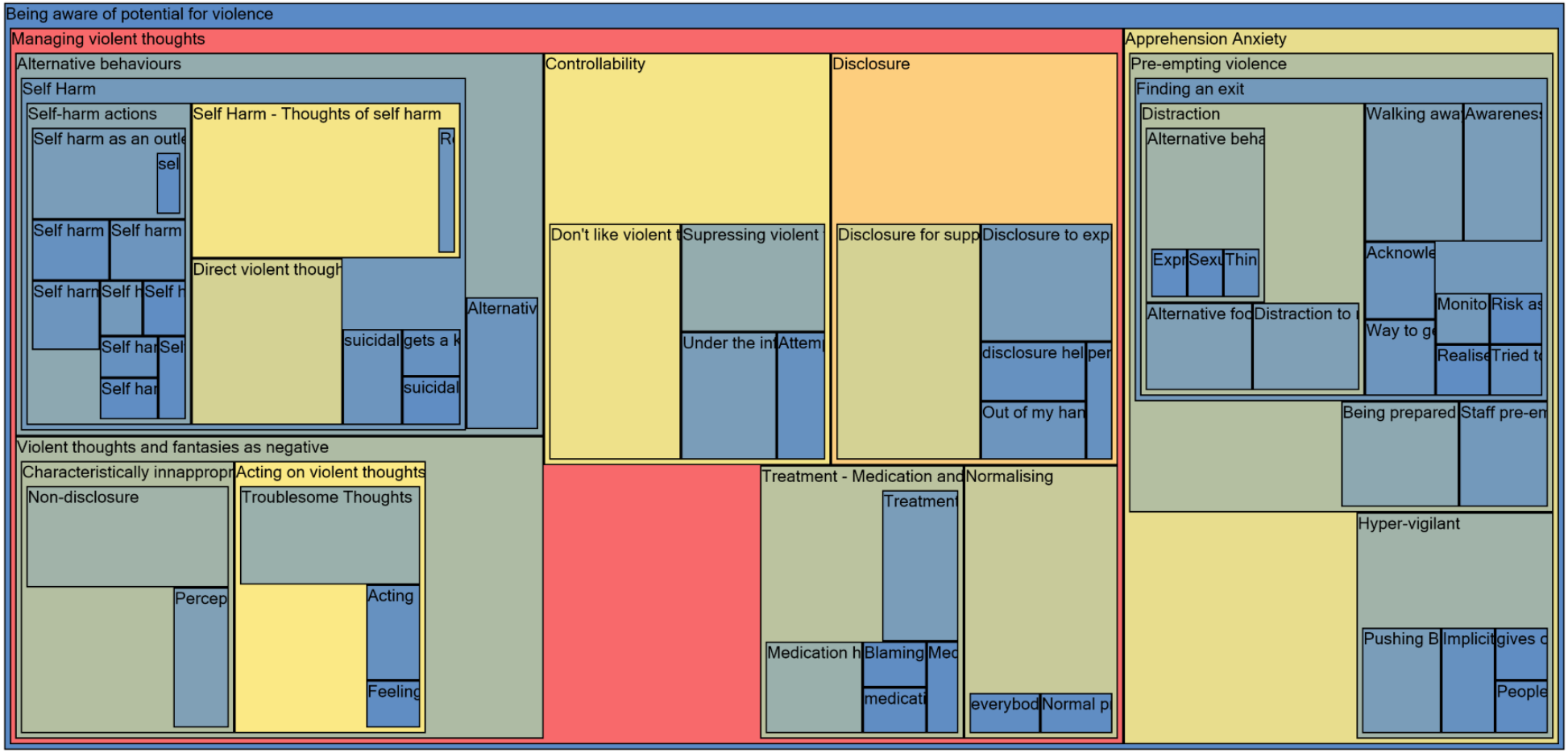
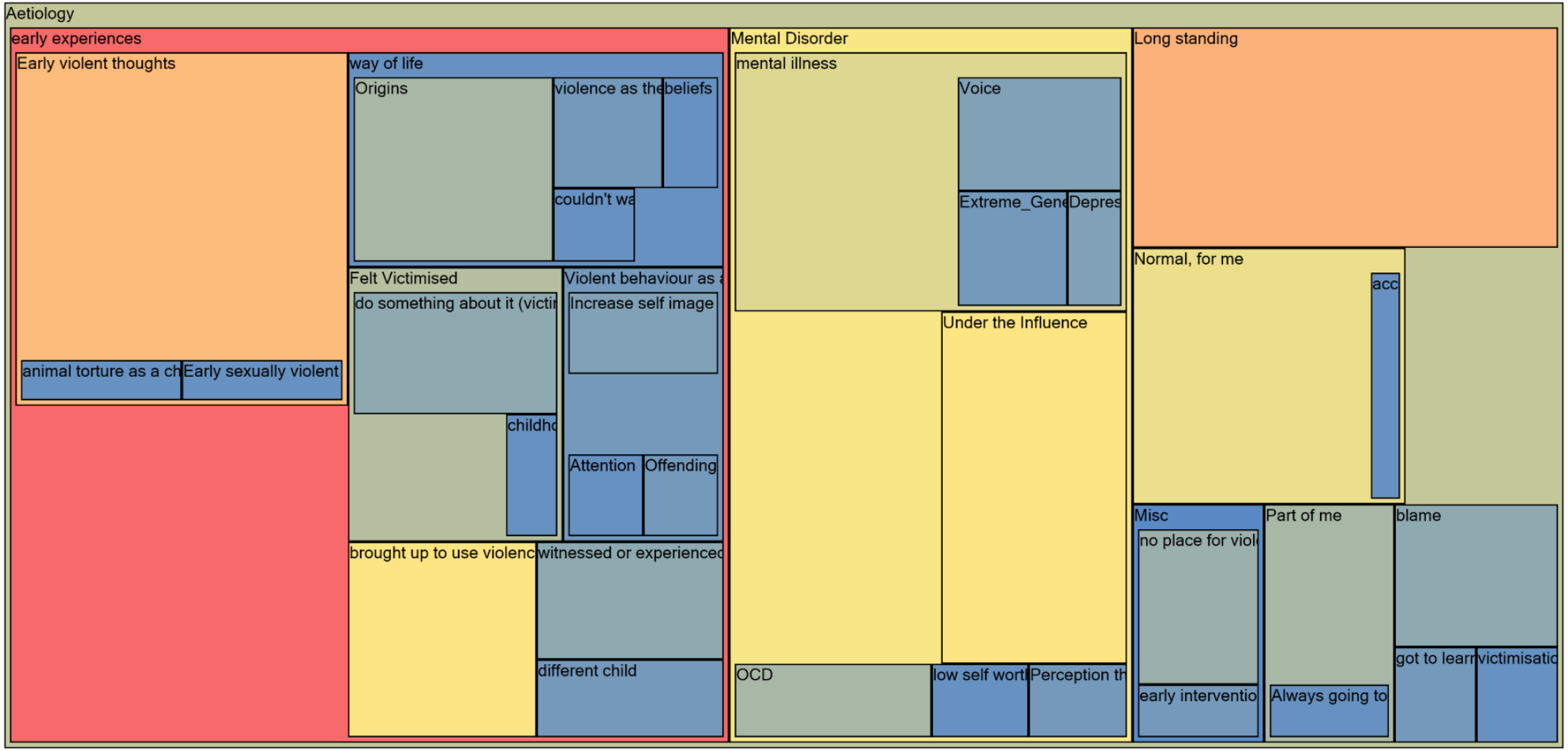


Nodes compared by number of items coded



3-I

Emerging Themes

- Takes them back to childhood memories of being abused. Target in fantasy is the abuser.

Brought up around violence - causes them to have violent thoughts now.

- Distraction

Letting it get that far. Progression / Escalation. Becomes too big → urge? - point of no return.

- Choice - allow it to over take you = violent act

- Fantasy differs from flashbacks but flashbacks inform fantasies

- Threats - real. Jeopardising progress.

The criminal code - you don't do that to one another (mutual respect).

- Choice in the carrying out - Awareness.

They're in control of action?

- Coping mechanism.

- Then + Now

Protective / Reactive - Get the first punch in.

- Anticipation of threat / violence and the need to defend + protect oneself.

Planning - realistic - trial planning - "is it going to work?".

- Self harm

- Normalising / Human being / Justification.

- Positive / Negative → morals → feeling bad / guilty / wrong.

Bitter Sweet

Violent with / without imagery

Premeditated crimes

3-I

Personal thoughts.

- They're all model patients. Describe then + now and how they would have dealt with things but now they don't act violently. Describe 'now' behaviour as model patients. i.e. don't rise to it, just walk away + tell staff.

- It sometimes feels like they're talking to me as if it their interview does go back to the team. Follows on from model patient stuff its like they say things which aren't really related to the study but they want to tell me how well they're doing, moving on soon etc. Like I am in charge of their release - assessing suitability for release almost. Don't say anything that might get them into trouble.

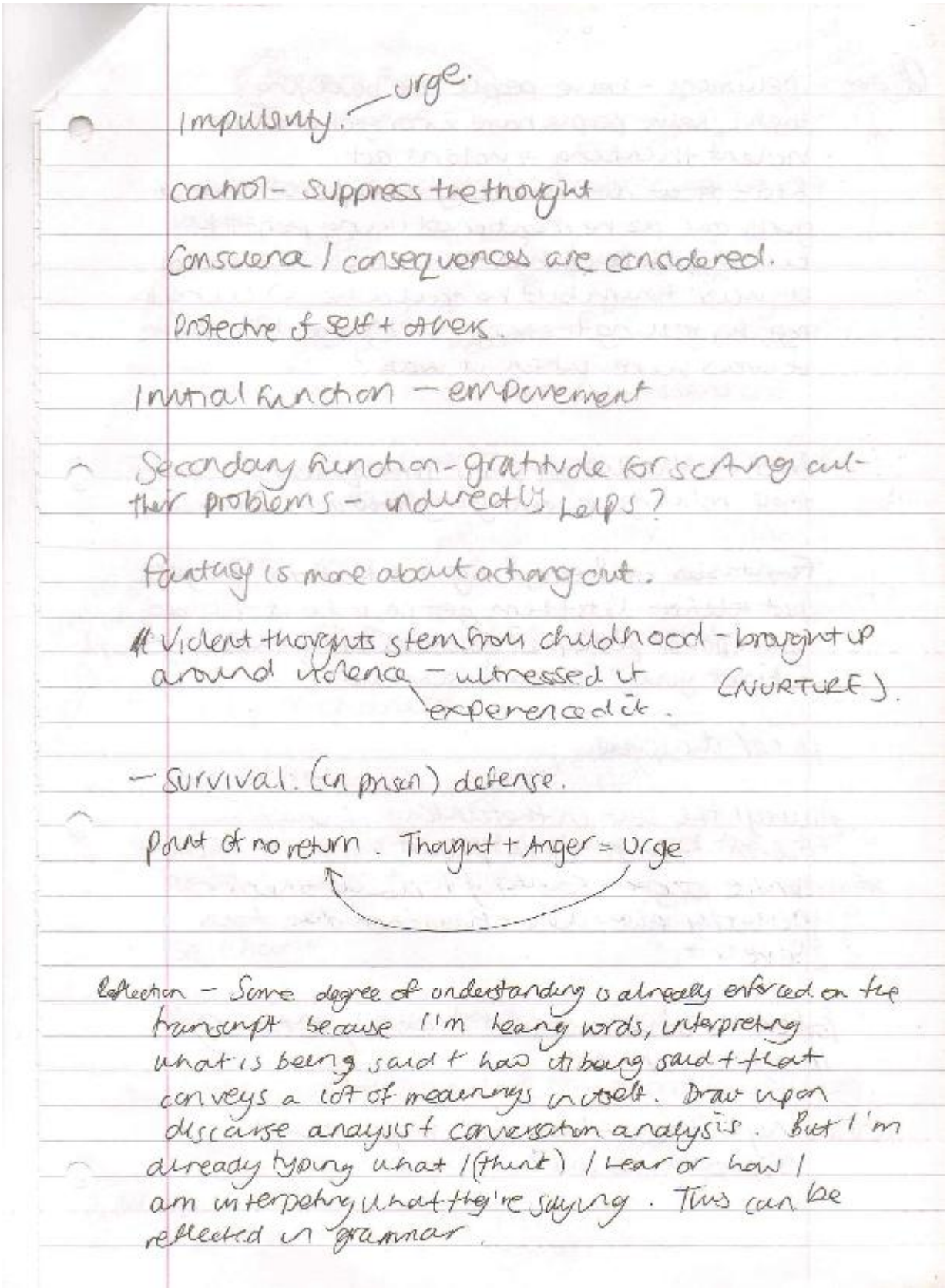
/ Or. They could be honest. Takes a lot to take part in a sensitive research study. Maybe these 'changed' patients really don't have anything to hide. ?

Discussion notes - some ppl might not have them - might be useful to use measure of impulsivity next time to see if just acting' on impulse is related to absence of fantasy

level of education of participant. whether they can convey what they want to using language abilities. - own insight

/

Alexythymia - ppl having difficulty identifying emotions like when I ask, how did it make you feel?



impulsivity. — urge.

control - suppress the thought

Conscious / consequences are considered.

Protective of self + others.

Initial function — empowerment

Secondary function - gratitude for scaring out their problems - indirectly helps?

fantasy is more about acting out.

Violent thoughts stem from childhood - brought up around violence — witnessed it / experienced it. (NURTURE).

— survival. (in prison) defense.

Point of no return. Thought + Anger = Urge

Reflection - Some degree of understanding is already enforced on the transcript because I'm hearing words, interpreting what is being said + how it being said + that conveys a lot of meanings in itself. Draw upon discourse analysis + conversation analysis. But I'm already typing what I (think) I hear or how I am interpreting what they're saying. This can be reflected in grammar.

Kellehan - Delusions - belive people are bullying them. Belive people have wronged them → violent thinking → violent act.
R46 - did he really steal petrol out of guns car as he mentioned using petrol to kill the bloke in his fantasies. He said it wasn't him but he could be a) lying to me, b) telling the truth or c) doesn't belive it was him when it was?

" Pats found it difficult to ans. some questions - namely those relating to identifying their own emotions.

Fantasies of "easy" fight situations. Target just ~~relents~~ lets them get on with it → to do with power perhaps? + control? Fantasising about your 'ideal' situation?

Inner dialogue.

Always the self in the fantasy during the harm - to do with power, control. Taking centre stage - fantasy is about them + nobody else. What function does this serve?

Often it's own insight + ability to convey thoughts → to me.

Nothing to loose - last bit of pleasure "might as well"?

Remembering being a victim of violence – doesn't go under 'guides violent behaviour'. Open it up + move things around.

The person whose fantasy is, is always the perp. – Is this to do with control / power?

urge is the thought.
impulsive is the act without thinking.
Trigger for mental illness – believing something in relation to delusional beliefs about others – then they become the target.

Anger ⇒ violent actions.

Driven by it – attribution / externalising blame.

managing violent thoughts.

fantasy ⇒ unrealistic
↙ acting (guns / SAS).
↓ playful / imagina[illegible].

~~[illegible]~~ – Making sense of things // Making sense / any mistakes?

Driven by revenge / emotion?

– Reflecting on what has happened.

angry with self – reflecting on what has happened? What I should have done.

wishful fantasies related to perception of self-worth?

Bitter-sweet (moral acceptability?)?

Try it out ... (acting out) acting.

managing violent thoughts
major, not minor theme.

gender?

bugged me, bugged me & bugged to the point where I just gave into it .... Could individual differences eg. personality traits be imp. here?

getting a kick out of sth - up reg power & control as he has the choice to do it.

Something to do with identity - not wanting people to know it was you. // "they'd know it was me

Bitter-sweet - like cognitive dissonance.

Fantasy in reality // reality in fantasy.

uncontrollability makes it scary.

continuation - changing fantasy (using reality) to make it more enjoyable.

? Trigger - split this category up. → perceived; ↓ trigger thoughts

External sources trigger?

Distraction,

Managing violent thoughts – not part of 'being aware of potential for violence'

Separate them. Disclose. acting out to get rid of violent thoughts.

violent thought occurs as an urge / impulsive thought or of action?.

Fantasy compared to what happened in reality } sex-from guides behaviour.

alternative outcomes// could have acted differently

R 30 + R31 – kid stuff – no help. Just acted on it in an attempt to get rid of the thoughts.

Wishful – things that aren't real, but that you would like to be.

he's the good guy.

Strategy → continuation.

real life – what worked/didn't work in fantasy.

media / external as triggers?
or
Triggers in reality.

Managing violent thoughts as separate to re-emphasising violence?

targets & responding to environment.

revenge to restore balance / emotional harmony.

media triggers [something]

progression to intention.

~~can't control~~
frightened / of things you can't control eg. others misfortunes.

Need to think about anger as separate to managing violent thoughts.

responding to environment (deep & necessary violence stress... vulnerability?

controllability + attribution

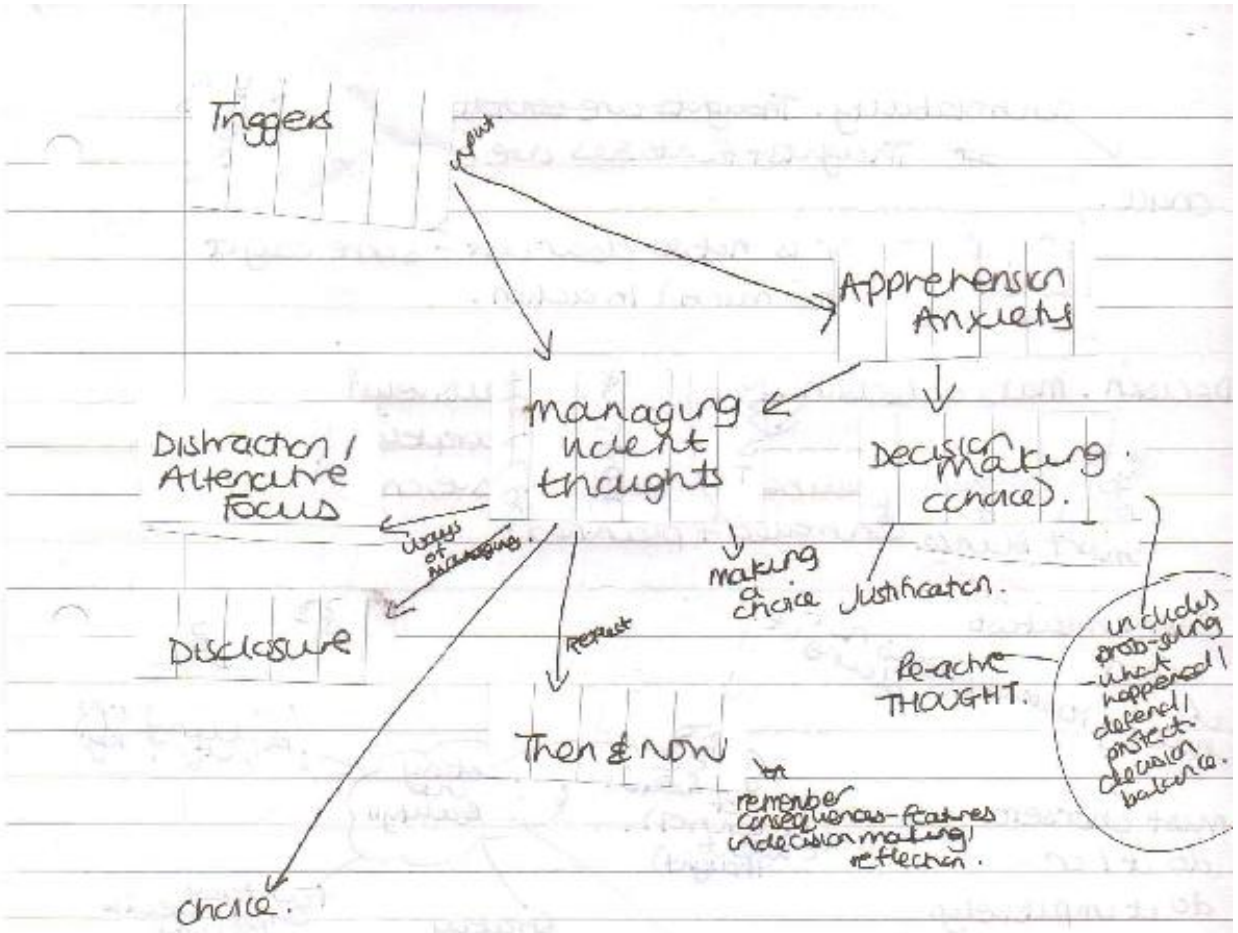
thinking not doing + up-regulation?

bias? — externalise blame.

expressive + why?

cognitive distortions.

redressment / wish I didn't have to do it.



Controllably or lack of control goes in fantasy → reality. (compulsive / took over / just happened).

Manage by not avoid action — distraction, disclosure.
Since need to be aware — of apprehension anxiety
∴ need to make a decision about how to react

Something about controllably + choice.
~~Some say feat thoughts uncontrollable~~

Apprehension anxiety - am I going to be attacked? Need to retaliate / defend / protect myself.

Make a decision about violent behaviour-balance.

controlability. ~~Thoughts are controllable + behaviours~~
or Thoughts + fantasies are controllable.

choice.

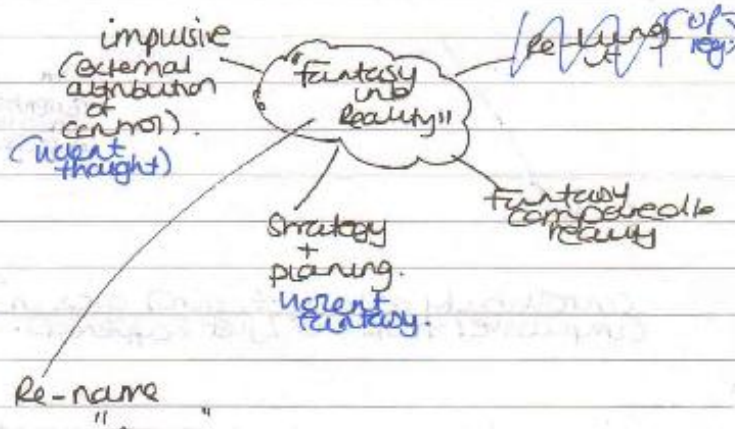
Choice however is not so clear cut - some say it "spills over" (too much) to action.

Decision. Make a decision → Act on it (impulsively)
→ Act on it (deliberately).
or Both deliberate - one impulsive, one more controlled + planned?

Choice related to action
choosing to do it / versus not it during

must choose to do it / or do it impulsively.

~~For those choosing~~
For some, may externally attribute choice / decision . . . for some reason.



Apprehension anxiety includes disclosure and ~~abbc~~ awareness of needing to be careful.

Consolidated criteria for the reporting of qualitative studies (COREQ; Tong, Sainsbury & Craig, 2007). Application of COREQ to Thematic and Functional Analysis research.

No.	Item	Guide questions/ description	How domain met
Domain 1: Research team and reflexivity			
Personal Characteristics			
1	Interviewer/ Facilitator	Which author/s conducted the interview or focus group?	Researcher - Gita Patel, PhD student.
2	Credentials	What were the researcher's credentials?	BSc (HONS) Psychology; MRes Psychology.
3	Occupation	What was their occupation at the time of the study?	Employed as a Research Assistant during the development of the study and then as PhD student whilst collecting and analysing data. Employed as an Assistant Psychologist during write-up of research.
4	Gender	Was the researcher male or female?	Female
5	Experience	What experience or training	In addition to MRes and several Research Assistant posts, the Researcher had also

	and training	did the researcher have?	engaged in relevant research methods workshops including Thematic Analysis training, risk in research, research ethics and interviewing skills workshops. The researcher had also previously worked on qualitative research studies.
Relationship with participants			
6	Relationship established	Was a relationship established prior to study commencement?	All participants met with the researcher at several points during the recruitment and informed consent process, prior to their engagement in data collection sessions.
7	Participant knowledge of the interviewer	What did the participants know about the researcher?	Participants were fully informed about the purpose of the study in that it was being undertaken for fulfilment of the researcher's PhD. Some patients may have already known the Researcher from their engagements with other research projects within the same hospital and were thus aware of the researcher's identity as a member of staff as well as University student.
8	Interviewer characteristics	What characteristics were reported about the interviewer/ facilitator?	The researcher's interests and motivations for conducting the study are reported. In addition some demographic factors such as gender and age, relative to participants, were reported.
Domain 2: Study design			

Theoretical Framework			
9	Methodological orientation and theory	What methodological orientation was stated to underpin the study?	Two methodologies were used: Thematic Analysis and Functional Analysis.
Participant selection			
10	Sampling	How were participants selected?	Participants were purposively sampled from a population of mentally disordered offenders detained within a high secure hospital.
11	Method of approach	How were participants approached?	For ethical reasons each Responsible Clinician from across the three target services were asked to screen all of their patients using the inclusion and exclusion criteria. All those who met criteria were then approached by the Researcher for recruitment and informed consent.
12	Sample size	How many participants were in the study?	Forty-eight patients took part in the study.
13	Non-participation	How many people refused to participate or dropped out?	One hundred and twenty seven patients did not consent to participate in the study, of which 27 provided reasons for non-participation. These included non-participation due to lack of experience of violent thoughts/fantasies; has

			experience but does not wish to discuss them; other reasons not disclosed. Fifty patients consented to participate but two were withdrawn (one lost the capacity to consent and the other withdrew his own participation). This left 48 patients participating in the study.
Setting			
14	Setting of data collection	Where was the data collected?	Data were collected from patients on their respective wards at Rampton Hospital. Sessions took place in a quiet interview room off the main ward/day area.
15	Presence of non-participants	Was anyone else present besides the participants and researchers?	Thirty-nine interviews were conducted individually, with just the researcher and the patient present. Due to risk and security procedures, 8 patients were interviewed with 1 member of nursing staff present and 1 patient was interviewed with 2 members of nursing staff present.
16	Description of sample	What are the important characteristics of the sample?	Demographic data, admission source (where the patient was admitted to the hospital from), length of stay within the hospital, mental health section and index offence information.
Data collection			

17	Interview guide	Were questions, prompts, guides provided by the authors? Was it pilot tested.	Follow up questions and prompts were included on the interview schedule. The schedule was pilot tested on another sample prior to its use in the current study.
18	Repeat interviews	Were repeat interviews carried out?	Repeat interviews were not carried out.
19	Audio/visual recording	Did the research use audio or visual recording to collect the data?	All interviews were audio recorded using a digital Dictaphone.
20	Field notes	Were field notes made during and/or after the interview?	Some field notes were made during and some were made after each interview. These have been retained as part of the data corpus.
21	Duration	What was the duration of the interviews?	All interviews varied in duration. The average time was approximately 40 minutes. Word counts are available for all transcripts to illustrate the amount of data obtained from each interview.
22	Data saturation	Was data saturation discussed?	Data are thought to have saturated after 37 interviews had been analysed. However, given the heterogeneity of the sample data analysis continued until all 48 transcripts had been analysed to ensure representativeness of the different

			groups approached for participation.
23	Transcripts returned	Were transcripts returned to participants for comment and/or correction?	Transcripts were not returned to participants.
Domain 3: Analysis and findings			
Data Analysis			
24	Number of data coders	How many data coders coded the data?	One coder (Researcher, GP) coded all transcripts for both the thematic analysis and functional analysis. Discussions about codes and theme development were held with two other researchers involved in the project to increase validity. A second coder coded a random 20% of transcripts for the functional analysis aspect of the research.
25	Description of the coding tree	Did authors provide a description of the coding tree?	Description of a coding tree was provided for the functional analysis only.
26	Derivation of themes	Were themes identified in advance or derived from the	For the thematic analysis, themes were inductive and were derived from the data.

		data?	For the functional analysis the functions were derived from the findings of the thematic analysis and from the literature (deductive).
27	Software	What software, if applicable, was used to manage the data?	NVivo (version 9).
28	Participant checking	Did participant provide feedback on the findings?	Participants were not invited to provide feedback on the findings.
Reporting			
29	Quotations presented	Were participant quotations presented to illustrate the themes/ findings? Was each quotation identified?	Quotes are presented to illustrate themes. All quotes are identified by unique participant codes to preserve anonymity.
30	Data and findings consistent	Was there consistency between the data presented and the findings	Yes.
31	Clarity of major themes	Were major themes clearly presented in the findings?	Yes. Frequencies of themes are also detailed to illustrate representation within the data set.

32	Clarity of minor themes	Is there a description of diverse vases or discussion of minor themes?	Disconfirming case analysis was used to highlight and discuss discriminant cases.

9-A Functions Checklist

Data collection template for functional analysis – Functions Checklist

Function	Description	Definitely present (√)/ absent (X)
Gain positive affect	VTF to increase positive feelings. Positive intrapersonal process e.g. wishful or grandiose cognitions; may function to increase feelings of powerfulness or control; may function to provide reassurance to self-esteem, enhance or sustain it.	
Reduce negative affect	VTF used to self-soothe, includes using VTF to feel safe, escape or functions as a coping strategy or outlet. Negative intrapersonal process which may function to restore emotional equilibrium following a negative arousal state e.g. anger.	
To deal with provocation	VTF May facilitate problem solving and decision making in a social situation. This might include thinking about a violent response but without acting violently; the thought or fantasy may substitute action in this case.	
Sensation Seeking	Use of VTF for stimulation purposes e.g. actively selected for arousal, not necessarily sexual but does include sexual arousal and sadistic gratification e.g. observing victims distress. May also be used to create or intensify arousal.	
To guide behaviour	Use of VTF to plan or guide violent behaviour e.g. planning steps involved in a violent behaviour.	