The Traumatic Effect of Homicide in Mentally Disordered Offenders and Implications for Treatment

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Alison Bromley, BA (hons), MSc.

ABSTRACT

This thesis provides a broad and diverse investigation into the field of traumatic responses in mentally disordered perpetrators of homicide and group treatment for such offenders. A range of methods including a systematic review, a single case study and a primary phenomenological investigation were used to explore issues in the field. Following an introduction in Chapter 1, Chapter 2 reviews trauma responses in homicide offenders. The results indicate that trauma reactions among homicide offenders as a direct result of the offence are highly prevalent which has implications for potential interventions. The existing literature is obstructed by weak studies using suboptimal scientific designs and future research is recommended. In Chapter 3 a single case study explores a homicide offender's progress in a group treatment. The group therapy under investigation adopts a recovery oriented approach, addressing both criminogenic need and the well-being of the offender. The impact of the treatment is determined using a range of psychometric measures. The results indicate improvements in the targeted areas with clinically significant change demonstrated. Chapter 4 explores the lived experience of a group treatment for homicide using the principles of Interpretive Phenomenological Analysis. Three areas were discussed: (1) the Group (2) Recovery and (3) Risk. Recurrent

themes reflected the importance of shifting narratives and hope for the future in both domains of recovery and risk, lending support to the utilisation of narrative approaches in Index Offence work. The results have implications for clinical practice and are discussed in the context of directions for further research. Chapter 5 evaluates the Inventory of Complicated Grief which was used as an assessment measure in Chapter 3. Finally, Chapter 6 provides a discussion and close to the thesis drawing together the implications of the research.

Statement of Authorship

This thesis is submitted to the University of Nottingham in part fulfilment of the Doctorate in Forensic Psychology. The idea for the thesis was the authors own and reflects their interest in homicide offenders and their treatment. In chapter two, the systematic review was supervised by Dr Nigel Hunt, while all other chapters were supervised by Dr Simon Duff, indicating collaborative working. Gratitude is extended to Dr Kiara Bird for double scoring critical appraisals of a selection of the included studies for chapter two. Chapter four also indicates collaborative working with Dr Estelle Moore and Dr James Tapp, and this will be reflected upon submission for publication. I am the primary author for each of the studies within this Thesis. The findings from chapter four formed part of a poster presentation presented at the British Psychological Society, Division of Forensic Psychology Annual Conference, Glasgow, 2014.

I hereby declare that:

- I am the primary author of this thesis.
- I have fully acknowledged and referenced the ideas and work of others, whether published or unpublished, in my thesis.

- I have prepared my thesis specifically for the degree of Doctor of Forensic Psychology, while under supervision at the University of Nottingham.
- My thesis does not contain work extracted from a thesis, dissertation or research paper previously presented for another degree/diploma at this or any other university.

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I would also like to thank Dr. Estelle Moore and Dr. James Tapp for their supervision and contribution to the empirical research chapter of this thesis. I credit Estelle with shaping the way I think and feel about forensic practice, and for setting me on my pathway to become the clinician I aspire to be. An extra thank you to James for going above and beyond and never failing to provide me with academic support. It is certain that without these people this thesis would not have come to fruition. I am without doubt indebted to the men who participated in this study. Without them the project would not have been possible and I would like to thank them explicitly; for their time and for their insights.

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Contents

Tables and Figures

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GLOSSARY OF TERMS

ASD	Acute Stress Disorder
APA	American Psychiatric Society
BAI	Blame Attribution Inventory
BRI	Bereavement Risk Index
CASP	Critical Appraisal Skills Programme
CBI	Core Bereavement Items
CBT	Cognitive Behavioural Therapy
TF-CBT	Trauma Focussed CBT
CSU	Close supervision unit
DA	Discourse Analysis
DSM	The diagnostic and Statistical Manual
DSQ	Defense Style Questionnaire
EMDR	Eye movement desensitisation and reprocessing
GEM	Grief Evaluation Measure
GT	Grounded Theory
HCR-20	Historical, Clinical, Risk Management-20
HGRC	Hogan Grief Reaction Checklist
ICD	International Statistical Classification of Diseases and Related Health Problems
ICG	Inventory of Complicated Grief
IPA	Interpretative Phenomenological Analysis
IQ	Intelligence quotient

MMPI	The Minnesota Multiphasic Personality Inventory
MSFA	Multi-Sequential Functional Analysis
NA	Narrative Analysis
NCI	National Confidential Enquiry
NICE	National Institute for Health and Care Excellence
NIMH	National Institute of Mental Health
PPE	Personal Protective Equipment
PTSD	Post-Traumatic Stress Disorder
RCI	Reliable Change Index
RGEI	Revised Grief Experience Inventory
RSU	Regional Secure Unit
RQ	Relationship Questionnaire
SD	Standard Deviation
SED	Standard error of difference
STROBE	Strengthening the Reporting of Observational Studies in Epidemiology
TA	Thematic Analysis
TAS	Toronto Alexithymia Scale
TRIG	Texas Revised Grief Inventory
ONS	Office for National Statistics
WOK	Web of Knowledge

Chapter One

GENERAL INTRODUCTION TO THESIS

1.0 Thesis Structure

This research aims to provide a broad investigation into different aspects of the experience of homicide and the treatment of mentally disordered perpetrators. It aims to address contemporary issues in a field where further information is needed while also fulfilling the breadth of experience with the diversity of research methods required for an accredited professional doctorate. The thesis comprises of four main chapters including a systematic review, a case study, a qualitative research study and a critical review of a psychometric measure. Each chapter examines a different focus of the experience of homicide with a qualitative primary study branching out to investigate the lived experience of those at the centre of homicide specific interventions. The chapters follow in sequence however are varied enough in focus to stand independently as studies in their own right.

In chapter 2, the traumatic impact of homicide on the perpetrator is systematically reviewed in order to understand

better the impact of the crime on the offender and establish the need for recovery based therapies. The review contributes to a very limited field of research and uses rigorous methodology in order to increase the validity of the findings. In doing so, it was predicted that clearer information about the relationship between homicide and trauma would be established with a view to better understanding the outcome for the small number of offenders that commit such an offence.

Chapter 3 outlines a case study of a homicide offender in a high security psychiatric hospital undergoing group treatment for homicide. The offender moved through treatment to better understand his offence and his agency with respect to this, and generated positive outcomes on psychometric measures used to assess progress. The case study outlines a formulation of the aetiology of his offence and provides a working example of a murderer following a trajectory to offending. Treatment addressing areas of criminogenic need and recovery are discussed.

Chapter 4 aims to examine a relatively under-researched area in the field. It builds on the lack of clarity regarding the effectiveness of treatment for homicide offenders, and explores

the lived experience of five men engaging in group therapy in a high security hospital. The principles of Interpretive Phenomenological Analysis (IPA) were employed in the undertaking of this project. IPA was chosen due to its ideographic and hermeneutic foundations which lead researchers to invest in detailed examinations of sense making and personal experience in particular contexts (Smith, Flowers, & Larkin, 2009). The results have implications for treatment practice and are discussed in the context of directions for further research.

Finally, Chapter 5 evaluates the Inventory of Complicated Grief (ICG) (Prigerson, Maciejewski, et al., 1995) which was used in Chapter 3 to assess levels of grief before and after group homicide treatment. The scale has been used to assess grief in bereaved populations and its psychometric properties are relatively well established. However, this chapter aims to explore how the ICG compares with the alternative measures in the field, both in terms of its psychometric properties and ability to tap into implicit theories about the grief process, and discusses this within the context of its usefulness in a forensic population for which the bereaved are culpable for their loss.

1.1 Homicide

Homicide has been defined as *"unlawful death purposefully inflicted on a person by another person"* (UNODC, 2013). Studying homicide is important not only because of the impact at an individual level, but because it is often considered the 'ultimate crime' which victimises the family and community of the victim as well as the victim themselves.

There are two types of 'lawful' homicide; *justifiable* homicide is committed on behalf of the state and *excusable* homicide which is committed by accident. 'Unlawful' homicide includes murder which carries a mandatory life sentence, and manslaughter or culpable homicide which entails discretionary sentencing from imprisonment to community sentences or to hospital disposal, infanticide which is sentenced similarly to manslaughter (although this is different in Scotland), and death by dangerous driving with sentencing decisions ranging from 3-14 years in custody. Homicide is also categorised into two subgroups: 'normal' homicide in which the perpetrator is free from psychiatric disorder, and 'abnormal' homicide in which the offence was infanticide and/or was committed by an individual with psychiatric disorder; though this is a legal definition rather than a psychiatric one (Semple & Smyth, 2013).

1.2 Rates of Homicide

Homicide is a relatively rare event: The Home Office Homicide Index showed there were 526 homicides in 2013-2014 in England and Wales, inclusive of manslaughter, homicide and infanticide. This is at a similar level to 2011-2012, in which there were 528 offences but 21 fewer than the 547 recorded in 2012-2013; a decrease of 4% (ONS; Office for National Statistics, 2015). Rates of homicide change over time, although have shown a general downward trend in recent years. In 2013-2014, around two-thirds of homicide victims were male, a trend also found in previous years. There were 343 male victims of homicide in 2013-2014, a reduction of 9% from 377 in the previous year. In contrast, the number of female homicide victims increased by 8% from 170 to 183 victims (ONS, 2015). For those perpetrators where proceedings had concluded, 90% were male and 10% were female (ONS, 2015). Rates of homicide recidivism are very low, with none of the 336 homicide offenders in the Roberts, Zgoba, and Shahidullah (2007) study committing a further killing during the course of the longitudinal study, although rates of other re-offending in this population is higher. That said, one confounder to this figure is the fact that homicide offences carry long sentences, thus reducing opportunities to re-offend.

There are gender differences in the pattern of relationships between victims and suspects. Women are far more likely than men to be killed by partners or ex-partners (46% of female victims compared with 7% of male victims), and men are far more likely than women to be killed by friends or acquaintances (40% of male victims compared with 8% of female victims) (ONS, 2015). In total, one fifth of homicides are perpetrated by the spouse or partner of the victim, and 94% of these victims are female (NCI; National Confidential Inquiry, 2014). Of all intimate partner homicides, 115 (12%) were carried out by a patient in contact with mental health services in the 12 months prior to the offence; and 90 (78%) of these were male. The most common diagnoses were affective disorders (bipolar disorder and depression) schizophrenia and other delusional disorders, alcohol dependence/misuse, and drug dependence/misuse (NCI, 2014).

For homicides of children under 16 years of age, the most likely perpetrators are a parent or step parent (50%) and only 9% were killed by a stranger in 2013-2014 (ONS, 2015). In fact, for all homicides, homicides by strangers only account for approximately 22% (Shaw et al., 2004), and on the whole,

most victims know their killer (Salfati & Canter, 1999). In the UK, the most common method of killing continues to be by knife or other sharp instrument, accounting for over 1 in 3 (38%) of homicides. Just 6% of the total homicides were killed by shooting in 2013-2014 (ONS, 2015). The fact that homicide rates are not stable over time indicates a need for research in this area.

1.3 Mentally Disordered Homicide Offenders

Between 2002 and 2012, 526 people or 10% of homicide offenders were confirmed as having been in contact with mental health services in the 12 months prior to the offence. As with all homicides, homicides by mentally disordered offenders have also been falling in recent decades. In total, 276 were either non-adherent or missed final contact with services prior to the offence, meaning that 49% were not in receipt of planned treatment before homicide. The vast majority (76%) or 465 homicides by mentally disordered offenders had a history of alcohol misuse, and 474 (77%) patients had a history of drug misuse (NCI, 2014).

The figures suggest that most homicides are not committed by offenders with mental disorder and 80-85% of the perpetrators

of homicides are free from serious mental illness (Richard-Devantoy, Olie, & Gourevitch, 2009). There is, however, an association between homicide and mental disorder, particularly with manifestations of schizophrenia, antisocial personality disorder and drug or alcohol abuse, although it is unclear what makes some individuals behave violently when others do not (Fazel & Grann, 2015; Richard-Devantoy et al., 2009).

1.4 Traumatic Responses to Homicide

Adshead, Bose, and Cartwright (2008) state that perpetrators of homicide can develop PTSD, complicated grief, and clinical depression in response to their offences, and require treatment for those conditions. There is limited literature to support this however, with most studies focussing on the impact of homicide on the victims' families. In discussing trauma in homicide offenders, the following paragraphs describe PTSD and it's conceptualisation before exploring the implications for homicide offenders in more depth. A more detailed exploration of PTSD in the wider population is explored in chapter two.

PTSD received much attention throughout the 20th century, with discussion of war related trauma emerging in 1941 by A. Kardiner (Kolb, 1993). Kardiner was the first to write about the

difference between neuroses of peacetime and of wartime and felt that they should be regarded as a "*physioneurosis.*" He noted the persistence of the startle reaction, and believed that the abnormality was based upon a process of conditioning (Kolb, 1993). Despite this, in the 1970s, veterans of the Vietnam War were being hospitalised and still receiving diagnoses of schizophrenia or other psychotic disorders (Ozer, Best, Lipsey, & Weiss, 2008). Later, clinicians began exploring the similarity in psychological suffering between rape victims and war veterans, particularly noting that their clients were observed to be avoidant, on guard, easily startled, and flooded with memories and images of the event that could not be easily be forgotten (Ozer et al., 2008).

Almost a decade later the study of posttraumatic symptoms culminated in the introduction of PTSD into the Diagnostic and Statistical Manual III (American Psychiatric Association, 1980). Presently, PTSD is understood to be a condition that is triggered by a terrifying event (either experiencing it or witnessing it) and is followed by symptoms which may include flashbacks, nightmares and severe anxiety, as well as uncontrollable and intrusive thoughts about the event. These symptoms are clustered into a triad of re-experiencing, avoidance/numbing,

and hyper-arousal (Friedman, Resick, Bryant, & Brewin, 2011). There is a body of research that evidences the role of extreme stress and long lasting psychopathology (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995; Morgan, Scourfield, Williams, Jasper, & Lewis, 2003; Neria, Nandi, & Galea, 2008; Norris & Slone, 2007; Whalley & Brewin, 2007), and in the DSM-5, new symptoms have been added to address negative appraisals and mood, and reckless, self-destructive behaviour (American Psychiatric Association, 2013).

Because the traumatic event that precedes PTSD is typically one of immediate life threat and horror (e.g. sexual assault at knifepoint, torture, combat, being in a serious accident), there is also accompanying high adrenergic arousal (Ozer et al., 2008). The Amygdala and the hippocampus have been found to be the key brain areas involved in the registration of potentially dangerous situations and in the later formation of the memories of such events, and give the hypothalamic–pituitary–adrenal (HPA) axis a key role in both the development of PTSD and its maintenance (Yehuda, 2002). This indicates that memories formed under circumstances of emotional arousal behave differently than those which are not (Ozer et al., 2008). Understanding PTSD from a neurobiological perspective may

help shed light on the issue of the wide heterogeneity of traumatic events that give rise to PTSD (Ozer, et al., 2008).

However, despite over half of all adults experiencing at least one traumatic event; just 7.8% experience PTSD, with women twice as likely as men to have PTSD at some point in their lives (Gradus, 2007). What makes some more likely to experience PTSD than others is an interesting question, and a number of factors are proposed (NIMH; National Institute of Mental Health, 2011) including:

- Trauma type (intentional or not).
- Perceived sense of threat.
- Perceived self-efficacy.
- Cognitive flexibility and appraisal style.
- Perceived/anticipated support/help.
- Social support before during and after the event.
- Initial PTSD symptoms: psychological and physiological distress.
- Heritable risk: personal and family history of psychiatric, alcohol and drug problems.
- Childhood adversity/trauma

- Predictors of future trauma: personality, alcohol, drug use, patterns of services use.
- Meaning attached to the trauma experience.
- Sense of control: over especially grotesque events and perceived threat.

When considering death as the traumatic event, Brunning (1982) described the similarity of psychological responses between those who have killed and those who have been bereaved by killing. He described a therapeutic group for male homicide offenders and outlined how they had experiences following the act which were symptomatic of grief. Brunning (1982) reported that they went through an initial phase of disbelief, reliving the trial, denial, and depression.

Fraser (1988) also emphasised the importance of personality factors which may make someone more vulnerable to experiencing complicated grief. For example, an individual who is unable to tolerate extremes of emotional distress is more likely to suffer a complicated grief reaction. Furthermore, grief is described as a social as well as a personal process, therefore there are likely to be problems if the circumstances of a death

make it uncomfortable for others (i.e. suicide) or if the bereaved does not have access to a social support network. These personality and social factors which predict complicated grieving will almost certainly be relevant to those who kill, particularly when one can hypothesise that the offence will at times be an extreme reaction to stress to which the individual was unable to find a suitable response (Fraser, 1988). Additionally, the act of homicide is universally condemned, with typical responses being of shock and disgust. Therefore the offender will have to encounter a hostile rejection by society as well as by members of the deceased's family.

Parkes and Prigerson (2013) described a process of pathological grieving in which bereavement triggers a wide range of psychiatric disorders of which affective disorders are the most common. Parkes and Weiss (1983) explored why some people do well after bereavement while others do not. They identified risk factors to identify who, after bereavement, were at risk of problems later. They also noted the characteristic reactions that followed sudden, unexpected, and untimely deaths, the deaths of partners for whom the bereaved person had been very dependent, and the conflicted grief of people whose relationships were highly ambivalent (Parkes & Weiss, 1983).

Factors that predispose the individual to pathological grief reactions are as follows (Parkes & Prigerson, 2013; Parkes & Weiss, 1983):

(1) Mode of Loss

- Sudden or unexpected losses for which people are unprepared.
- Multiple losses.
- Violent or horrific losses.
- Losses for which the person feels responsible.
- Losses for which others are seen as responsible.
- Disenfranchised losses (i.e. losses that cannot be acknowledged or mourned).

(2) Personal Vulnerability

- Dependent on deceased person (or *vice versa*).
- Ambivalence to deceased person.
- Persons lacking in self-esteem and/or trust in others.
- Persons with previous history of psychological vulnerability.

(3) Lack of Social Support

- Family absent or seen as unsupportive.
- Social isolation.

The modes of loss and lack of social support cited here are especially likely to be conditions that accompany bereavement as a result of committing a homicide offence; and this is particularly salient when considering the volume of homicides perpetrated by spouses or family members. For example, a homicide is likely to be violent or 'horrific', involve a sense of personal responsibility, and be difficult to mourn due to the offender's culpability. Furthermore, the personal vulnerability factors are particularly relevant to homicide because killing someone you know, as is so often the case, likely entails an ambivalent relationship to the victim. For mentally disordered homicide offenders, the evidence for a pathological bereavement response is supported by the association with psychological vulnerability and issues with trust and self-esteem. Overall it could be concluded that the work of Parkes and Prigerson (2013) lends support to the notion that mentally disordered homicide offenders may suffer complex bereavement in response to their offence.

Complex grief has similarities to post traumatic stress disorder (PTSD) in that the trauma response is longer lasting, and more severe than the 'normal' reaction. Early studies of violent offenders report prevalence rates for PTSD of between 15 and

32% following the violent act (Pollock, 1999b). Therefore, while PTSD is usually associated with being the victim of an event, there is increasing evidence that PTSD can be caused by a person's own actions (Gray et al., 2003).

In support of this, Manolias and Hyatt-Williams (1993) explored PTSD in police officers who had had to shoot people. They found that 12% of these police officers developed severe PTSD. However, the aim of this thesis is to explore the incidence of trauma responses in deliberate, non-sanctioned homicide, which excludes killings that are mandated in the line of duty (i.e. while at war or killings committed by the police) and for whom the trauma responses may therefore be very different.

With this in mind, Harry and Resnick (1986) were the first to describe PTSD as a direct consequence of committing a homicide offence. They identified a number of factors that may be important in the aetiology of PTSD following homicide. These included; being young, having a chaotic childhood and a problematic developmental history, having a minimal criminal history, having a significant relationship with the victim, and being in an altered mental state at the time of the killing (Harry

& Resnick, 1986). The PTSD symptoms reported were directly linked to their respective homicides, and included the following:

- Recurrent and intrusive memories of the killings.
- Nightmares and flashbacks of the offence.
- Guilt.
- Intrusive thoughts triggered by external stimuli.
- Avoidance of activities that aroused recollections of the killing.

From these findings, Harry and Resnick (1986) concluded that the killing itself constituted the traumatic event. Because these factors were identified based on a very small number of cases, the conclusions must be interpreted with caution. However, due to their relevance to clinicians working with forensic populations these findings warrant further exploration.

Studies of violence more generally have investigated whether PTSD is caused by violent offending. Kruppa (1991) found high rates of both current and lifetime PTSD (22% and 32% respectively) in people detained under the Mental Health Act (1983) under the legal category of 'psychopathic disorder'. In half the cases the trauma associated with the PTSD symptoms was the index offence, and females reported particularly high

rates of lifetime diagnosis of PTSD (64%), twice that of Vietnam veterans (31%) (Kruppa, Hickey, & Hubbard, 1995).

High rates of PTSD in that particular population was perhaps to be expected, given that they were detained under the legal category of psychopathic disorder, meaning that they were all diagnosed with some form of Axis II personality disorder under DSM IV criteria (American Psychiatric Association, 1994); and this has particular relevance to this thesis. The most common forms of personality disorder identified in psychiatric services are borderline personality disorder (BPD) and anti-social personality disorder (ASPD) (Gray et al., 2003), and it has been suggested that borderline personality disorder is akin to a prolonged and severe form of PTSD, often arising out of difficult childhood circumstances (Golier et al., 2003; Kudler, 1993; McLean & Gallop, 2003).

Regarding mentally ill perpetrators of homicide; Thomas, Adshead, and Mezey (1994) reported a case of a woman who killed her children in the context of a psychotic depression. The authors noted that the co-morbidity between PTSD and depression appeared to delay recovery. In addition, Rogers, Gray, Williams, and Kitchiner (2000) described the outcome of

behavioural treatment in a patient who developed PTSD as a consequence of killing her boss when clinically depressed. They argued that when PTSD is co-morbid with another serious mental illness, PTSD acts as a chronic stressor and relapse indicator (Rogers et al., 2000).

Exploring a sample of 37 primarily mentally ill offenders, Gray et al. (2003) found that 33% met diagnostic criteria for PTSD and 54% had significant PTSD symptomatology. PTSD symptoms were more frequent in those who had committed violent offences than in those who had committed sexual offences, and in those who had an affective diagnosis (Gray et al., 2003). They concluded that the high frequency of PTSD symptoms in this population may serve as a significant stressor and may therefore worsen psychiatric illness and contribute to poor treatment response and even relapse.

These findings are relevant when considering that future risk has been associated with unstable mental state (Walsh, Buchanan, & Fahy, 2002) and therefore the development of PTSD post-offence may serve to prolong or increase the perpetrators risk of harm to both self and others. With this in mind, comprehensive assessment of PTSD and appropriate

intervention is potentially important for mentally disordered offenders and it is this that will be explored throughout this thesis.

1.5 Disposal and Intervention for Mentally Disordered Homicide Offenders

As briefly aforementioned, there are different sentencing decisions made for different types of homicide, taking into consideration whether or not they are found to be 'abnormal' (Semple & Smyth, 2013). The Mental Health Act (MHA) is the law which can be used to admit an individual to hospital for assessment and/or treatment for a mental illness or disorder. To be detained or 'sectioned', the individual must have a mental disorder which needs assessment or treatment, and detainment must be in the interests of their own health or safety, or to protect other people (Bowen, 2007).

The criminal courts can use section 37 if they think an offender should be in hospital instead of prison. Criminal sections can be implemented with or without restrictions and section 41 is a restriction order implemented to protect the public from serious risk of harm. The crown court can add this order to a section 37

if they have concerns about public safety and the person's level of risk. The restrictions affect leave of absence, transfer between hospitals, and discharge; all of which require Ministry of Justice permission (Bowen, 2007). If a prisoner on remand has a mental illness that cannot be managed in prison, the Secretary of State for Justice can be asked to transfer a prisoner to hospital using section 48/49. The patient could be moved back to prison to complete their sentence if their condition improves (Bowen, 2007).

For the small number of mentally disordered homicide offenders, verdict and disposal varies with diagnosis and perceived culpability for the offence. A study by Shaw et al. (2006) found that most of those with schizophrenia received a diminished responsibility verdict and/or a hospital disposal. In addition, those who received a diminished responsibility verdict were more likely to be female, less likely to have previous convictions for violence and more likely to have had hallucinations at the time of the offence (Shaw et al., 2006).

Among those with a lifetime history of affective disorder, a diminished responsibility verdict was associated with having

depression or delusions at the time of the offence and with killing a family member or spouse. Hospital disposal was more likely in those who were psychotic at the time of the killing and less likely if there was a history of alcohol misuse or drug dependence. Hospital disposal was also associated with health service contact in the year before the offence, psychotic or delusional symptoms, being unmarried, belonging to a minority ethnic group and killing a family member or spouse (Shaw et al., 2006). Among those receiving a verdict of manslaughter on the grounds of diminished responsibility the outcome was a hospital order in 56% of cases. In the remaining cases, the disposal was prison for 37%, 5% received a probation order, 1% received a suspended sentence and 0.7% received Guardianship under the Mental Health Act (1983) (Shaw et al., 2006).

In summary, it would seem that both a verdict of diminished responsibility and a hospital order disposal are related to severe mental illness rather than alcohol or drug dependence or personality disorder; and in particular are related to illnesses that put the perpetrator into an abnormal state of mind, such as psychosis, at the time of the killing (Shaw et al., 2006). However, a small number of those with acute and severe mental

illnesses are sent to prison, even after a verdict of diminished responsibility (Shaw et al., 2006). Such differential disposal decisions may indicate the way in which we as a society view and treat certain groups of people. The fact that more women receive a hospital disposal could highlight the way that female behaviour is conceptualised, indicating that women who offend are viewed as 'mad' rather than 'bad'; and the same applies for those who kill a spouse or family member.

The system also seems to favour hospital disposal for those whose illnesses are considered 'treatable'. However, such decisions must be kept under review because as evidence about the aetiology and treatment of personality disorder and substance misuse is collected, perceptions of responsibility and 'treatability' in these conditions are changing (Bateman & Fonagy, 2000; Linehan, Armstrong, Suarez, Allmon, & Heard, 1991; Perry, Banon, & Ianni, 2014; Ryle & Golynkina, 2000). The way the courts deal with acute or severe mental illness also needs to be examined recurrently because people with such illnesses may not receive the care they need if they are imprisoned (Gray et al., 2003).

With such long sentences, either in custodial or mental health care, the question arises of how to intervene, and how to reduce the risk posed by these individuals. The stakes are high, they have killed and thus they have demonstrated the potential to be lethally dangerous. Group work is still the main form of psychological therapeutic intervention available to prisoners, and group-based cognitive therapy is recommended for antisocial men and women by the National Institute for Clinical Excellence (2009, Cited in Duggan & Kane, 2010). Treatment in forensic psychiatric inpatient services usually involves both medication and psychological therapies, especially therapies that address risk reduction and understanding of the index offence (Glorney et al., 2010).

There is very limited literature in the field of homicide specific interventions, however it is possible that the standard interventions designed to address offending behaviour, anger, or violence may not be adequate. This is because not all homicides are committed as a result of anger, with some being instrumental (Cornell et al., 1996). Similarly, violence reduction programmes may also be inadequate, since many homicide offenders are not career criminals and many do not have a long

history of violence (Blackburn, 1971; Brookman & Maguire, 2003; Brunning, 1982).

Therefore, given the aforementioned plausibility of homicide perpetrators experiencing trauma and bereavement in response to their offence (Parkes, 1976; Parkes & Prigerson, 2013; Pollock, 1999b) and due to the link between PTSD and future violence (Beckham, Feldman, Kirby, Hertzberg, & Moore, 1997; Collins & Bailey, 1990; Fehon, Grilo, & Lipschitz, 2005; Watson, 2013), trauma therapies may be valuable as these would not only address offender well-being, but also the risk posed by the offender to others.

Adshead (2014) advocates for dynamic, narrative, based therapies that offer space for reflection on conscious and less-conscious processes, viewing this as essential for offenders who have damaged their social identities by their offences, and who need to demonstrate to themselves and others that they have thought about their offending and its consequences. These are recovery based therapies that move beyond a definition of mental health recovery as solely a reduction of mental health symptoms and have incorporated functional, social and personal recovery in combination with a focus on history of

offending (Ferrito, Vetere, Adshead, & Moore, 2012). The experience of such interventions will be explored throughout this thesis.

To summarise, the aims of this thesis are as follows:

1. To explore the concept of trauma responses in homicide offenders.
2. To formulate a single case of homicide and determine the impact of treatment for the individual.
3. To explore the lived experience of group treatment for homicide offenders
4. To critically evaluate the ICG as a measure of grief in an offender population.

Chapter Two

TRAUMA RESPONSES IN PERPETRATORS OF HOMICIDE: A REVIEW OF THE LITERATURE

Abstract

Background: It has been suggested that perpetrators of homicide can develop PTSD, complicated grief, and clinical depression in response to their offences although this is a claim that has received little attention in the homicide literature, with most studies focussing on the impact of homicide on the victim's families. Research into the psychological sequelae of homicide offenders has been largely dominated by qualitative, descriptive, or case studies.

Aims: The current systematic review aimed to bring together the small pool of existing quantitative psychological research examining PTSD, grief, and other trauma responses in adult homicide offenders as a direct result of their offence.

Methods: By systematically searching multiple databases and applying strict inclusion/exclusion criterion studies were selected and quality assessed.

Results: The findings indicate that PTSD and other trauma symptoms are highly prevalent in homicide offenders, with avoidance and guilt being particularly salient. Suggestions are made for future research and interventions.

1.0 INTRODUCTION

1.1 Post-Traumatic Stress Disorder

In the mid nineteenth century, psychiatrists and physicians began recognising syndromes in war veterans that embodied many of the symptoms that we now recognise to be Post-Traumatic Stress Disorder (PTSD) (Friedman et al., 2011). Explanatory models (psychoanalytic, Pavlovian fear conditioning, Mowrer's two-factor theory, Selye's theories of stress and adaptation, cognitive theories and neurobiology) proposed mechanisms by which trauma may result in PTSD (Friedman et al., 2011). By the mid 1970's, clinician's recognised the need for a disorder that incorporated the multitude of syndromes that had been postulated during the DSM-II era, including; rape trauma syndrome, post- Vietnam syndrome, prisoner-of-war syndrome, concentration camp syndrome, war sailor syndrome, child abuse syndrome, and battered women's syndrome, and the DSM III integrated all of these discrete syndromes into PTSD criteria (American Psychiatric Society, 1980).

There have been some alterations since the original DSM-III PTSD criteria were outlined. For the DSM IV, the number of

possible symptoms increased from 12 to 17, and what were originally three symptom clusters of re-experiencing, numbing, and miscellaneous became a triad of re-experiencing, avoidance/numbing, and hyper-arousal (Friedman et al., 2011). However, the fundamental construct that overwhelming stress may precede the onset of clinically significant alterations in cognition, thought, and behaviour remains, and there is a body of research that evidences the role of extreme stress and long lasting psychopathology (Kessler et al., 1995; Morgan et al., 2003; Neria et al., 2008; Norris & Slone, 2007; Whalley & Brewin, 2007). Three new symptoms have been added to the DSM-5 to address negative appraisals and mood, and reckless, self-destructive behaviour (American Psychiatric Association, 2013).

PTSD symptoms of nightmares, avoidance behaviour and hypervigilance are also seen in the temporary distress of traumatised individuals whom recover normal functionality relatively quickly, but it is the persistence of these symptoms that characterises PTSD (Friedman et al., 2011). In summary, PTSD reflects a failure to adapt following a significant and traumatic event, where normal stress reactions do not resolve over time.

The heterogeneity of traumatic events is understood (O'Donohue & Elliott, 1992) though it is considered that victim profiles of psychopathology are similar in response to trauma (Meichenbaum, 2006). Therefore, each individual exposed to trauma will have a unique response to this experience; some being strengthened, others distressed, and others unaffected. The occurrence of PTSD symptoms is influenced by a number of interplaying factors, including; features of the trauma experienced, the individual's and other people's responses to the trauma, pre-trauma factors and post-trauma recovery factors (Meichenbaum, 2006).

1.2 Complicated Grief

Grief is a normal reaction to loss and refers to the distress resulting from losing someone. Research among bereaved elders has shown that certain symptoms of grief form an integrated component of emotional distress that is clearly distinguishable from the symptoms of depression and anxiety (Prigerson, Maciejewski, et al., 1995). Symptoms such as irritability, nervousness, tenseness, and restlessness are best characterised as symptoms of anxiety, while sad mood, apathy, and guilt are best characterised as symptoms of depression. A

third group of symptoms, however, appears to be unique to grief: preoccupation with thoughts of the deceased, searching and yearning for the deceased, disbelief about the death, crying, being stunned by the death and not accepting the death. These symptoms are also thought to predict long term dysfunction such as impairments of global functioning, sleep, mood, and self-esteem at 12-18 months following the bereavement (Prigerson, Maciejewski, et al., 1995).

Complicated grief or complicated grief disorder (CGD) is a proposed disorder for those who are significantly and functionally impaired by prolonged grief symptoms for at least one month after a six month bereavement period (Shear et al., 2011). At six months following the loss, the bereaved is expected to still experience some residual symptoms of grief, but should have integrated these into their life, such that they no longer impact on their ability to function on a day to day basis (Shear et al., 2011). There is however, a subgroup of individuals for whom their grief is more persistent and intense. For these individuals, bereavement is considered a severe stressor that can trigger the onset of a physical or mental disorder (Shear et al., 2011).

Some of the longer lasting symptoms can become 'pathological'; including symptoms such as survivor guilt, bitterness over the death, jealousy of others who have not experienced a similar loss, distraction to the point of disruption in everyday activities, and lack of trust in others as a consequence of the loss (Prigerson, Maciejewski, et al., 1995). Indeed, symptoms which suggest elements of shock such as functionally debilitating intrusive thoughts about the deceased and resentment because the person died are the best items to differentiate persons with complicated grief from those with uncomplicated grief (Prigerson, Maciejewski, et al., 1995).

In short, complicated grief is caused by experiencing grief as traumatic distress and shares some symptoms of PTSD including; intrusive thoughts about the deceased, associated functional impairments, and hostility, in accordance with DSM-5 criteria (American Psychiatric Association, 2013). However, complicated grief is distinguished from non-impairing grief and other disorders such as PTSD and Depression and Anxiety. Individuals experiencing complicated grief experience a sense of persistent and disturbing disbelief regarding the death and resistance to accepting the painful reality. Intense yearning and longing for the deceased continues, along with frequent pangs

of intense, painful emotions. Thoughts of the bereaved remain preoccupying, often including distressing intrusive thoughts related to the death, and there is avoidance of a range of situations and activities that serve as a reminder of the loss. It is estimated that between 10 and 20% of bereaved individuals will develop complicated grief (Byrne & Raphael, 1994; Middleton, Burnett, Raphael, & Martinek, 1996; Prigerson & Jacobs, 2001)

1.3 Homicide as a Traumatic Event

In chapter one, the concept of homicide as a traumatic event was explored in depth. There is limited literature to support this however, with most studies focussing on the impact of homicide on the victim's families. However, the mechanisms by which homicide may produce a traumatic or complicated grief reaction are worthy of consideration here.

Neimeyer (2005) suggested moving away from the traditional stages of grief model, with a new focus on the cognitive and active processes in mourning, as well as the emotional consequences of loss. Research indicates that the ability to find meaning in experiences of loss predicts positive adaptation, whereas a persistent and unsuccessful struggle for meaning is

associated with intense and chronic grief (Davis, Nolen-Hoeksema, & Larson, 1998; Prigerson, 2004; Uren & Wastell, 2002). This seems relevant in the case of committing homicide, as the offender may struggle to find meaning in the event which simultaneously ends both their victim's life and their own life as they know it.

In support of this, research on large numbers of people bereaved by violent death (e.g. survivors of suicide, homicide, and accidents) shows that the inability to make sense of the loss is the main factor that sets them apart from those whose losses are more anticipated in the context of serious illness in the deceased (Currier, Holland, Coleman, & Neimeyer, 2008).

Furthermore, Uren and Wastell (2002) proposed that the intensity of grief is a function of both attachment security and the ongoing search for meaning (Neimeyer, 2005). Their findings supported the conceptualisation of grief as an interpretive phenomenon, elicited by the loss of a primary attachment figure, thereby devastating core life purposes, and implicating the need to re-establish meaning (Uren & Wastell, 2002). Given that the vast majority of homicides are relational, i.e. committed by a family member, friend, or spouse;

attachment and its relationship to trauma seems to be particularly salient.

Attachment has its roots in theory postulated by Bowlby (1969), and is based on the influences from ethology, information processing, psychoanalysis and developmental psychology. Attachment refers to the way humans relate to one another and Bowlby (1969) argues that children are genetically inclined to form attachments in the first years of life and are evolutionarily prepared to internalise interpersonal and emotional experiences with caregivers. It is these relationships with caregivers which impact on whether the child sees themselves as having self-worth or not, and whether they see others as reliable or not, and the caregiver's reactions to the child's expression of emotion are central to this process (Bowlby, 1969, 1982, 2005).

The reaction of the primary caregiver to emotional distress is fundamental in helping the child to learn how to manage their arousal and emotional reaction, as they are not born with this capacity. Through insecure attachment, the individual might be left with either an inability to manage their arousal levels and fear in response to threat, or to develop an appropriate

response. Violence therefore arises as a way to regulate and manage angry feelings (Bowlby, 1982).

When considering adult responses to feeling threatened, whether actual or perceived, it is important to understand what attachment behaviour is being activated (Mikulincer & Shaver, 2010). If, in childhood, they only learnt to manage unpleasant feelings physically and were not taught appropriate self-soothing and self-management techniques, this translates into maladaptive coping strategies, such as the use of violence, which has implications for the risk of the individual.

When considering a forensic population, adults displaying seemingly unmanageable or irrational violence tend to be those who were not enabled in childhood to develop secure attachment in which they felt cared for and contained (Parsons, 2009). In fact, Fonagy, Target, Steele, and Steele (1997) found that violence is a solution for resolving psychological conflict in offenders and concluded that the problem is not in violent tendencies but in regulating negative emotions, where the emotion turns into action. In the case of relational homicide, violence possibly occurs within the context of a triggered

attachment response, and an inability to manage subsequent emotional arousal.

The homicide of a family member is said to force the remaining relative to visualise how the murder took place and to identify psychologically with the thoughts and feelings of the victim (Rynearson, 1996). These intense 're-enactment fantasies' present as intrusive, repetitive flashbacks during the day, and sometimes as recurring dreams during sleep (Rynearson, 1996; Rynearson & Sinnema, 1999; Rynearson, 1984, 1986) and this shares similarities with PTSD symptomology (Friedman et al., 2011). While these findings are taken from research with bereft non-perpetrators, some of the elements are almost certainly shared with homicide perpetrators. This is supported by the finding that high emotional arousal and extremes of violence are associated with risk for non-recovery of traumatic grief (Rynearson, 1996).

The idea that offending leads to difficult emotions is not a new one, and Spitzer et al. (2001) found that in a sample of 53 mentally disordered forensic in-patients, 56% met lifetime criteria for PTSD. However, this followed exposure to different types of trauma including childhood physical abuse and so

whether their offence was the specific cause is questionable. That said, 9.4 % of their offenders were homicide offenders and this was found to be the second most common trauma resulting in PTSD (Spitzer et al., 2001). Importantly, co-morbid symptoms of depression and anxiety commonly co-occur with PTSD (Solomon, Gerrity, & Muff, 1992), creating a problem for the conceptualisation of PTSD as a distinct syndrome. For this review then, studies investigating symptoms of PTSD, depression and anxiety were included within the exposure criteria as they have been identified as relevant to the experience of trauma.

2.0 OBJECTIVE

The aim of the current review is to consolidate the limited existing psychological research examining PTSD, complicated grief, and other trauma responses in adult homicide offenders. Examining the factors involved in increased levels of PTSD amongst this population may then be used to inform interventions at a more systemic level, thus contributing toward individual recovery and rehabilitative pathways.

The aim of the review is to answer the following research questions:

1. What factors are involved in increased trauma responses following committing homicide?
2. How do trauma symptoms present in homicide offenders following the offence?
3. With what frequency are trauma symptoms present in homicide offenders?

3.0 METHOD

The focus of this review is adult perpetrators of homicide. Therefore, studies were eligible for inclusion if they were (1) adult perpetrators of homicide (Male or Female) and (2) had a formal diagnosis of either PTSD, complicated grief or other trauma. Exclusion criteria included the following: (1) general offenders who had not committed homicide and (2) adolescent homicide offenders (<18 years). For full inclusion criterion please see the selection proforma, illustrated in figure one.

Figure 1: Inclusion Criteria

INCLUSION CRITERIA	CRITERION MET?	COMMENT
Is the study quantitative?	Yes Unclear Discuss No	
Is the study dated on or after 1970?	Yes Unclear Discuss No	
Does the population consist of adult homicide offenders?	Yes Unclear Discuss No	
Has PTSD been measured using either structured clinical interview or a by use of a validated tool? **And/or**	Yes Unclear Discuss No	
Has grief been measured using by use of a validated tool?	Yes Unclear Discuss No	

If Yes to all questions then include in the study

3.1 Search Strategy

The search strategy aimed to find both published and unpublished studies. Articles written in languages other than English were not automatically excluded; articles that seemed relevant to the study were translated. The search strategy was limited to articles dated after 1970. An early date was suggested in order to retrieve as many articles as possible given the paucity of research in this area. An early date allowed for studies to be collected that included non-PTSD related trauma such as anxiety and depression, as well as those papers that reflect the shift in understanding and subsequent development of PTSD in the 1980's in which PTSD was conceptualised as a distinct disorder (Prigerson & Jacobs, 2001).

A three step search strategy was used in order to locate relevant papers. An initial limited search of Cochrane and Campbell Collaborations, PsycInfo, Web of Knowledge (WoK), and Google Scholar was undertaken in order to locate any relevant systematic reviews or primary research studies as a scoping exercise. Reference lists of related systematic reviews and accepted papers were also scanned in order to locate potentially relevant primary research studies. Next, a full search was conducted using all relevant terms relating to (1) person

specification – adult offenders (2) context – homicide offenders (3) Trauma/PTSD and (4) Complicated grief. See table 1 for a complete break-down of search terms.

Table 1: Search Terms

Person Specification	(Adult) **AND**
Context	(Homicide) OR (homicide offend*) OR (Murder*) OR (KILL*)
Trauma	(Trauma*) OR (PTSD) OR (PTS) OR (post-traumatic stress) OR (post-traumatic stress disorder) OR (posttraumatic stress) OR (posttraumatic stress disorder) OR (trauma) OR (distress) OR (difficulties) OR (issues) OR (coping) OR (cope) OR (well-being) OR (depression) OR (anxiety) OR (stress)
Complicated Grief	**OR** (complicated grief) OR (complex grief) OR (complicated grief disorder) OR (CGD) OR (grief) OR (bereavement) OR (Loss)

Furthermore; grey literature, e-Thesis websites and experts in the field were also contacted in order to locate unpublished research. The third stage of the search strategy involved scanning reference lists of accumulated primary studies in order to locate further potentially relevant papers which had not already been captured. See table 2 for a comprehensive list of resources.

Table 2: Resources

Primary Searching	1. Cochrane Collaboration Library (*searched during scoping exercise: see below)*
	2. Campbell Collaboration Library (*searched during scoping exercise: see below)*
	3. PsycINFO (OVID 1970 – present)
	4. APA PsycNET (1970 – present)
	5. EMBASE (OVID 1970 – present)
	6. Medline (OVID 1970 – present)
	7. ASSIA: Applied Social Science Index and Abstracts
	8. Web of Knowledge
	9. Google Scholar
Secondary Searching	OpenGrey Portal
(Grey Literature)	*E-Thesis Websites*
	1. DART: Europe E-Thesis Portal
	2. University of Nottingham E-Thesis Portal
	3. University of Birmingham E-Thesis Portal
Experts	Dr Friedman, The VA's National Center for PTSD
	Dr Papanastassiou, Consultant Psychiatrist
	Dr Pollock, North & West Belfast Health and Social Services Trust, Northern Ireland

4.0 SELECTION OF STUDIES

4.1 Inclusion process

Following execution of the search strategy, titles and abstracts were scanned for relevance to the present review. Articles immediately noted to be irrelevant were discarded. Further inspection of the remaining abstracts was undertaken and those found to have no relevance at that stage were also discarded. Detailed inclusion criterion are shown in table three.

Table 3: Inclusion Criteria

	Inclusion	**Exclusion**
Population	1. Adult men and women (>18 years) 2. Homicide offenders (Remanded to prison, serving a prison sentence for a criminal offence, on licence for a criminal offence, serving a community sentence for a criminal offence, disposal to mental health settings, or community mental health settings.)	1. General offenders who have not committed homicide 2. Adolescent homicide offenders (<18)
Exposure	Commission of an offence of homicide	No homicide
Comparator	No comparator or other types of adverse experience	None
Outcomes	1. Formal diagnosis of PTSD via structured clinical interview (including but not limited to: The SCID*, PTSD symptom scale interview**, SI-PTSD: structured interview for PTSD***, and the	N/A

	CAPS: Clinician Administered PTSD Scale****) or diagnoses by use of self-report measures (including but not limited to: The PCL; PTSD check list^, The DTS; Davidson Trauma Scale^^, The PDS; Post traumatic stress diagnostic scale^^^, DAPS detailed assessment of post-traumatic stress^^^^). 2. Complicated grief measured by the ICG; Inventory of complicated grief or other validated tool. 3. Mental health difficulties identified through standardised assessment tools thought to be associated with trauma, such as anxiety and depression.	
Context	1. State and private prisons 2. State and private forensic mental health services 3. Community based settings e.g. probation/community mental health services	Non-forensic settings
Study Design	All types of quantitative study: a. RCT b. Non-randomised controlled trials c. Quasi experimental d. Before and after e. Observational studies	Reviews, opinion papers, qualitative research.

* *(First, Spitzer, Gibbon, and Williams, 1996)*

** *(Foa, Riggs, Dancu, and Rothbaum, 1993).*

*** *(Davidson, Kudler, and Smith, 1990).*

**** *(Blake et al., 1995).*

^ *(Weathers et al., 1993)*

^^ *(Davidson et al., 1995)*

^^^ *(Foa, 1995)*

^^^^ *(Briere, 2001)*

5.0 QUALITY ASSESSMENT

Guidelines from the Critical Appraisal Skills Programme (CASP, 2011) checklist were followed to assess the quality of each study selected for inclusion following a full text review. The checklist was adapted to be relevant for all observational studies, including cross-sectional studies. Appendix One shows the adapted version of the CASP used in this study, and includes guidelines for its use in this context. The guidelines are useful because without these the CASP as a standalone proforma could overestimate the quality of the studies by not taking into account the risk of bias. For example, the checklist considers selection bias, measurement bias and classification bias, confounding and generalisability, through eleven questions.

The purpose of these questions is to understand the extent to which features of the study introduce bias; affecting the overall validity of the study. Although the CASP framework does not apply a strict scoring system; there is a model for applying a numerical score whereby the paper is categorised as either: a 'key paper' ('conceptually rich and could potentially make an important contribution to the synthesis'); a satisfactory paper (a paper that is irrelevant to the synthesis); and a fundamentally flawed paper (a methodologically fatally flawed

paper) (Toye et al., 2014). The concepts of a 'fatally flawed' and a 'satisfactory' paper are not defined, but it is suggested that they are intuitive judgements made by the appraiser, however 'fatally flawed' papers consistently scored below 20 on CASP (Toye et al., 2014). With this in mind and for the purposes of this review the categories are relabelled 'unsatisfactory' (a score below 20); 'satisfactory' (a score of 20-25) and 'good' (a score of 25-30). Although a cut off for the latter is not recommended, application of a numerical score allows for closer comparison of the categories.

Ideally, the literature advocates the use of a second reviewer to assess all papers and agreement would be made about quality and inclusion (Van Tulder, Furlan, Bombardier, Bouter, & Group, 2003). However, for the purposes of this review, a second reviewer assessed 33% of the six total papers using the same checklist, in order to ensure inter-rater reliability, with an 81% agreement.

6.0 DATA EXTRACTION

Differential extraction techniques can introduce data extraction bias (Yeaton & Wortman, 1993). It is therefore good practice to ensure a standard proforma is used to capture the same data

across studies. For this review, an adapted version of the STROBE checklist (Von Elm & Egger, 2004) will be used in order to extract relevant data. Appendix one shows a template of the checklist, and includes data extraction template notes to demonstrate how the proforma was reliably used for all studies. The Strobe was not technically designed as a data extraction checklist, however, it provides a useful framework from which to ensure relevant information is suitably extracted, thus increasing the validity of the review (da Costa, Cevallos, Altman, Rutjes, & Egger, 2011).

7.0 SCOPING EXERCISE

In order to establish feasibility of the review, a scoping exercise was completed on 26th March 2015. The purpose of which was to locate potential systematic reviews which may be relevant and primary research studies. Cochrane and Campbell Collaboration Libraries were searched along with Google Scholar, PsycInfo and Web of Knowledge (WoK), using a limited selection of the search terms outlined in Table four.

7.1 Scoping Search Results

The Cochrane Library yielded 5 results, none of which were relevant as they focussed on studies of PTSD in the families of

genocide survivors or of families who have lost a member by homicide. There were no hits at all from the Campbell collaboration library. There were 12 hits from PsycInfo, however none were relevant as they too focussed on victims of homicide. A WoK search found 7 results, 2 of which were duplicates of those found in the google scholar search. A related paper, concerning violent offenders with PTSD was found and downloaded, and its reference list searched for relevant journals (Gray et al., 2003). There were 14,600 results in Google Scholar, many of which were either studies of juveniles, the victims of homicide, or were studies of PTSD in general offenders/violent offenders rather than relating to homicide specifically. A search of the first 25 pages produced the findings shown in table 4.

Table 4: Scoping Search Results

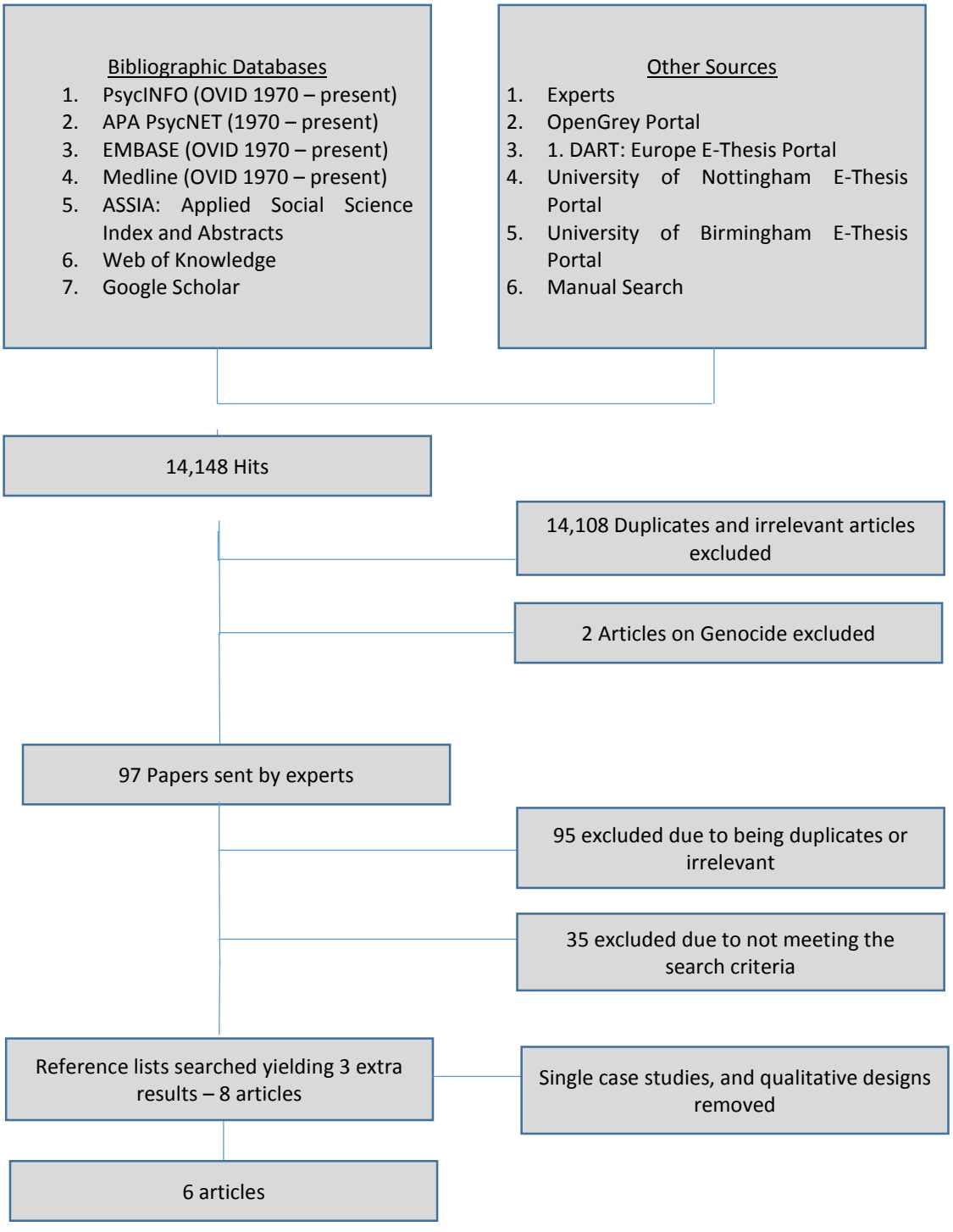
Web Of Knowledge Results
1. Hambridge, J. A. (1990) The grief process in those admitted to Regional Secure Units following homicide. J*ournal of Forensic Sciences*1990; 35, 1149–1154.
2. Harry B, Resnick P. J. (1986). Posttraumatic stress disorder in murderers. *Journal of Forensic Sciences*, *31,* 609–613.
Google Scholar Results
1. Fraser, K. A (1988) Bereavement in Those Who Have Killed, *Medicine, Science and Law, 2,* 127-130.
2. Pham, T. and Willocq, L. (2013) Evaluation of traumatic stress in incarcerated homicide offenders, *Acta Psychiatrica Belgica, in press.*
3. Papanastassiou, M., Waldron, G., Boyle, J., Chesterman, L. (2004). Post-Traumatic Stress Disorder in mentally ill perpetrators of homicide, *The Journal of Forensic Psychiatry & Psychology, 1*, 66-75.
4. Pollock, P. (2010) When the killer suffers: Post-traumatic stress reactions following homicide, *Legal and Criminological Psychology, 2,* 185–202.

The scoping study found that there are no existing literature reviews specifically concerning PTSD in adult homicide offenders. Preliminary scanning of the above studies indicates that they may be relevant to the study, further supporting the feasibility of this review. The initial scoping review indicates that research in this area has been sparse, lending support to the need for a focus in this area.

8.0 SEARCH RESULTS

The search terms yielded 14,148 'hits' across all databases. Duplicates were removed and article titles and abstracts scanned for relevance to the subject matter. Manual searches were conducted across all databases. There were just 37 relevant articles. These were imported into endnote and downloaded. Experts sent 97 studies, of which only 2 were not duplicates already found during the initial search. Case studies and qualitative studies were removed leaving a total of 6 studies to review. Main reasons for exclusion include (1) Article focussed on trauma symptoms in victims of crime (2) Article focussed on PTSD as a precursor to homicide rather than result (3) didn't meet search criteria i.e. used juvenile participants, was single case study or was qualitative by design or (3) The offence was diluted i.e. in the case of the genocide studies whereby the perpetrators included sexual and other violent offences in addition to homicide. In appendix two, a table illustrates all the reasons that specific studies were excluded. Figure 2. Outlines the search results in greater detail.

Figure 2. Search Results



8.1 Characteristics of Included Studies

All participants within the selected studies were incarcerated adult homicide offenders aged 18 and above. One study did not give details of the ages of the participants, however, as they were taken from adult facilities (RSU, Prison, Remand) with no mention of juvenile services, it was assumed that they were adults aged 18 years and above (Pollock, 1999). The included studies originated from Northern Ireland, England and Belgium. Males and females were included within this review, with three of the six studies including women. However in one study there were just 4 females out of 46 participants (Pham & Willocq, 2013), in the second, just 3 of 19 participants were female (Papanastassiou, Waldron, Boyle, & Chesterman, 2004) and in the third just 5 of 37 participants were female (Gray et al., 2003). All but one of the selected studies studied participants from a forensic mental health setting. However, a second study showed that the majority of their sample were drawn from a prison population and had no prior history of psychiatric illness (Pollock, 1999a). Four of the six studies used PTSD as the main outcome measure, a third measuring acute stress and the fourth measuring trauma more generally. Other measured variables included; depression, anxiety, guilt, partial PTSD, offender typology, type of violence used (reactive or instrumental), acute stress, intelligence quotient (IQ), impact

of event, attributional style, and psychopathology. Main findings from the selected studies are illustrated in table 5.

8.2 Quality of Included Studies

Of the six studies, two were rated 'good' and four rated 'satisfactory'. A breakdown of their scoring is shown in table 6.

Table 5: Table of findings from included PTSD and Homicide Studies

Authors, Year & Country of Study	Participants	Age (years)	Number (N)	Type of Study	Variables	Key Findings
Maria Papanastassiou Gerard Waldron John Boyle Laurence Chesterman 2004, London, UK	3 women 16 men	20-65	19	Cross Sectional	PTSD Partial PTSD Guilt	58% of patients had full PTSD at some time since their index offence. 21% met criteria for partial PTSD. 84% expressed significant guilt regarding their index offence. If the victim was a family member, the patient was more likely to develop PTSD. The relationship between the presence of guilt and development of PTSD was statistically significant. The relationship between early adverse events and development of PTSD was also significant indicating that early adverse events reduced the likelihood of developing PTSD after homicide for this population. There was no significant relationship between previous violent offending and PTSD.
Philip Pollock, 1999 Northern Ireland	80 Male	Unknown	80	Cross Sectional	PTSD Offender typology Violence: instrumental/reactive	52% met criteria for current PTSD diagnosis. Reactive violence was associated with 95% of these diagnosed cases. 82% of these cases reported the index offence to have been traumatising. 70% of the offenders with a PTSD diagnosis described no other trauma in their histories.

Thierry Pham Lawrence Wilcocq 2013, Belgium	42 men 4 women 23 homicide offenders 23 non-homicide offenders	Average age 33.48	46	Quasi-experimental cross sectional	Acute Stress Traumatic Stress Offences committed Age IQ	Acute stress disorder diagnoses were higher among homicide offenders (65%), compared with non-homicide offenders (35%). Those who reported homicide as their most traumatic event met the criteria for acute stress disorder (92%) compared to those who chose a non-homicide event (33%). Amongst homicide offenders, 56.5% gave homicide as their most traumatic event.
Christine Elizabeth Curle, 1989 London, UK	82 Male homicide offenders	Mean age at offence =30	82	Cross Sectional	Offender typology Trauma Attributional Style psychopathology	¾ suffered at least one symptom of stress response since the offence, distress was the most common symptom (41%). Pseudo hallucinations were low at 12%. Symptoms were at their worst within three years of the killing. 35% showed avoidance presently or in the past while denial was low, 22% denied at some point since the offence, only 1 person maintained their innocence at the time of interview. Those with mental illness rather than Personality Disorder were more likely to experience distress, and killing a family member or stranger was more traumatic than killing a spouse or lover.
Nicola Gray Nicole Carman Paul Rogers Malcolm MacCulloch Peter Hayward	32 Males, 5 female mentally disordered offenders. Not all homicide offenders but compared homicide	Mean age 35	37	Cross Sectional	PTSD Anxiety Depression Impact of event	The murder group scored significantly higher on the impact of events scale and demonstrated more intrusive symptoms than the violent group.

Robert Snowden. 2003, UK	separately so included in review.					
Elizabeth Payne Andrew Watt Paul Rogers Mary McMurran, 2008, UK	26 Male offenders – not all homicide offenders but included as compared homicide to other offenders.	Mean age 33.8	26	Cross Sectional	PTSD Impact of Event Trauma history	27% of the 15 prisoners who had killed met all criteria for current PTSD diagnosis The apparent slight difference in impact of event scores between killers and non-killers was not significant.

Table 6: Quality assessment of selected studies

	Papanastassiou et al. (2004)	Pollock (1999)	Pham and Willocq (2013)	Curle (1989)	Gray et al. (2003)	Payne, Watt, Rogers, and McMurran (2008)
Are the aims of the research clearly stated?	3	3	3	3	3	2
Was the stated method appropriate to answer the research question?	3	2	3	3	3	3
Were participants recruited in an acceptable way?	2	2	1	2	2	2
Were the measures used appropriate and accurately measured to reduce bias?	3	3	1	2	2	3
Were confounding factors taken into account or acknowledged?	3	3	2	2	2	3

	1	1	1	1	1	1
FOR COHORT STUDIES ONLY: Was follow up of participants complete and long enough?						
Were the methods of analysis appropriate?	2	2	2	3	2	3
Was the data analysis sufficiently rigorous?	2	2	2	3	3	3
Are the results precise? Is there a clear statement of findings?	2	2	2	3	3	3
Can the results be applied to the local population?	1	1	1	1	1	1
Do the results fit with the existing research?	3	3	2	3	3	2
Total Rating	**25 Satisfactory**	**24 Satisfactory**	**22 Satisfactory**	**26 Good**	**25 Satisfactory**	**26 Good**

8.3 Sampling

The included studies were not wholly representative of the population, and as such did not achieve the maximum score of 3. Papanastassiou et al. (2004) had a sample of just 19 purposively selected mentally disordered offenders, taken from one medium security facility in London. Men and women were not equally represented (Men =16, Women = 3) and there was no mention of ethnicity or social background. As a result of this it is unclear as to the extent the findings from this study could be generalised to the population of homicide offenders, inclusive of those without a pre-existing mental illness or disorder.

Pollock (1999a) had a sample of 80 male homicide offenders, who were not randomly selected but were obtained from consecutive referrals to a clinical psychologist working as part of a multidisciplinary team in secure hospital and prison settings. The nature of the referral varied across all participants (e.g. internal review of the case, difficulties adjusting to prison, part of admission assessment to hospital) and this process may have biased participant recruitment. However, the nature of the sample did entail that offenders from a variety of environments (i.e. criminal justice and mental health) were included, although

this was perhaps counteracted by their subsequent referral to a mental health service.

Pham and Willocq (2013) sampled 46 French-speaking prisoners from two high-security facilities in Belgium, with an unequal representation of men and women (42 men, 4 women). Participants were assigned to the homicide and non-homicide offender groups on the basis of four different sources of information: (a) criminal record specifying the individual's offence pathway; (b) admission file indicating reason for latest prison term; (c) essay of facts describing course of offence; and (d) forensic psychiatric expert opinion. The two groups were matched in terms of intelligence quotient (IQ) and age. For the homicide offender group, prisoners were chosen who had committed at least one homicide or attempted homicide. With this in mind, it cannot be concluded that the homicide group are representative of homicide offenders more generally, particularly given that the trauma responses in those who didn't succeed in killing their victim are likely to be different from those that did. The study doesn't state what proportion of the homicide group is made up of attempted homicide offenders and so this study lost points on this criterion. Finally, the sample

size is also particularly small, with just 23 offenders in each group.

Curle (1989) included 82 Male homicide offenders from within Broadmoor high security hospital. She described her sample as 'highly selected' in that to be admitted to Broadmoor in the first instance they must be considered to be acutely unwell or disordered and as a result they were not only unrepresentative of homicide offenders in general, but possibly were also not representative of mentally disordered homicide offenders. She approached all male homicide offenders within the hospital for participation in the study, based on whether they had killed someone. The average length of time since the offence varied greatly, with over 60% killing their victim more than ten years ago, which may impact on the results. She also included offenders who were young adolescents at the time of their offence. Being adolescent was an exclusion criterion to this study as the factors motivating their offences are suspected to differ along with their emotional reaction to it. However, the vast majority (all but one) of the participants were adults and so the study was included. Moreover, the individual was adult at the point of assessment.

Gray et al. (2003) approached all current inpatients in a medium security psychiatric hospital who were judged to be able to give informed consent to participate in the study. Not all participants were homicide offenders however the study was included on the basis that they considered homicide separately and compared incidences of trauma in that group to that of other offenders. 16.2% of their sample were homicide offenders compared to other violent, non-sexual offenders (51.4%), rape (8.1%), paedophilia (13.5%), arson (8.1%), and kidnapping (2.7%). At 37 participants the sample was small, with 5 females and 32 males.

Payne et al. (2008) randomly selected 27 of 56 life sentenced prisoners to take part in their study, and as such this was the only study to employ some form of randomisation in the selection of participants. The sample was divided into killers (n=15) and non-killers (n=11) with one prisoner refusing to participate.

It is noteworthy that recruitment and selection of participants within a secure setting is not straightforward. Access to participants is often limited and restricted by the prison regime and structure and there are ethical considerations when

recruiting mentally ill participants, particularly concerning their capacity to provide informed consent. By virtue of their offence, it could also be argued that participants have demonstrated higher levels of anti-sociality and as such are less likely to conform to rules, meaning that refusal and attrition may be higher in this population, providing an extra challenge to researchers.

8.4 Design

All of the studies included within this systematic review were appropriately designed given the difficulties in accessing and researching this population. All were cross sectional by design. Pham and Willocq (2013) included a comparison group in their quasi-experimental study, albeit small in size, and Payne et al. (2008) and Gray et al. (2003) compared homicide to other offences in terms of trauma outcomes. While it is difficult to assess the direction of the relationship in cross-sectional research, all studies went to reasonable effort to control for other factors influencing the development of PTSD in their sample, for example pre-existing mental illness or traumatic events other than homicide. This was achieved through statistical analysis measuring trauma responses to specific events and/or offences, or through direct questioning of

offenders and adaptation of measures to make them homicide specific. The implications of this are discussed later in this review.

Only one study discussed power when considering their sample size, and they concluded that a power calculation was unnecessary on the basis that in their analyses their t values were very low and p values were well outside the liberal alpha value (0.05). The probability of type II error was therefore low, and power analyses to estimate the sample size necessary to observe significant differences were deemed unnecessary (Payne et al., 2008). This is nonsensical given that their findings indicated increased trauma responses in homicide offenders which was then found to be statistically insignificant. Given their particularly small sample (n=26) it could be argued that a larger sample, as indicated by a power analysis, may have yielded a significant finding.

None of the other studies included power calculations and as such it is unclear as to the appropriateness of the sample sizes, although it is recognised that the sample sizes in the Papanastassiou et al. (2004) and Payne et al. (2008) studies were particularly small, at 19 and 26 respectively. In this field

of research it would appear that power analysis and sample size justification have been largely overlooked. This could be due to the aforementioned issues with accessing the population, and the exploratory nature of research within this group of offenders. However, this is an important requirement, as inadequate power or a small sample could significantly bias results, which, in the longer term, could lead to the implementation of practices or interventions which are ineffective.

There is little mention in any of the studies about the handling of missing data or values, although it is acknowledged that the measures were generally administered via clinician interview rather than self-report and as such the risk of missing values is somewhat minimised, with Curle (1989) noting this specifically.

The measures were reliable, although varied in their appropriateness for the task. Papanastassiou et al. (2004) used the Clinician-Administered PTSD Scale (CAPS) (Blake et al., 1995), a structured clinical interview designed to assess adults for the 17 symptoms for PTSD outlined in DSM-IV, as well as five associated features (guilt, dissociation, derealisation, depersonalisation and reduction in awareness of surroundings).

Papanastassiou et al. (2004) state that the CAPS was chosen over a wide variety of PTSD measures because of its excellent psychometric properties (high reliability, sensitivity and specificity), however the authors do not report exact figures of reliability estimates.

That said, other research has reported the value of Cronbach's alpha and inter-rater agreement as .95 and .89 respectively for this tool, and report that the CAPS is highly correlated with the impact of events scale, IES (r=.80), Beck Depression Inventory, BDI (r=.70), and the state-trait anxiety inventory, version 2, STAI-II (r=.56). 82% overall agreement was shown between the CAPS and clinical diagnosis, indicating that it shows a reasonable degree of reliability and validity and operates as a valuable tool to diagnose PTSD (Lee et al., 1999). The CAPS generates DSM-IV diagnosis of PTSD and is advocated for use in research in offender populations (Pollock, 1999a; Spitzer et al., 2001). The CAPS was altered slightly in order to ensure that homicide was the traumatic event under examination, and while the authors claim that the psychometric qualities were preserved, the validity of the tool may have been compromised.

Pollock (1999a) used the PTSD-I; PTSD Interview (Watson, Juba, Manifold, Kucala, & Anderson, 1991). Pollock (1999a) did not report on the specific reliability figures of the PTSD-I, although research indicates that it demonstrates very high internal consistency (alpha = 0.92) and test-retest reliability (Total score r = 0.95; diagnostic agreement = 87%). It is also reported to correlate strongly with the DIS; Diagnostic Interview Schedule criteria (Total score vs. DIS diagnosis r_{bis} = 0.94, sensitivity = 0.89, specificity = 0.94, overall hit rate = 0.92, and kappa = 0.84) (Watson et al., 1991). However, the conclusions which can be drawn reliably from the study are compromised by the fact that the measure administered to examine PTSD was derived from DSM-III-R criteria, and not DSM-IV. This is because Pollock (1999a) gathered his data over a five year period, which saw the introduction of the DSM-IV, a new conceptualisation of PTSD, and new tools with which to measure it.

Pollock (1999a) also used the SHAPS; Special Hospitals Assessment of Personality and Socialisation (Blackburn, 1986). Previous research has identified the SHAPS as an effective tool in examining risk of violent recidivism and the domains of sexual interest and distorted thinking. Each profile was scored

using guidelines provided by Blackburn (1996) for assigning participants to one of the four groups (primary psychopathic, secondary psychopathic, controlled, and inhibited). Ratings of form of violence was also used to reliably distinguish reactive from instrumental violence (Cornell et al., 1996).

Pham and Willocq (2013) utilised the Stanford acute stress reaction questionnaire (SASRQ) (Cardena, Koopman, Classen, Waelde, & Spiegel, 2000) for which satisfactory internal consistency coefficients have been obtained; from 0.64 to 0.98 for subscales; and from 0.80 to 0.95 for items overall (Pham & Willocq, 2013). It possesses good convergent validity, especially with the IES, $r>0.75$ and constitutes a good predictor of the PTSD diagnosis (Pham & Willocq, 2013).

However, the SASRQ is designed to assess acute stress disorder (ASD) within the first 30 days of the traumatic event, and in the Pham and Willocq (2013) study, traumatic stress was not evaluated immediately after the traumatic event but much later in the participants' prison term. Therefore, it is likely that participants actually reported PTSD rather than ASD. This is a limitation acknowledged by the authors who therefore emphasise that ASD is a predictor of PTSD and that the SASRQ

correlates with the IES, however, given that the participants had been incarcerated for an average of one year at the time of evaluation, a tool specifically designed to assess PTSD seems more appropriate.

Curle (1989) used interview to assess trauma symptoms. However, they did not use a validated interview for trauma when at the time there would have been interview schedules available for this purpose such as the aforementioned DIS (Diagnostic Interview Schedule) (Robins, Helzer, Croughan, & Ratcliff, 1981). However, their interview did allow for the exploration of symptoms not necessarily known to be relevant to homicide offenders, and it is noteworthy that there was, and still is, no tool specifically designed to measure trauma related to the perpetration of homicide. This is problematic because researchers are using tools based on research of trauma caused by other life events, which may not be applicable to those who kill. Even though Curle (1989) did not use a standardised interview to assess for PTSD, the study was included on the basis that they cross referenced their findings with file information and formal diagnosis for each participant, thus providing some triangulation of evidence for their conclusions.

This study also examined denial, avoidance and rationalisation, and used the LACS – Leeds attributional coding system (Stratton, Munton, Hanks, Heard, & Davidson, 1988). Test probes were used to test for trauma responses, (Rachman, 1980) but are criticised because of the lack of certainty surrounding whether it is possible to invoke stimuli of the event in this way. However, Curle (1989) maintains that this tool was simply used to bolster the findings from the interview. Finally, the CPRS; comprehensive psychopathological scale (Åsberg, Montgomery, Perris, Schalling, & Sedvall, 1978) is a standardised measure of psychopathology and was implemented although it is noted that this may just measure mental disorder already present in the population rather than that arising as a result of the homicide offence itself.

Gray et al. (2003) used information from interviews to establish the presence of PTSD symptoms based on DSM-III-R criteria. They did not use a validated interview assessment such as the DIS. It is also unclear as to why they utilised DSM-III-R criteria over the DSM-IV-R which will have been available at the time. They used information from depositions to reinforce the validity of the information gained at interview. However, they noted that 27% were too distressed to participate in the semi-structured interview and that as a result, their incidence rates

for DSM III-R PTSD may be an underestimate. Each participant also completed the following psychometric scales: (1) the Impact of Events Scale (IES) (Horowitz, Wilner, & Alvarez, 1979) (2) the Beck Depression Inventory (BDI) (Beck & Steer, 1987) and (3) the State-Trait Anxiety Inventory(STAI) (Spielberger, Gorsuch, & Lushene, 1970), all of which are considered reliable and valid tools.

Payne et al. (2008) used the Posttraumatic Stress Diagnostic Scale (Fao, 1995). The PDS diagnoses PTSD according to the DSM-IV diagnostic criteria (American Psychiatric Association, 1994). As well as diagnosing PTSD, it also provides information about symptom severity and has demonstrated good reliability and validity (Foa, Cashman, Jaycox, & Perry, 1997; Foa, Riggs, Dancu, & Rothbaum, 1993). Although no written amendments were made to the original PDS, some verbal suggestions were given to all participants on items that were problematic due to incarceration (work, household chores and duties, relationship with friends, etc.) which may have impacted on the reliability of the tool. This highlights the difficulty in using such instruments for this population, where incarceration makes it challenging to answer questions related to general satisfaction in life.

Two studies addressed reliability of the measures in their own data. Pham and Willocq (2013) calculated that the SASRQ's internal consistency was satisfactory, with an alpha coefficient of 0.92, which is in line with coefficients obtained in previous studies (Cardena et al., 2000). The tool was also found to be highly correlated with the IES (0.74). Papanastassiou et al. (2004) did test for inter-rater reliability for administration of the CAPS, however exact figures are not reported.

8.5 Analysis

Papanastassiou et al. (2004), Pham and Willocq (2013) and Payne et al. (2008) provided a rationale for the analysis used within their studies, whereas the other studies did not. None of the studies described the statistical measures appropriately, and there was no description given of basic tests in any of the articles. However, all studies accounted for confounding variables. For example, Papanastassiou et al. (2004) aimed to specifically measure PTSD in mentally ill perpetrators of homicide, so they ensured they had screened for Personality Disorder as a potential confounder. This is important because individuals with a personality disorder may not necessarily have a mental illness, but their personality traits may have an impact on their experience of PTSD (Golier et al., 2003). Individuals

with personality disorder have increased incidence of early adverse experiences, such as childhood abuse and trauma, and have been found to be twice as likely to develop PTSD later in life (Golier et al., 2003). The authors also made certain that they were measuring homicide induced PTSD rather than general trauma by altering the CAPS administration and by administering the life events check list to screen for other traumatic events.

Pollock (1999a) also controlled for non-homicide related trauma, though this was achieved by asking the participants directly which could render them vulnerable to response bias. To counter this, they obtained a clinician view of their symptoms, and controlled for non-offence trauma statistically by use of one-way analyses of variance (ANOVA) which investigated the effect of non-offence trauma categories on participants' PTSD presentations.

Pham and Willocq (2013) selected a tool (the SASRQ) that could measure the type of traumatic event and as such controlled for non-offence related trauma, however they didn't control for gender and they included attempted homicide offenders in their 'homicide' sample which could have had a significant impact on

their findings. Curle (1989) used both clinician and patient report to ascertain whether or not the trauma symptoms were related to the offence or other trauma symptoms more generally, though did report that the heavy reliance on participant self-report was problematic.

Because of the limited research in this area, it would be difficult to interpret the findings in relation to normative data, although Gray et al. (2003) did do so. They found a mean IES score of 25.8 (SD = 21.4). This compares with a mean score of 6.9 (SD = 6.8) in the general population, and 35.3 (SD = 22.6) in a population of people attending a stress clinic. It is problematic to compare levels of PTSD amongst homicide offenders to PTSD in the general population, as we are interested primarily in whether there is something specific about perpetrating a homicide offence. Many homicide offenders, as with the general population, will have other traumatic events in their lives, but these were accounted for in these studies such that the authors could explore the psychological consequences of murder specifically, hence comparisons are not necessarily helpful. It would have been beneficial however, for the authors to draw comparisons of levels of PTSD caused by a homicide offence, to levels of PTSD caused by other violent offending, to explore how

homicide offenders compare to their counterparts with regard to traumatic stress responses. Three of the six studies did this directly in their research (Gray et al., 2003; Payne et al., 2008; Pham & Willocq, 2013).

The other studies drew comparisons with existing literature. For example, Papanastassiou et al. (2004) compared their findings to that of Spitzer et al. (2001) and Pollock (1999a), and recognised that they yielded similar findings with regard to prevalence rates of PTSD. However, they go on to state that comparisons are difficult because Pollock (1999a) conducted the research on a prison population. This may be true in the sense they originally received disposal to the criminal justice system, however Pollock (1999a) does state that participants were referred to a clinical psychology department of a regional forensic psychiatric service, so the assertion that they were not mentally disordered is questionable. Papanastassiou et al. (2004) goes on to report that they examined PTSD specifically related to the offence of homicide, whereas the other cited studies examined PTSD following a variety of traumatic events. This is true only for Spitzer et al. (2001), as Pollock (1999a) clearly set out to examine PTSD in homicide offenders.

Pollock (1999a) draws comparisons with Kruppa et al. (1995) who examined the prevalence of PTSD in a high security hospital, and states that they discovered much higher levels in their research, although they do not report the exact figures of the study, which is unhelpful for the reader. Pham and Willocq (2013) compared their study to findings from a larger body of research and note that data from the scientific literature suggests that homicide perpetrators are vulnerable to severe mental disorders (Brink, Doherty, & Boer, 2001; Hodgins, Côté, & Toupin, 1998; Hodgins & Janson, 2002; Teplin, Abram, & McClelland, 1996), and that not only can mental disorders precede offending, but homicide itself can produce traumatic stress reactions (Franklin, Sheeran, & Zimmerman, 2002; Gottlieb, Gabrielsen, & Kramp, 1987; Mueser, Rosenberg, Goodman, & Trumbetta, 2002; Schanda et al., 2004). However, the studies cited by Pham and Willocq (2013) address PTSD more generally than the articles included in this review. As the earliest study in this review, Curle (1989) had very little literature with which to draw comparisons. However they referenced case studies which found similar trends in terms of traumatic or bereavement responses in homicide offenders (Brunning, 1982; Fraser, 1988). In summary, all but one of the studies reported some significant findings, with significance levels no lower than to the .05 level, lending support to their

hypotheses (Curle, 1989; Gray et al., 2003; Papanastassiou et al., 2004; Pham & Willocq, 2013; Pollock, 1999b).

9.0 DESCRIPTIVE DATA SYNTHESIS

There was much heterogeneity between the studies regarding the outcome measures, and indeed the measures used to capture PTSD within the study samples. This is a reflection of the change in the conceptualisation of PTSD since its recognition as a discrete disorder, and of the paucity of research within this specific field. Due to the disparate methods and measures of studies within this review, a narrative approach was taken to synthesise the data, with regard to the three stated research questions:

1. With what frequency are trauma symptoms present in homicide offenders?
2. How do trauma symptoms present in homicide offenders following the offence?
3. What factors are involved in increased trauma responses following committing homicide?

9.1 Frequency of trauma symptoms present in homicide offenders

Papanastassiou et al. (2004) found that every patient in their sample identified their homicide as a traumatic event according to the CAPS criteria. No patient described further life events that gave rise to significant PTSD symptoms, using the life events checklist. Specifically, 58% of their sample had experienced full PTSD at some time since their index offence and a further 21% met the criteria for partial PTSD. In total then, 79% of homicide offenders within this sample experienced some form of PTSD as a result of their offence. The prevalence of current PTSD was 42%, which consisted of 26% with full PTSD and 16% with the partial syndrome. With regard to other trauma responses, 84% expressed significant guilt, using CAPS criteria, regarding their index offence. Twelve participants had killed a family member. Of these, eight developed full PTSD and the remaining four developed partial PTSD (Fisher's exact = 8.85, $p<.03$) (Papanastassiou et al., 2004).

Pollock (1999a) found that of the total sample, 52% met criteria for current PTSD diagnosis. 82% reported the index offence to have been traumatising (χ^2 (1) = 21.9, $p<.01$), and 70% of offenders with a PTSD diagnosis described no other trauma in

their histories which might have accounted for their symptomatic presentation (χ^2 (3) = 12.0, p<.01).

Pham and Willocq (2013) reported that the SASRQ yielded a higher prevalence of ASD diagnoses among homicide offenders (65%), compared with non-homicide offenders (35%), χ^2=4.261, *p*=.039. The former also obtained higher SASRQ total scores than did the latter, t(44)=-2.26, *p*=.015. The difference was particularly salient on the avoidance subscale, t(44)=-3.27, *p*=.025.

Curle (1989) found that overall, 75% of their sample suffered at least one symptom of stress response since the offence, distress being the most common symptom, with 41% of participants experiencing it. Symptoms were at their worst within three years of the killing. Just 20% appear never to have shown a stress response at some time since the killing. 20% showed symptoms in the past which are now remitting and 33% showed some remittance in some symptoms and a further 26% had symptoms which had not remitted.

Gray et al. (2003) conducted a one-way ANOVA comparing the murder group with the violent group and found a marginally significant effect on total IES scores ($F(1,23) = 2.43$, $p = .065$). A similar comparison on intrusive symptoms was significant ($F(1,23) = 2.96$, $p<.05$) while that of avoidant symptoms was not ($F(1,23) = 1.41$, $p>.1$).

Payne et al. (2008) presented results which were anomalous to the other studies in this review, and was the only study to find no difference between homicide offenders and other offenders in levels of reported trauma. Eight (31%) of the whole sample met all four of the DSM-IV criteria for current PTSD diagnosis. Within this group, four of the participants reported their index offence as the event on which the diagnosis was based, all four being murderers. Thus, 27% of their 15 prisoners who had killed met all criteria for current PTSD diagnosis. However, independent samples t-tests confirmed that the apparent slight difference in total IES-R scores between killers and non-killers ($t(24) = .23$) was non-significant.

Overall, prevalence rates of PTSD ranged from 52-58% for homicide offenders (Papanastassiou et al., 2004; Pollock, 1999a) and this was as high as 80% inclusive of partial PTSD

or some other form of distress (Curle, 1989; Papanastassiou et al., 2004). 65% of homicide offenders experienced acute stress disorder, compared to 35% of non-homicide offenders (Pham & Willocq, 2013).

9.2 The presentation of trauma responses following homicide

The presentation of trauma responses refers to the particular symptoms of PTSD, or individual emotional/trauma responses to homicide. Papanastassiou et al. (2004) reported that there is overlap between the symptom profile of PTSD and depression, as well as abnormal grief reactions. In their study, those who killed a family member were significantly more likely to suffer from PTSD after the offence, which is perhaps a result of experiencing bereavement in addition to PTSD. They also found that guilt was strongly related to PTSD, a finding which is consistent with previous case reports (Harry & Resnick, 1986; Rynearson, 1984). It is perhaps not surprising that those who have some capacity for guilt in relation to their victim appear more likely to develop post-traumatic symptoms.

Pham and Willocq (2013) explored disorders among the homicide offenders and found that alcohol abuse had the

highest prevalence at (50%), followed by depression (40%), somatic disorders (30%), and phobic disorders (25%), however, these were not thought to be as a result of the offence itself and were also found amongst the non-homicide offenders, albeit to varying degrees. The most prevalent disorders for non-homicide offenders were alcohol abuse (70%), generalised anxiety (35%), depression (30%), somatic disorders (25%) and phobic disorders (25%).

Within this study, the vast majority of the participants who reported homicide to be their most traumatic event met the ASD criteria on the SASRQ (92.3%), compared with one third of those who chose a non-homicide event (33%), $\chi^2=12.98$, $p<.001$. Furthermore, the two event categories differed significantly in terms of SASRQ total score, $t(44)=2.90$, $p=.003$. More specifically, homicide generated significantly more avoidance symptoms than did non-homicide events, $t(44)=4.76$, $p<.001$, while the other subscales did not discriminate significantly between the two event categories (Pham & Willocq, 2013), indicating higher levels of avoidance in homicide offenders following the offence.

Curle (1989) found that of a possible 40 symptoms with a maximum score of 3 per symptom on the comprehensive psychopathological scale (CPRS), an average score of 15.5 was observed, the most common being issues with concentration. On only 11 symptoms did patients score as pathological. 24% had concentration difficulties, and 19% experienced agitation. 17% had a severe or incapacitating illness, 38% moderate. 35% showed avoidance presently or in the past while denial was low, 22% denied at some point since the offence, with only 1 person maintaining their innocence at the time of the interview. Gray et al. (2003) found no particular PTSD symptom to occur at a rate higher than any other.

9.3 Factors involved in the development of trauma responses amongst homicide offenders.

Papanastassiou et al. (2004) found that in their sample, 63% suffered from schizophrenia, 11% each had a delusional disorder, major depressive disorder and a schizoaffective disorder, while 5% suffered from a psychotic disorder. In all, 85% were on antipsychotic medication and 58% on antidepressant medication at the time of the interview. However, from this, the impact of mental health/diagnosis on PTSD in homicide offenders cannot be said to be causal because

the figures could simply be representative of mental disorders within the hospital population as a whole. It would have been helpful to statistically explore the impact of homicide on mental health status and/or diagnosis however this was perhaps not feasible due to the small sample size.

More interestingly, several factors impacted the prevalence of PTSD in the homicide offenders. If the victim was a family member, the patient was more likely to develop PTSD. Of twelve participants who had killed a family member, eight developed full PTSD and the remaining four developed partial PTSD (Fisher's exact = 8.85, $p<.03$), and the relationship between presence of guilt and the development of PTSD was significant (Fisher's exact = 9.11, $p<.01$). The relationship between early adverse events and development of PTSD was also significant (Fisher's exact = 9.43, $p<.03$), and indicated that early adverse events (one or more of early separation from parents, physical or sexual abuse or victimisation) *reduced* the likelihood of developing PTSD after homicide in this population. This is an unusual finding given that research indicates that early adverse experiences do predispose an individual to PTSD (Andrews, Brewin, Rose, & Kirk, 2000; Golier et al., 2003; Heim, Owens, Plotsky, & Nemeroff, 1997; McLean & Gallop,

2003) and it is possible that for these individuals they had become de-sensitised to trauma or that they had developed better coping skills having previously experienced difficulties. There was no significant relationship between previous violent offending and PTSD (Papanastassiou et al., 2004).

Pollock (1999a) explored the presence of PTSD amongst different types of offender. The four types are defined as: primary psychopath (P) and secondary psychopath (S); and controlled (C) and inhibited (I). These are an elaboration of Megargee's (1966) description of violent offenders (Cited in Blackburn, 1971). Megargee (1966) suggested that aggressive behaviour occurs when anger arousal exceeds the individual's usual level of inhibitory control. For an *over-controlled* individual, an aggressive act is likely only when the instigation is intense, as a result of either extreme provocation or the culmination of instigation over time. The ensuing act will therefore match the level of instigation in its intensity. Comparisons of the personality characteristics of extreme and moderate assaulters have supported this prediction (Blackburn, 1986). Blackburn (1971) identified two types of offender showing under-controlled characteristics (P and I) and two showing traits of over-control (C and I).

The relationship between the offender typology and the form of violence is displayed in table 7, alongside the extent to which the experience of the offence was reported as traumatising and the categorisation of a current PTSD diagnosis.

Primary psychopathic offenders (P) were least likely to demonstrate reactive violence or to be diagnosed as currently suffering from PTSD or to report trauma associated with the index offence. The S type reported a mixed pattern of violence, offence-related trauma and PTSD diagnoses. C and I types were akin to one another in showing high rates of reactive violence, more self-reported offence-related trauma and a higher occurrence of current PTSD diagnosis.

Table 7: Comparison between offender types on form of violence, trauma for the offence and current PTSD diagnosis

	Offender Type				
PTSD-I scale	**Primary**	**Secondary**	**Controlled**	**Inhibited**	**χ^2**
Form of Violence (instrumental)	18	8	1	3	χ^2 (3)=36.9**
Offence Trauma	1	7	18	17	χ^2 (1)=40.3**
PTSD Diagnosis	1	9	17	15	χ^2 (1)=31.0**

**p<.001.

Of the 52% of homicide participants meeting the criteria for a PTSD diagnosis in the Pollock (1999a) study, reactive violence was used in 95% of cases (χ^2 (1) = 29.5, p<.01). Furthermore, 82% of these cases reported the index offence to have been traumatising (χ^2 (1) = 21.9, p<.01). Therefore, the hypothesis that reactive violence is associated with the development of PTSD symptoms was supported. A MANOVA examining the relationship between the form of violence and PTSD-I scales showed a significant main effect (F(3,76) = 10.46, Wilks' λ =

.60, $p<.001$) and univariate effects for the three PTSD-I symptom scales are shown in table 8.

Table 8: Table demonstrating the relationships between the form of violence and PTSD-I scales.

	Type of Violence		
PTSD-I scale	**Reactive (N=50) Mean and (SD)**	**Instrumental (N=30) Mean and (SD)**	***F Ratio***
Trauma re-experiencing	16.5 (5.9)	9.5 (6.1)	$F(1,78)=26.1$**
Avoidance	21.2 (8.2)	13.4 (8.2)	$F(1,78)=16.8$**
Arousal	19.8 (8.6)	13.5 (8.1)	$F(1,78)=10.5$**
Total PTSD Symptoms	57.6(16.2)	36.4(19.8)	$F(1,78)=26.1$**

**$p<.001$.

Higher scores were noted for reactive violence on all of the scales. For the total PTSD-I scale, a significant effect was also observed ($F(1,78) = 26.1$, $p<.001$). In summary, offender type had an effect on the development of PTSD, with greater prevalence amongst controlled and inhibited offenders, from the 'over-controlled' category. PTSD was also more likely to occur following an act of reactive violence, rather than instrumental (Pollock, 1999a). Killing a family member, and

experiencing guilt also increased the development of PTSD, whereas early adverse events decreased the likelihood of experiencing trauma post-homicide, as discussed above.

Curle (1989) performed cluster analysis on their sample of homicide offenders and found that their participants could form either two or three clusters. The three cluster level included a mental illness group (MI) in which the motivation for the offence was purely delusional, another mental illness group whereby the homicide was motivated by social factors, and was not purely delusional (MI Social) and a 'Convicted' group who were well enough to stand trial and was comprised largely of Personality Disordered offenders (Convicted). The two cluster level separated offenders simply into either mental illness (MI) or convicted groups.

There was no difference between types of offender at the two cluster level (Convicted or MI) in present trauma symptoms. However, there were differences in symptoms that occurred in the past (χ^2 (1) = 3.87, $p<.05$), with 4/5 of the MI group experiencing trauma symptoms in the past, compared to just over half of the convicted group. The three cluster group (Convicted, MI social, and MI chronic) showed no significant

differences presumably because the MI groups were so similar. A slightly higher number of the MI group have present symptoms, although this was not significant indicating that while the MI group were more likely to experience symptoms overall, these were no more likely to persist.

ANOVA was used to determine whether other variables had any impact on the number of symptoms experienced. Past violence made no significant impact, planning of the offence was not significant, but there was a significant difference for relationship to victim (χ^2 (9) = 18.37, $p<.03$). Most notable were the large number of patients who had killed family members other than their spouse or lover, and the stranger homicides, with unremitted symptoms. This was reflected in the significant relationship found for the presence or absence of current symptoms (χ^2 (3) = 7.87, $p<.05$), but not for the presence or absence of past symptoms. This reflects that while the majority of offenders experience symptoms of intrusion or denial states at some time following the homicide, this relationship to the victim appears to be important with regard to the persistence of symptoms; with those who kill family members and those who kill strangers faring worse than those who killed a spouse or lover. Those who had a motive for the offence were less likely

to experience symptoms than those that did not (χ^2 (1) = 3.97, p<.05), although this related to past symptoms only.

Gray et al. (2003) found that diagnosis and whether the offender felt the offence was deserved had an effect on trauma response. For both the affective variable (β= 0.41, t = 2.30, p<.05) and the deserved/not deserved variable (β =70.48, t =72.73, p<.05) the regression equation was found to be significant. This indicates that both these variables account for a significant amount of the variance of PTSD symptoms as measured by the IES.

As well as finding no significance in trauma responses between killers and non-killers, Payne et al. (2008) found no significant difference in trauma responses in prisoners who had used reactive rather than instrumental violence *t*(24) = 0.243. However, given that their sample was very small (n=26) the possibility of a type 2 error cannot be discounted.

10.0 DISCUSSION

10.1 Findings of the review

The aim of this review was to explore traumatic stress responses resulting from the offence of homicide. Overwhelmingly, and with just one exception, this review lends support for the idea that committing homicide is traumatic for the perpetrator, with prevalence rates of PTSD ranging from 52-58% for homicide offenders (Papanastassiou et al., 2004; Pollock, 1999a) and this was as high as 80% inclusive of partial PTSD or some other form of distress (Curle, 1989; Papanastassiou et al., 2004).

Homicide offenders were found to experience high levels of PTSD and depression as well as abnormal grief reactions (Papanastassiou et al., 2004; Pollock, 1999a). They also experience particularly high levels of guilt (Papanastassiou et al., 2004), avoidance (Curle, 1989; Pham & Willocq, 2013), decreased concentration, and increased agitation (Curle, 1989), with the experience of guilt being closely linked to the development of trauma symptoms. Homicide offenders were found to be highly susceptible to the development of acute stress disorder, which is characterised by severe anxiety,

dissociative states, and reduced emotional responsiveness (Pham & Willocq, 2013).

A number of factors were found to be related to the development of trauma symptoms. If the victim was a family member (but not a lover or spouse) the offender was more likely to develop PTSD or a trauma reaction (Curle, 1989; Papanastassiou et al., 2004). Papanastassiou et al. (2004) found that early adverse events reduced the likelihood of developing PTSD after homicide, a result they found unexpected. However, it may be that these individuals are perhaps are more accustomed, and therefore desensitised, to distress. This finding was not consistent, a separate study found that a history of adverse early events was associated with the development of trauma symptoms (Curle, 1989), so those accustomed to trauma were just as likely to experience traumatic responses to homicide; and this is supported by literature that suggests that early adverse events are a risk factor to the later development of PTSD (Andrews et al., 2000; Golier et al., 2003; Heim et al., 1997).

Curle (1989) also found that there was no difference in trauma responses for homicide offenders who had a history of violence

compared with those for whom it was an isolated extreme act. However, there was some evidence to suggest that reactive violence was associated with the development of PTSD symptoms (Pollock, 1999a), although Curle (1989) and Payne et al. (2008) did not support this finding; indicating that it is not always possible to predict the outcome of an offence and therefore planning does not always reduce the likelihood of the killer suffering afterward.

However, those with a clear motive were less likely to experience trauma symptoms following homicide (Curle, 1989), perhaps because they are better able to justify their offence to themselves. This is supported by Curle's (1989) finding that killing a spouse or lover was not associated with the development of trauma symptoms, one explanation being that in killing a partner, there is likely to be a build-up of resentment over time. As such the killer may have in their mind some reason for the offence or some idea that the victim was deserving, which would lessen their guilt and reduce their suffering. This hypothesis would be supported by the finding that believing the offence was deserved impacts upon trauma symptomology (Payne et al., 2008), and the idea that killing a stranger was as traumatic as killing a non-spousal family

member is in accordance with this finding (Curle, 1989). One cannot blame a stranger or find a reason to justify the offence by seeing them as deserving and so trauma responses cannot be mediated by a reduction in guilt in this scenario.

Finally, Psychopathic and personality disordered offenders were least likely to develop a traumatic response to the offence compared to mentally ill perpetrators (Curle, 1989; Pollock, 1999a), which is perhaps unsurprising given that one would expect to be able to experience empathy (a trait lacking in psychopathic offenders) in order to experience guilt, guilt being linked with an increased susceptibility to developing a trauma reaction subsequent to the homicide (Papanastassiou et al., 2004).

10.2 Strengths and Limitations

The present study attempted to bring together the small amount of research relating to traumatic responses following the commission of a homicide offence. All but one of the included studies sampled homicide offenders within a mental health setting. This is true even of Pollock (1999a), who, while their sample was originally from a custodial setting, had been referred to them within a forensic mental health service. As

such, it is unclear as to the extent that these findings can be applied to homicide offenders more generally, both in custody and community settings such as probation. However, given that there were some commonalities of findings in these studies and that a strict inclusion criterion was applied, it is proposed that these findings are representative of mentally disordered homicide offenders more widely. It is hoped that this review will highlight the importance of research in this area and encourage others to explore the nature of trauma in this population.

There were some limitations to this study. Time constraints and resources may have affected the impartiality of the methodology; where one individual is responsible for the process of systematic reviewing, process bias may occur. Ideally, the selection and quality assessment of studies would have been carried out by a team of researchers; however, that was not possible in this instance, although the small selection of studies found did mean that 33% could be appraised by two researchers. It is believed that all relevant studies were included; unpublished thesis were obtained, and the author translated non-English papers in order to assess their viability for the review.

The heterogeneity of measures used across the different studies made it more difficult to compare the results, which meant that narrative synthesis was the best method of comparison within this study. Whilst there are benefits to narrative synthesis, quantitative methods such as meta-analysis may have allowed for more concrete exploration of patterns and differences within the data.

10.3 Interpretation of findings

The results from this review provide useful insight into a much neglected field and are therefore valuable. However, the results should be interpreted with caution, especially considering that just two of the studies were considered to be of 'good' quality. The fact that the majority of the studies failed to reach this standard highlights the need for more robust and methodologically sound research within this area.

It is also noteworthy that none of the included studies were longitudinal in nature. Cross-sectional studies provide a useful snapshot of information relating to a particular population at a particular time, but in order to explore causality, more longitudinal research needs to be completed. Most of the studies did take place a considerable length of time since the

offence occurred, such that some exploration of the development and remission of trauma symptoms could be explored. However, without an understanding of the participant's presentation at discrete points in time, it is difficult to draw accurate conclusions based on this. Moreover, length of time since the offence can serve as a limitation considering the expectation on the participant to reliably recall their experiences. Finally, only one of the studies had a comparison group, and even then, the sample size was very small. Two other studies looked at offending more generally, and had small homicide samples to compare with other crimes. It would be helpful to have compared the prevalence of trauma responses in homicide offenders with trauma responses in other types of offender, with larger samples, to establish whether there is something unique and more traumatising about homicide as an offence.

Within a forensic setting, longitudinal research provides its own set of unique challenges, as it is potentially likely that prisoners or patients are moved around, may get released or be prohibited from completing the research (e.g. through regime restrictions). One must also consider the role of confounding variables. Concepts such as trauma are multifaceted, and it can

be expected that any number of confounding variables will affect the results (for example, the use of medication in mentally disordered populations). Whilst, for the most part, the included studies within the review attempted to control for confounding variables, there is always the possibility that other factors may influence the direction of a participant's response.

10.4 Conclusions and Recommendations

This review found evidence to suggest that homicide offenders suffer a range of traumatic responses, particularly PTSD, following the commission of their offence. The high levels of trauma symptoms reported lend support to the concept of recovery oriented treatments for this population, focussing specifically on their experience of the offence and how to move forward. This is particularly pertinent given that PTSD has been shown in a number of studies to be linked to violence (Beckham, Feldman, Kirby, Hertzberg, & Moore, 1997; Collins & Bailey, 1990; Fehon, Grilo, & Lipschitz, 2005; Watson, 2013), so in treating trauma in the homicide offender, clinicians are also reducing their risk of future violence.

A specific focus on reducing guilt and avoidance may be helpful with regards to developing a treatment for homicide offenders,

with the personality type of the offender taken into consideration when it comes to selection, as highly psychopathic offenders are unlikely to require such an intervention for PTSD due to the fact they are less likely to be traumatised by their offence and that treatments can exacerbate their difficulties, though this is a finding that has been disputed (D'Silva, Duggan, & McCarthy, 2004).

Finally, further good quality research is required, using consistent and comparable measures of PTSD, and using adequate sample sizes to lend support to the findings of this review. Comparisons of trauma responses in homicide offenders to other violent offenders are warranted alongside the inclusion of offenders from a wider range of environments, to include community, custodial, and mental health, to determine whether there is something unique about the experience of the homicide offender.

An Introduction to Chapter Three

Chapter three is a case study of a young man found guilty of manslaughter, who for the purpose of this study and to maintain confidentiality will be referred to by the pseudonym Sam. Sam engaged in homicide treatment in a high security hospital. This case study will focus on his progress within the Homicide Group, and is the same group treatment which is explored in chapter four. The homicide group aims to reduce the risk of reoffending by using a recovery approach aimed at reducing the psychological distress caused by the homicide offence. The author was not involved in the facilitation of the homicide group, and as such, interview with Sam, consultation with his clinical team, and review of progress reports were used to determine his progress throughout treatment. The author administered a battery of assessments both prior to and six months into treatment, to monitor change over time. Case study design is employed in this thesis in order to explore in detail the aetiology of a homicide offender's trajectory to the offence, and to explore his progress in group treatment.

The case study is an approach to research that facilitates exploration of a phenomenon within its context using a variety

of data sources (Baxter & Jack, 2008). This ensures that the issue is not explored through one lens, but rather a variety of lenses which allows for multiple facets of the phenomenon to be understood. There are two key approaches that guide case study methodology; one proposed by Stake (1978) and the second by Yin (2013). Both endeavour to fully explore a topic of interest, and ensure that the essence of the phenomenon is revealed, but the methods that they each employ are quite different.

Both Stake (1978) and Yin (2013) base their approach to case study on a constructivist paradigm. Constructivists claim that truth is relative and that it is dependent on one's perspective. Constructivism is built upon the premise of a social construction of reality (Baxter & Jack, 2008). The advantage of this approach is the close collaboration between the researcher and the participant, while enabling the participant to tell their story in full (Baxter & Jack, 2008).

According to Yin (2013) a case study design should be considered when: (a) the focus of the study is to answer 'how' and 'why' questions; (b) you cannot manipulate the behaviour of those involved in the study; (c) you want to cover contextual

conditions because you believe they are relevant to the phenomenon under study; or (d) the boundaries are not clear between the phenomenon and context (Baxter & Jack, 2008). In this chapter, the reasons 'why' Sam committed homicide are explored alongside the context of the offence, followed by an exploration of his progress through subsequent treatment.

One of the difficulties in case study research is attempting to answer a question that is too broad or a topic that has too many objectives for one study. In order to avoid this problem, several authors including Stake (1978) and Yin (2013) have suggested placing boundaries on a case to prevent this from occurring. Suggestions on how to bind a case include: (a) by time and place (b) time and activity and (c) by definition and context (Baxter & Jack, 2008). Binding the case will ensure that the study remains reasonable in scope. In this case study, binding is created by implementing a time limit. For example, data is collected from Sam at the start of treatment and then six months into treatment. This is firstly because of the time limitations of the research process, but also because the treatment group is ongoing and as such data could be collected on an on-going basis, the scope of which would be unmanageable in this context. The six month follow up period

allows for treatment effects to be observed, and adds a greater depth of understanding about homicide group treatment for the individual. Binding was also achieved by focussing solely on his progress in homicide group treatment, rather than exploring his progress in all the therapies he was concurrently engaged in. This allowed for a detailed focus on homicide intervention specifically, which is in keeping with the overall theme of the Thesis.

There are different terms to describe a variety of case studies. Yin (2013) categorises case studies as explanatory, exploratory, or descriptive. He also differentiates between single, holistic case studies and multiple-case studies. Stake (1978) identifies case studies as intrinsic, instrumental, or collective. The case study in chapter three is descriptive in that it describes an intervention and the real-life context in which it occurred (Baxter & Jack, 2008). Stake (1978) uses the term intrinsic which also applies in this instance because the intent is to better understand the single case, the purpose is not to come to understand some abstract construct or to build a model or theory (Baxter & Jack, 2008).

The use of multiple data sources, a strategy which enhances data credibility, is advocated in case study research (Baxter & Jack, 2008). In this case study, numerous reports written by different authors are cited, in addition to the use of interview by the author with the participant, and a battery of psychometric assessments. Each data source is one piece of the 'puzzle', with each piece contributing to the researcher's understanding of the phenomenon as a whole (Baxter & Jack, 2008). The 'propositions' (Yin, 2013) or 'issues' (Stake, 1978) in this study concern the reasons for the offending, and the efficacy of group treatment for the offender. Keeping this in mind also keeps the scope of the research manageable and enables analysis to stay on track. In this chapter, a combination of qualitative and quantitative analyses are used to synthesise the data sources.

Chapter Three

HOMICIDE GROUP THERAPY: A SINGLE CASE

ABSTRACT

Objective: The objective of the case study reported in this paper was to explore the progress made by a male patient through group treatment for Homicide.

Methods: An in-depth analysis of needs informed a rigorous Multiple Sequential Functional Analysis (MSFA), in order to inform the choice of intervention for the individual. His progress was monitored via a battery of psychometric assessments, patient self-report, staff report, and clinical judgement.

Results: The patient made several treatment gains. From a recovery perspective he experienced a marked decline in alexithymia symptoms and complicated grief. From a risk reduction perspective, he demonstrated an increase in secure attachment style, and an increase in guilt feelings related to his offence. Overall it appears he is taking greater responsibility for his offence, and is learning to integrate the emotions associated with his act of Homicide into his life, and is responding in an increasingly adaptive manner following treatment.

Conclusions: This case represents an individual with a complex presentation whom has historically demonstrated high levels of violence. His progress through therapy is explored, with specific reference to his progress through a psychodynamic form of group treatment for Homicide.

1.0 INTRODUCTION

For the purposes of this case study and to maintain anonymity, the client will be referred to as 'Sam'. Client information within was obtained through accessing psychology records and client self-report during interview. Specific records within the high security hospital in which he is detained included:

1. Psychological Admission Assessment (Dr Noble, 2010)
2. Psychiatric Assessment (Dr Scott, 2013)
3. HCR-20, Version 2 (Dr Andrews, 2013)
4. Understanding Mental Illness Report (Dr Gwyn, 2013)
5. CBT for Psychosis report (Dr Smith, 2013)
6. Homicide Group Report (Dr Gwyn, 2013)

In addition, the author liaised directly with staff involved in Sam's case and psychometric assessment and behaviour observations also contributed to the case study. To maintain confidentiality, all names for all individuals within this case study have been removed and replaced with a pseudonym. Dates of offences and dates of his trajectory from prison to hospital are also removed in order to preserve Sam's anonymity. Sam's age and other details are factual. The author was not involved in the treatment of Sam, and was not a

facilitator of the homicide group, with a view to providing an unbiased appraisal of his progress in treatment. Sam consented to participate in the study and a copy of the informed consent form can be found in appendix four.

1.1 Client Introduction and Referral Details

Sam was convicted of the manslaughter of a man, Khaliid, and of possession of a firearm with intent to endanger life. The victim died in hospital after being found with a shot gun wound to the right side of his chest (Scott, 2013). Sam is a 21 year old man from a war torn country, who was admitted to a high security hospital after becoming mentally unwell in the prison environment following the commission of an Index Offence of Manslaughter and possession of a firearm with intent to endanger life (Noble, 2010).

Reports indicate that following his Index Offence, Sam was remanded in custody, where concerns were raised by staff about his mental health following a series of assaults on prison staff which precipitated his transfer to the Care and Segregation unit (CSU). He was transferred to another location, and after another assault on a staff member he was once again relocated to the (CSU). There were frequent episodes of violence toward

members of staff which entailed that his behaviour be managed on a four man unlock with members of staff wearing personal protective equipment (PPE) (Noble, 2010).

Reports from prison indicate that Sam's behaviour was bizarre and he complained of hearing voices. Following an assessment, he was referred to a high security hospital under section 48/49 of the Mental Health Act 1983, amended 2007 (MHA). Sam attended the Old Bailey Central Criminal Court whereby he was convicted of manslaughter and possessing a firearm with intent to endanger life. He was placed on Section 37/41 of the MHA. Later that year, his section 37/41 was overturned in a court of appeal by the Crown Prosecution service (CPS) and was replaced with an indeterminate sentence for public protection (IPP) with a tariff of 6 years. He was returned to a high security hospital under Section 47/49 of the MHA (Noble, 2010). Sam was then referred to the centralised group work service within the hospital for assessment and treatment.

1.2 Psychosocial background of client

A psychological report by Dr Noble (2010) states that Sam has few memories of his time growing up in an African country. He had been told that his mother moved to America soon after he

was born and he had first grown up with his father. After his father went abroad, he received care from his grandmother who was later killed by a stray bullet. During interview with Dr Noble, he said that, while he was aware of problems in his society, his immediate family were not violent and he only ever witnessed fist fights in the street. Between the ages of 8 and 11 Sam lived with an uncle and attended school. His father was living and working in the UK, and he himself moved to the UK after the death of his uncle.

While in the UK, Sam lived with his father but they had a strained relationship. His father was very strict and beat him when he did not adhere to rules or boundaries. He was expelled from school in year 8 (aged 12) due to fighting with other pupils but re-joined the following year, it is reported that he then attended anger management sessions (Noble, 2010).

Subsequent to this, aged 12, Sam's father felt unable to cope with his increasingly difficult behaviour (school truancy, fighting, not abiding by home rules) and so he was sent to live with an uncle in his home country. Sam later ran away and returned to the UK without a passport as an unaccompanied minor and was taken into the care of Child and Family services.

Sam Frequently absconded from foster placements and was reported missing numerous times. While in secondary school, Sam was convicted of violent disorder due to serious fights with other pupils. It is thought that at this time Sam was becoming involved with gangs and that the fights with other pupils were due to disagreements over 'territory'. As he was getting older, he was sent to live in bed and breakfast accommodation rather than foster homes (Noble, 2010).

1.3 Psychiatric History

A psychiatric report by Dr Scott (2013) states that Sam did not believe himself to have any symptoms of illness at the time of his index offence. Psychotic symptoms were first reported when he was remanded in custody following his Index Offence. Sam was seen by a consultant psychiatrist and reported hearing a voice saying 'he knows'. No other signs of psychosis were found on this assessment and his diagnosis was one of dissocial personality disorder.

When Sam was relocated to a second prison, he presented as depressed, although not suicidal, and again was eventually relocated to CSU following numerous assaults on staff where, as aforementioned, he was managed by use of a 4 man unlock

using personal protective equipment (PPE). Reports are of bizarre behaviour and he complained of hearing voices. He had committed various assaults on prison officers, which staff reported to be unprovoked. At one point he reportedly concealed a strip of torn sheet in his room, expressing suicidal ideation (Scott, 2013).

Over the following 3 months his mental state deteriorated and he became increasingly paranoid and delusional. Sam was displaying evidence of ideas of reference and thought broadcasting, commenting: *"I thought I was on the radio and everyone was listening to me."* These beliefs also contained grandiose elements as evidenced by his statement: *"I thought I was God because I was all alone and the voices agreed with me…. I thought I owned the world*." (Scott, 2013). He was referred to a medium security psychiatric hospital, but was declined on the grounds that he was too violent. This precipitated a move to a high security hospital (Noble, 2010).

During interview with the author, Sam stated that he no longer experiences psychotic symptoms, but reports that historically, these were intense. Reports indicate that Sam has insight into his mental illness quoting, "I *was sick. I believed in a lot of*

things that are untrue – beliefs that others didn't share. I was hearing voices. The voices encouraged the beliefs." (Scott, 2013). He accepted that this could be described as a psychotic episode and believes that this was helped by his current medication (Interview with the author, 2013). Consultation with members of Sam's clinical team confirmed that his mental illness is currently well managed, and that psychotic experiences are no longer a feature of his everyday life.

Sam relates the hallucinations to his violence in prison: "*The voices were telling me to fight the guards with shields.*" (Noble, 2010). He noted how they performed a psychologically protective function: "*The voices promised me things – like you'll get out of prison and get money."* (Noble, 2010). This changed when he came to Hospital and he began treatment: "*When I came here, I got the courage to fight the voices… After I thought about it, I decided, no more."* (Noble, 2010). During interview, Sam commented that he learned how to 'fight' (challenge) the voices and feels that he has benefitted from CBT for psychosis in addition to medication. Sam has mixed feelings about this, stating that at the time they made him feel powerful and safe. It took him some time to adjust to no longer hearing voices,

and he suffered low mood in response to feeling lonely without them (Interview with the author, 2013).

1.4 Substance Misuse

Sam used to spend approximately £20 per day on cannabis although he shared some of this with his peers. He said that this was mostly funded by social benefits and the income that he was given by his drug supplier for dealing although he recalled undertaking one (unconvicted) street robbery which he said that he now regrets. He denied ever undertaking burglary or shoplifting (Interview with the author, 2013).

Reports indicate that when asked why he started dealing drugs; Sam replied *"It was simply working for someone."* However, he added that he did try to stop dealing but it was "*the focus of my life*" and he felt "*pressured"* to continue. During assessment interview, when asked about emotional difficulties Sam commented, "*I might have been angry at the time of the offence but I was more like scared during it."* (Noble, 2010).

1.5 Relationship History

Sam said that his longest relationships with females only lasted 1 or 2 months and he commented that he has never had a long term girlfriend. He recalled one relationship ending when he went to prison for violent disorder. He commented that he has only seen his father occasionally in the years prior to the index offence. However, he had just been to visit his father a few days before the offence and recalled this meeting as having gone well. He added that his relationship with his father has improved as a consequence of him receiving visits from him while in custody (Scott, 2013).

Sam had a positive relationship with his grandmother who had raised him before his move to the UK to live with his father. However, she was killed by a stray bullet which precipitated his move to England. He recalls feelings of horror concerning the death as he had been playing with a cola can which popped at the time his Grandmother was shot. He remembered feeling as though he had killed his grandmother. Sam had a 'reasonable' relationship with his Uncle in his home country however lost contact with him following his arrest. He never met his mother but believes she lives in America. None of Sam's relations know that he is in hospital and he has had no contact with them since

his incarceration. He attributes this to the shame of mental illness within his culture and his father's keenness to 'keep it a secret' (Interview with the author, 2013).

1.6 Forensic History

At the age of 16, Sam started smoking cannabis. He tried unsuccessfully to get regular employment and spent most of his time taking drugs. It was at this age that he received his first convictions for cannabis possession and criminal damage. Sam was convicted for violent disorder after a fight at school between rival groups and received a custodial sentence. At the age of 17, Sam joined a gang. This led to him dealing drugs as a form of income (Scott, 2013).

1.7 Index offence

Sam was convicted of the manslaughter of a man, Khaliid, and of possession of a firearm with intent to endanger life. The victim died in hospital after being found with a shot gun wound to the right side of his chest (Scott, 2013).

The day prior to his Index Offence, Sam was selling drugs and saw a group of men which made him suspicious. He later left

and collected a fire arm from an associate (Scott, 2013). The ease in which Sam obtained a firearm is reflective of the anti-social subculture he was involved in. The report by Dr Scott (2013) states that the following day he returned to the area to sell drugs, he saw the men and according to witness statements taken from friends of Khaliid, Sam was seen removing a shot gun from under his coat and letting it discharge into the air. Sam then ran away and Khaliid and a friend gave chase. When they were close to him Sam allegedly said "*I swear to God I'll kill you"* before continuing to run (Noble, 2010). They continued to chase Sam into a block of flats and a fight ensued. The three men wrestled on the landing and during the struggle Khaliid pushed Sam to one side and took hold of the barrel of the gun, as he did so Sam fired a shot, fatally injuring Khaliid. Sam then ran away. Sam was able to evade arrest on a number of occasions by dramatically altering his appearance and by stopping contact with all his associates and family (Noble, 2010).

2.0 ASSESSMENT, ANALYSIS, FORMULATION

2.1 Assessment of Needs

Sam's first language is not English, and although he now has a competent working knowledge of the English language, upon admission to hospital (2010) it was felt by his team that his vocabulary was limited and he was not totally idiomatic in the English language. It was therefore decided that administration of a self-report psychometric questionnaires such as the Millon Clinical Multiaxial Inventory III (Millon & Davis, 1997) would not be appropriate at that time.

An assessment interview conducted by Dr Noble in 2010 drew the following conclusions: "*Sam appears to have made a substantial improvement in his mental health compared to his self-report and accounts of an apparently severe psychotic episode in prison that was still evident when he first arrived in Hospital. While psychometric testing has not been deemed appropriate with Sam due to him not being fluent in English, it is apparent from his offending history, his involvement with gangs, his dependence on drug-dealing for an income and his recent history of violent behaviour some of which was prior to*

his current psychotic episode indicates that he does display some anti-social personality traits."

This assessment concluded that there were 3 areas of psychological need (Noble, 2010):

1. Psycho-education relating to mental illness and the importance of medication compliance as well as self-monitoring relapse signatures.
2. Substance misuse therapy with links to mental health and anti-social lifestyle.
3. Therapy relating to managing the triggers of anger and violence.

Dr Noble (2010) concluded that given the improvements he had made since his admission into high security hospital, he could continue to address his identified areas of need within Medium Security. However, a demand of most medium security units is that the Index Offence should have been addressed within high security, and as such it was suggested that Sam join the Homicide Group once he had acclimatised to therapeutic groups (Noble, 2010). Sam joined the Homicide group in 2013, three years after his admission assessment. This meant that his

English had improved to a standard that facilitated this, and his mental state was sufficiently stabilised.

Against this background, there are no mental health or other issues that would exclude Sam from homicide group treatment. A responsivity interview with Sam indicated that there were no current cultural or other issues that he felt he would need extra support with during treatment.

2.2 HCR-20, version 2.

The HCR-20 Version 2 is an assessment tool. It consists of a list of 20 questions about the person being evaluated for violence. The clinician gathers qualitative information about the person being assessed, guided by the HCR-20 Version 2, and the results are used to make treatment decisions (Douglas & Webster, 1999). The HCR-20 Version 2 consists of three main areas: historical (H), clinical (C), and risk management (R) and operates as a form of structured clinical judgement (Douglas & Webster, 1999).

The HCR-20 Version 2 provides significantly improved valid predictions over previous testing methods with overall high

predictive validity (AUC = .80) (Belfrage, Fransson, & Strand, 2000). Douglas, Reeves, Otto, and Douglas (2010) summarised interrater reliability research on the HCR-20 Version 2 scale scores across 36 studies. Version 2 median reliabilities were .85 (Total), .86 (H), .74 (C), and .68 (R). Earlier testing methods tended to be more subjective, less focussed, and relied more heavily on anecdotal clinical judgement, or on comparing characteristics of the person being tested with base rates of violent behaviour in populations with similar characteristics. The HCR-20 Version 2 extends the methods of earlier tests and supplements them with a review of dynamic variables, such as stress and lack of personal support, both factors important to the person's future adjustment.

At the time of completion, version two of the HCR-20 was the most recent edition of this tool. This has now been replaced with a third revision. Dr Andrews (2013) completed an HCR-20 Version 2, identifying Sam's risk of future violence as 'moderate', and suggested that obtaining further insight into his Index Offence may serve as a protective factor, further supporting his attendance in the homicide group.

3.0 FORMULATION

Functional analysis is an assessment approach used to establish the function of a behaviour by exploring the relationship between an individual and their environment, often referred to as an A:B:C analysis (Sturmey, 1996). The A:B:C in functional analysis refer to *antecedents* (A), *behaviour* (B) and *consequences* (C). Antecedents can be distal (historical) or proximal (current) and as the formulation of functional analysis relies heavily on available information, it may not always be possible to identify all distal antecedents. It is also important within functional analysis to consider reciprocal determination, which is the concept of environment, behaviour, and consequences being interrelated or interactive. For example, a consequence could become an antecedent for a future behaviour and consequence cycle.

A multiple sequential functional analysis (MSFA) is a series of functional analyses which link together to account for complex historical behaviour chains (Daffern, Jones, & Shine, 2010) Sam's case was formulated by the author using the MSFA approach (see Tables 9-10). The MSFA is linear, representing a developmental process; an initial A:B:C: sequence explicitly

contributes to the antecedents of the next A:B:C: sequence, and so on, aiming to demonstrate the influence of prior events on subsequent behaviour. Following each MSFA, a summary of learning (referred to as 'key learning') is made; these learning points are essentially working hypotheses developed to explain how the individual may have changed consequent to the detailed events and are modified according to their accuracy and predictive utility (Hart, Gresswell, & Braham, 2011). MSFA was chosen as it offers benefits in terms of organising case material, understanding the aetiology of the behaviour, planning interventions and understanding dangerousness (Hart et al., 2011).

Table 9: Early Experiences

Antecedents	**Sam**
The contexts associated with the onset of behaviours; associations, conditions, or triggers for behaviour (Kuyken, Padesky, & Dudley, 2009).	Very little is known about Sam's Early life in his home country. His childhood was disrupted with him moving back and forth to the UK. He experienced physical abuse perpetrated by his father and has no knowledge of, or contact with his mother. He lost his Grandmother following her being hit by a stray bullet and felt responsible for this.
Behaviour	
In MSFA, this can include cognitive processes such as worry (Kuyken et al., 2009)	Sam had difficulty in school and fought with other young people and started selling drugs.
Consequences	Sam left foster care and went into accommodation alone. Sam was expelled from school, accepted back the following year and had to attend anger management classes (Noble, 2010). He continued to sell and to use drugs. Sam joined a gang.
Key Learning	Sam was subject to some of the risk factors identified for gang affiliation (Thornberry, 1998). He was socially isolated, a victim of violence, unemployed, lacked parental supervision and had difficulty at school. Joining a gang will have potentially met some of his unmet needs for family and

	affiliation, particularly following the loss of his Grandmother to whom he was close. Sam felt traumatised by this loss as he struggled to make sense of his own culpability for it. His early experiences of gun violence in his home country perhaps normalised the use of weapons and violence. He also would have gained a sense of belonging through his gang affiliation, excitement, and a means to make money by selling drugs.

Table 10: Index Offence

	Sam
Antecedents	Increasing anti-social and offending behaviour. Affiliation with gangs. Carrying a Weapon Possibility of prodromal phase of psychotic illness
Behaviour	Suspicious of other groups of men/gangs. Use of cannabis. Lack of knowledge of 'alternative options' (due to anti-social/ gang culture) led to him trying to frighten the men away by firing his gun. Carrying a gun meant he had a weapon at his disposal
Consequences	Firing the gun did not scare the men away, but encouraged them to pursue Sam.

	A fight occurred between Sam and the 2 men who chased him. Sam fired the gun, fatally wounding the victim. Sam evaded custody for several months by changing his appearance and ceasing contact with associates. Subsequently arrested and charged with an indictable offence. Taken into custody.
Key Learning	Several elements appeared to have played a role in the attack on his victim. The fact he carried weapons meant that it was at his disposal to commit a fatal attack. Arming himself could have been in response to increased paranoia associated with his drug dealing and gang affiliation and increased alignment with an anti-social lifestyle. In turn this may have been exacerbated by the early stages of a mental illness, which later became pronounced when in custody.

3.1 Summary of formulation

Sam's childhood was chaotic and disrupted. He had a strained relationship with his father, no contact with his mother, lost his grandmother to whom he was close, and was subject to corporal punishment. He spent his time being moved between his country of birth and the UK, was unable to settle into foster care and ultimately ended up living alone at a young age. He then

joined a gang, which met his needs for a sense of belonging and enabled him to earn money through selling drugs.

It is unclear whether his suspicions about the group of men of which the victim was a member was a justified response in relation to inter-gang conflict or whether it represents the early signs of mental illness and paranoia. Nevertheless, it was this that activated his purchase of a gun. Sam returned to the area in which he had felt threatened, perhaps due to pressure to sell drugs, or as a means to ensure that the area was protected for him and his gang. His attempts at warding off the other men were unsuccessful and ultimately resulted in a fight and the gun being fired, killing his victim. In custody, his psychiatric symptoms worsened, and he was transferred to high security hospital. Sam's history indicates several risk factors for the development of PTSD as a result of his offence of homicide and these include not knowing his victim (Curle, 1989), early exposure to and previous use of weapons and violence (Curle, 1989; Papanastassiou et al., 2004), and previous traumatic experiences (Curle, 1989; Golier et al., 2003; Herman, 1992).

4.0 INTERVENTION

Sam attended several groups facilitated by the centralised group work service within the hospital aimed at targeting the needs identified, including:

1. CBT for psychosis
2. Substance Misuse Group
3. Anger Treatment Programme
4. The Homicide Group

This case study will focus on his progress within the Homicide Group. As aforementioned, the author was not involved in the facilitation of the Homicide Group, and as such interview with Sam, consultation with his clinical team, and review of progress reports were used to determine his progress within the group. In addition, the author administered a battery of assessments both prior to and six months into treatment, to monitor change over time.

4.1 The Homicide Group for People who have killed a Stranger (HGS)

In line with the research, and the description of homicide in chapter one, there are two homicide groups at the study site. One for individuals who have killed someone they know, and

one for individuals who have killed a stranger. This is because the motivations and potential trauma reactions are different for different types of homicide, and are perhaps better explored separately. The Homicide Group for people who have killed strangers (HGS) is based on the Recovery Model of therapy for complex mental disorders. A central theme of the recovery approach is the empowerment of the service user (Repper & Perkins, 2009). Empowerment is facilitated by increasing the autonomy of the individual and is conceptualised as hope, opportunity and control (Green, Batson, & Gudjonsson, 2011). This is particularly relevant in forensic services, as there is a dual task: recovery from mental illness and the recovery task of re-building of an identity post offending (Drennan, Law, & Alred, 2013). There is always a dual focus for the treatment targets in forensic settings to cover mental state, behaviour and the interaction between the two (Drennan et al., 2013)

The homicide group is routed in this recovery orientation, and aims to address the issues facing perpetrators of such an offence. Most people do not kill others, and there are just 600 reported deaths reported per annum as a result of homicide (Adshead et al., 2008). Understanding why homicide occurs then is important from a risk perspective as one could

hypothesise that knowing 'why' could help prevent a similar offence occurring in the future. According to Adshead et al. (2008) further questions arise for the perpetrators that are important to their recovery: How do I live now that I have done this? How can I think of myself in relation to others? What identity can I let myself have? It is these questions that form the basis of homicide group treatment.

All homicides occur within a group, whether it is in the family, community, a gang, or society (Adshead et al., 2008) and so from the perspective of risk reduction, it seems relevant to consider the group dynamics surrounding acts of murder, to better understand why some people kill others. However, there is a marked lack of literature on group work with homicide offenders. What Adshead and her colleagues purport is that group treatment provides a forum in which to observe and better understand the forensic patient, and is one in which psychodynamic change can occur.

For a number of reasons group therapy for homicide offenders is often contraindicated in institutions (Adshead et al., 2008) this is because; (1) It is commonly thought that victims and their families are the only ones who deserve help (2) homicide

offenders are often isolative within institutions (Hillbrand, Alexandre, Young, & Spitz, 1999) (3) personality characteristics of homicide offenders (such as the inability to develop group dynamics such as altruism, trust, or sense of universality) make it difficult to form a cohesive group and (4) there is anxiety about what feelings might arise out of shared homicidal experiences (Adshead et al., 2008).

Adshead (2008) also suggests that these offenders are both victims of trauma, who have been suddenly bereaved, but are also '*fearsome perpetrators'.* One of the tasks of group therapy then becomes to integrate these two oppositional aspects of the group and its members, and to pose the question "*How do you survive the disaster, when you are the disaster?"* (Adshead et al., 2008).

In summary, the group offers a supportive, safe, reflective space for group members in which to discuss:

a) The experience of having killed someone they did not know; and of living with that experience.
b) Their understanding of their actions and the resultant effects their actions have had on themselves, the victim, the victim's family, their own families and society.

c) Thinking about their future and the impact their offence has on this.

It is a semi-structured therapy group in which the patients are responsible for what is discussed in each session. The therapist's role is to help the group members to find their own voice and tell their own story. Mentalising techniques are utilised to help group members develop the narratives of their past and their future. It is an open-ended group that offers a continuous supportive space. Group members can stay in the group until they leave the hospital. They are expected to attend every week; but each member works at their own pace.

5.0 OUTCOMES

5.1 Engagement in the group treatment process

Dr Gwyn's (2013) progress report indicates that over a period of six months, Sam attended nearly all sessions offered, with two absences due to procedural security. When invited to discuss with the group members, and give feed back to his clinical team about his experience of the group so far, Sam said he has learned from the group that he is to blame for his index

offence, rather than seeing it as an "accident". He stated that he values the group because he has learned from it. He continued to say that other people in the group have their own perspective and he appreciates this as this has helped him to form his own views. Sam has been able to talk about the circumstances of his offence and his state of mind at the time of killing his victim; indicating engagement with the therapeutic process.

5.2 Progress within the group

During interview with the author (2013) Sam reported that he entered the group with a 'story' of his offence which entailed that he killed the victim by accident in a struggle. He has since changed his account to allow for more personal responsibility. He describes it as being "*his life or mine*" and that he chose his own. He has a greater awareness of the effect of his offence on the victim's family and friends, and has been working through his own remorse relating to the offence, a concept which is aligned with the recovery model. He seems to have a sense that he needs to make reparations for his offence, stating that he "*wants to do something good for other people",* and would like to coach football for people with mental illness.

6.0 PSYCHOMETRIC ASSESSMENT

Sam completed a range of psychometric assessments to assess his progress within the group over time. It was felt by the author, Sam, and his clinical team that his understanding of the English language had improved considerably since his admission to hospital, and would not serve as a barrier to this. The assessments Sam completed were:

1. The Defense Style Questionnaire (DSQ)
2. The Relationship Style Questionnaire (RQ)
3. The Blame Attribution Inventory (BAI)
4. The Toronto Alexithymia Scale (TAS)
5. The Inventory of Complicated Grief

These tests were selected as they measure risk and recovery treatment targets of the homicide group and measure relational and trauma symptoms in the offender. Because the Homicide Group is open ended and ongoing, and Sam is likely to remain in the group until he leaves the high security hospital, 'post treatment' scores therefore were collected at 6 month follow up.

6.1 Clinically significant change

Clinically significant change can be defined as the extent to which an individual moves outside the range of a dysfunctional population following treatment (Jacobson, Follette, & Revenstorf, 1984). This is commonly calculated through comparing the outcome of treatment scores on assessment measures with cut-off scores for that measure (Speer, 1992). In the case of Sam, this type of analysis of change is not meaningful, as the types of assessment used were not designed to capture a move towards 'normality', but rather, to record the extent to which Sam changed his thoughts, attitudes and beliefs following treatment. A more meaningful way to capture this statistically is through use of the Reliable Change Index (RCI; Jacobson & Truax, 1991). Reliable change is calculated by subtracting the 'after' score from the 'before' score and dividing by the standard error of the difference (SED) of the test. A resulting value of ≥1.96 is considered to represent statistically significant change at the $p<.05$ level (Wise, 2004). Reliable change values were calculated for each of the aforementioned psychometric assessments and the results are displayed in the following sections.

6.2 The Defense Style Questionnaire (DSQ)

The DSQ-40 is a self-report measure of characteristic defense styles consisting of 40 items to which participants provide ratings of agreement on scales ranging from 1 (strongly disagree) to 9 (strongly agree). The instrument measures the conscious behavioural results of 20 defense mechanisms organised into four broad defense styles: Maladaptive (consisting of acting out, passive aggression and projection), splitting (consisting of omnipotence and splitting), self-sacrificing (consisting of reaction formation and pseudo altruism) and adaptive (consisting of humour, suppression and sublimation) (Huband, Duggan, McCarthy, Mason, & Rathbone, 2014), recorded as mature, neurotic, and immature styles. Reliability of the tool is moderate-good, with internal consistency coefficients of .58-.80 and test-retest correlations of .60-.71 (Andrews, Singh, & Bond, 1993).

Ego defence mechanisms were seen by Freud as unconscious processes that protect the individual from painful emotions, ideas, and drives (Huband et al., 2014). Huband et al. (2014) found that high levels of personality disorder pathology are related to immature defence styles and that treatment non-completion is associated with immature, defensive functioning.

Given that defense style appears to have the potential to inform assessment and measure change in offenders with personality disorder, the DSQ was administered both pre and post intervention, and Sam's scores are displayed in table 11.

Table 11: DSQ-40 pre and post intervention score, comparison with norms, and RCI

	Pre Treatment	**Post Treatment**	**Norm & SD**	**Reliability**	**SED**	**RCI**
	Raw Score	**Raw Score**				
Mature	7.63	5.88	31.55 (1.6)	0.70	0.88	1.99*
Neurotic	5.5	5.38	15.79 (1.5)	0.61	0.94	1.41
Immature	3.17	2.29	14.79 (1.6)	0.83	0.66	1.33

**Clinically significant change*

These changes show that Sam demonstrated a decrease in immature defense styles, although this was not found to be clinically significant. Immature defense styles lessen distress and anxiety for the individual but are perceived by others as socially undesirable, in that they are immature, difficult to deal

with and out of touch with reality. Research indicates that these defense styles are associated with depression and disordered personality traits, and include acting out and passive aggression (Vaillant, Bond, & Vaillant, 1986).

Sam also evidenced a decrease in neurotic defense styles, although this finding was also not significant. Neurotic defense styles are fairly common in adults, and have short term advantages in coping. However they often cause long-term problems in relationships, occupation and daily living when used as a primary coping strategy (Vaillant et al., 1986), examples include dissociation and reaction formation. A decrease in the above would indicate reductions in acting out, reduced passive aggression, and improved ability to form positive relationships. This is especially pertinent given that acting out and passive aggression are linked to 'inhibited' offender typologies, associated with infrequent but explosive and serious acts of violence (Blackburn, 1986) and that relationships can serve as protective to offending (Ward & Brown, 2004).

While Sam showed decreases in the aforementioned maladaptive defense styles, he also evidenced a decrease in mature defense styles and this was found to be clinically

significant (≥1.96). Mature defenses are found among emotionally healthy adults and are considered mature, even though many have their origins in an immature stage of development. They differ in that over the years they have developed to optimise success in human society and relationships (Vaillant et al., 1986). Using these defenses enhances pleasure and feelings of control, and helps to integrate conflicting emotions and thoughts whilst still remaining effective, examples include humour and anticipation (Vaillant et al., 1986).

In summary, Sam evidenced a reduction in immature defense styles which has implications for treatment outcome (Zeigler-Hill, Chadha, & Osterman, 2008), this finding has to be interpreted with caution however for two reasons. Firstly, the seemingly positive outcome was non-significant and Sam also evidenced a decline in mature and desirable defense styles, which was clinically significant. Secondly, his scores were more than five standard deviations outside of the norm, this would indicate that perhaps Sam did not understand the scale and interpretation of these findings is not meaningful. It is possible that Sam's understanding of the English language impeded his responding.

6.3 The Relationship Style Questionnaire (RQ)

The relationship questionnaire (RQ) was developed by Bartholomew and Horowitz (1991) to assess attachment patterns in close adult peer relationships. Attachment was explored in this context due to the aforementioned links between attachment and aggression (Bowlby, 1969, 1982, 2005). The RQ can be used to assess general orientations to close relationships, orientations to romantic relationships, or orientations to a specific relationship (or some combination of the above). It can also be reworded in the third person and used to rate others' attachment patterns. Alpha coefficients computed to assess the reliability of the RQ range from .87 to .95 (Bartholomew & Horowitz, 1991). Test-retest data suggest the RQ classifications have moderate stabilities over a period of eight months (Scharfe & Bartholomew, 1994). Using a multitrait-multimethod approach, Griffin and Bartholomew (1994); (a) report evidence for both the discriminant and convergent validity of the RQ; and (b) provide factor analytic data supporting the two dimensional (self-other) structure of its conceptual base. Griffin and Bartholomew (1994) also provide support for the concurrent validity of the RQ by demonstrating theoretically consistent relations between (a) persons' self-

models and the positivity of their self-concepts; and (b) persons' other-models and the quality of their interpersonal orientations. Relationship styles were measured during homicide group treatment to assess this and Sam's results are displayed in table 12.

Table 12: Sam's Pre and Post Treatment RQ Scores, comparison with norms, and RCI

Attachment Style	Pre-treatment scores	Post-treatment scores	Norm & SD	SED	Reliability	RCI
Secure	15	18	4.14 (1.54)	0.62	0.84	4.87*
Fearful	8	8	3.21 (1.77)	0	0.84	0
Preoccupied	11	13	3.09 (1.67)	0.67	0.84	-2.99*
Dismissing	11	14	3.49 (1.60)	0.64	0.84	-4.69*

**Clinically significant change*

Sam demonstrated an increase in his secure attachment style, and this was found to be clinically significant (RCI ≥1.96) indicating that over time he is finding it easier to become emotionally close to others and assumes greater satisfaction and adjustment in his relationships (Sable, 2008). Considering the links between insecure attachment and emotional

deregulation and violence, it could be inferred that this would reduce his level of risk.

However, Sam also showed clinically significant increases in preoccupied (a tendency to seek high levels of intimacy, approval, and responsiveness from others) and dismissing (favouring independence over close relationships) relationship styles. It is unclear what the implications are for this on his recovery and risk reduction, although it would seem that Sam is experiencing some inconsistency regarding his interpersonal relationships and attachment to others and this will be explored further in the discussion.

6.4 Blame Attribution Inventory (BAI)

The revised Gudjonsson Blame Attribution Inventory (BAI) is a 42-item questionnaire determining attribution of blame for crimes (Gudjonsson & Singh, 1989). The inventory has three subscales measuring external, mental element, and guilt feeling attributions. 'External' attribution occurs when the offender blames the crime he committed on social circumstances, victims or society. 'Mental-element' attribution involves the offender's crime being blamed on mental illness, poor self-control or distorted perception and 'guilt feeling' attributions are

associated with the offender having feelings of remorse, regret and a need for punishment for having committed the offence (Fazio, Kroner, & Forth, 1997). Reliability of the tool is good, with test-retest correlations reported to be .85, Internal consistency Cronbach's alpha coefficients range between .77 and .81 (Murphy & Maiuro, 2009). Sam's results on the BAI are shown in table 13.

Table 13: Sam's scores on the Blame Attribution Inventory, comparison with norms, and RCI

Blame Attributional Style	**Pre Treatment Scores**	**Post Treatment Scores**	**SED**	**Norm & SD**	**Reliability**	**RCI**
External	7	2	2.84	10.1 (4.6)	0.62	1.76
Guilt	7	12	1.85	2.8 (3.0)	0.62	-2.70*
Mental Element	5	3	1.08	5.6 (2.7)	0.84	1.85

**Clinically significant change*

The results indicate that Sam demonstrated a decrease in his tendency to attribute blame for his offence on both external and mental elements. Concurrently, his 'guilt' scores demonstrate a noticeable increase, which was found to be significant. This

indicates that following treatment Sam was better able to take responsibility for his offence, and had a lessened propensity to blame other factors, and as a result of this, feelings of guilt and remorse increased.

Guilt can be conceptualised as an adaptive response to a wrongdoing because it is more likely to have a positive effect on future behaviours. Guilt-prone individuals are inclined to take responsibility for their transgressions and errors, and are disinclined toward aggression, indicating a move toward reducing his future level of risk (Tangney, Stuewig, & Hafez, 2011).

However, this is not a straightforward finding. While guilt proneness has been shown to negatively and directly predict re-offending, shame proneness does not (Tangney, Stuewig, & Martinez, 2014). While proneness to guilt predicts lower rates of reoffending, the implications of proneness to shame are more complex. Individuals inclined to feel shame, and who are also defensive and blameful of others, are more likely to return to crime. Individuals who are shameful but who don't externalise blame are less likely to reoffend (Tangney et al., 2014). This means that potentially, Sam is less likely to offend

in the future because he showed a reduction in externalisation in addition to his increased guilt.

6.5 The Toronto Alexithymia Scale (TAS)

The TAS is a 20-item instrument that is one of the most commonly used measures of alexithymia (Bagby, Taylor, & Parker, 1994). Alexithymia refers to people who have trouble identifying and describing emotions and who tend to minimise emotional experience and focus attention externally. The TAS-20 has 3 subscales: Difficulty Describing Feelings, Difficulty Identifying Feelings and Externally-Oriented Thinking. The TAS-20 demonstrates good internal consistency (Cronbach's alpha =0.81) and test-retest reliability .77 ($p<.01$) (Bagby et al., 1994).

Higher scores on the subscales of the alexithymia scale would indicate deficits in mental representation of emotions and in the ability to regulate emotions through cognitive processes (Parker, Taylor, & Bagby, 1998). It has also been suggested that alexithymia is associated with a repressing defense style in which there is little capacity to experience stress, which, rather than being helpful can result in greater somatisation and

negative emotion (Taylor, Bagby, & Parker, 1999). Sam's scores are displayed in table 14.

Table 14: Sam's scores on the Toronto Alexithymia Scale, comparison with norms, and RCI

Subscale	**Pre Treatment Scores**	**Post Treatment Scores**	**SED**	**Norm & SD**	**Reliability**	**RCI**
Difficulty Describing Feelings	9	5	1.65	11.5 (3.3)	0.75	2.42*
Difficulty identifying feelings	19	10	2.30	11.9 (4.9)	0.78	3.91*
Externally Orientated thinking	32	3	2.09	22.3 (SD: 3.6)	0.66	13.82*
Totals	60^	18	4.27	49.3 (8.9)	0.77	9.84*

**Clinically significant change*

^ *Cut off for alexithymia: 61*

Sam experienced a substantial reduction across all scales of alexithymia, and each of these findings were significant (RCI ≥1.96). This indicates that overall, 6 months into treatment, he was better able to describe and identify his feelings, with a reduced tendency for externally orientated thinking. With

regard to recovery, this could mean that Sam understands himself and his own emotions to a greater degree and could contribute toward his improved overall well-being. On the other hand, he may experience a greater sense of remorse and regret which may be unpleasant, particularly due to his reduction in external orientated thinking and its links with defense styles and blame attribution. However, as aforementioned, this may impact on future risk, and entail a lessened reliance on violence or aggression (Tangney et al., 2011).

A cautionary point would be to consider whether the TAS is a suitable instrument for someone whose first language is not English. Low scores on the TAS may indicate a lack of understanding of language nuances rather than an inability to understand and identify one's own emotions. Sam's improvements in Alexithymia symptoms could therefore designate improvements to his understanding of the English language. Sam's scores on the TAS were also way outside of the norm, which may indicate a lack of understanding of the instrument, or again is linked to his understanding of the English language.

6.6 The Inventory of Complicated Grief (ICG)

The Inventory of Complicated Grief (ICG) is a 19 item self-report instrument that allows for the dimensional assessment of the severity of complicated grief symptoms. Scores of 30 or higher (over a range of 0 to 76) indicate a high likelihood that the syndrome is present. The ICG has high internal consistency (Cronbach's alpha coefficient of 0.92 – 0.94) and has received a test-retest correlation score of 0.80 (Prigerson et al., 1995). As described in chapter two, complicated grief is caused by experiencing grief as traumatic distress and shares some symptoms of PTSD. Sam's scores are shown in table 15.

Table 15: Sam's complicated grief scores, comparison with norms and RCI.

Pre-treatment Score	Post Treatment Score	SED	Norm & SD	Reliability	RCI
30	21	2.93	10.28 (6.55)	0.80	3.07*

**Clinically significant change*

Results indicate that Sam met the clinical cut-off for complicated grief prior to treatment; this was significantly reduced at 6 month follow up, indicating he no longer suffered

with the disorder. This means that Sam was experiencing grief and trauma as a result of the offence to a lesser degree following treatment. As discussed in the formulation, it is unsurprising that Sam was experiencing a complicated grief reaction following his act of homicide, with some of the predisposing factors being present in his life trajectory. His reduction in this area has positive implications for his recovery and risk reduction.

7.0 FOLLOW UP

Nine months into treatment the author followed up with Sam. He was still located at the same high security hospital. Staff members report that he was progressing well and had been referred to a medium security hospital.

8.0 DISCUSSION

8.1 Sam's Progress

Sam made considerable clinical gains through group treatment within the hospital. From a recovery perspective he experienced a marked decline in alexithymia symptoms and his complicated grief scores reduced from being clinical present as a syndrome,

to no longer meeting the criteria, and these findings were clinically significant. From a risk reduction perspective Sam demonstrated an increase in secure attachment style, and an increase in guilt feelings related to his offence which were also found to be clinically significant. Overall it appears he is taking greater responsibility for his offence, and is learning to integrate the emotions associated with this into his life, and is responding in what seems to be an increasingly adaptive manner following treatment.

There are some complexities to these outcomes however, because alongside these positive outcomes, Sam also evidenced a decrease in mature (and therefore desirable) defense styles and increases in preoccupied and dismissing attachment styles. One explanation for these contradictory findings could be that prior to treatment Sam had limited experience of pro-social relationship experiences, particularly given his disrupted upbringing, separation from caregivers, and gang affiliation. Group treatment may therefore represent a forum in which Sam is only just beginning to explore his attachment to, and relationships with others, and may have resulted in some confusion or ambivalence. Furthermore, because of the hospital environment, he is restricted in the sorts

of relationships that he can experience, as intimate relationships are prohibited, and friendships are restricted to other offender patients, which may be difficult to forge and maintain. The artificial environment may therefore have contributed to Sam's increase in less helpful attachment styles. However, given that Sam made notable changes in just six months of treatment, it is possible that further progress will be made as he remains in treatment.

8.2 Narrative Approaches to Offender Intervention

This case study tells a story of an individual who has experienced considerable gains during a narrative treatment for homicide offending. The Homicide groups within the study site are non-directive and utilise Mentalising techniques. The idea being that before homicide patients can leave the hospital, the group members have to fundamentally alter their offender identity. They arrive with a narrative (a story) of themselves and their offences, and it is this 'cover story' that needs to change (Adshead, 2011).

It is evident that over time Sam's 'cover story' has changed. Originally his story was characterised by neutralisation techniques, such as the belief that the offence was an accident.

Indeed, this is reflected in his conviction of 'manslaughter' rather than homicide, which means that Sam was not the only person who viewed his culpability as somewhat diminished under the circumstances.

Offender narratives, contain 'neutralisation techniques' such as "it wasn't me" or "who are you to judge" which are employed as defenses of responsibility. One aim of the Homicide Groups therefore is to increase a person's sense of agency, or ownership of the offence, thus working towards rehabilitation of the offender. If the offenders can, through their changing narrative, and through a lessened reliance on neutralisation, 'own' their offender identity, then this identity can be thought about and worked on in the group so that change can be established (Adshead, 2011). This is something that Sam demonstrated explicitly, he moved from understanding his offence as an accident, to describing it as a decision *"it was my life or his, and I chose mine".* With Sam's changing account came a change in mental state and increased agency. He now talks about wanting to move forward and make positive changes, and make reparations for his offence, and this is in accordance with the recovery model, which emphasises the role of hope (Green et al., 2011).

In support of this approach, Maruna (2001) studied the narratives of recidivist offenders and compared them with narratives of those who desisted from offending and found that those who avoided future offending talked about themselves in different ways than those who persisted in their offending. The desisters provided reflective commentary with a temporal element comparing how they used to see themselves to how they see themselves now. Desistence narratives included themes of coherent identity which incorporated and accepted the past offending, a sense of agency and control, responsibility, purpose, and hope for the future (Maruna, 1997, 2001; Maruna, Porter, & Carvalho, 2004). These concepts are not well accessed in standard offending behaviour programmes, and lend themselves better to narrative approaches to offender recovery.

The type of intervention that this case study described is subject to debate (Adshead, 2011), with many researchers and clinicians favouring a cognitive behavioural treatment (CBT) approach (Allen, MacKenzie, & Hickman, 2001; Andrews et al., 1990). Andrews et al. (1990) went so far as to state that, Psychodynamic and nondirective client-centred therapies are to

be avoided within general samples of offenders, since these therapies are designed to free people from certain types of psychological distress, and this distress is not part of the criminogenic problems for a majority of offenders. They also argue that the opening up of conversation amongst an offender population may well be criminogenic (Timmerman & Emmelkamp, 2005).

However, Sam has demonstrated that he did experience psychological distress, meeting the clinical criteria for complicated grief prior to treatment, and almost reaching the clinical cut off for alexithymia. Furthermore, his gains on the measures relating to defenses, relational style, and blame attribution have implications for a reduction in his risk. There is therefore no evidence to suggest that the group had a criminogenic impact on Sam. Straub, Zielke, and Werbik (2005) have argued that psychodynamic approaches can enhance the offender's capacity for narrative intelligibility leading to an integration of dissociated thoughts and emotional affect, and to an associated cessation of violent behaviour, and there is some evidence to suggest that this is the case here.

However, the results of this case study must be interpreted with caution. At the same time as attending the homicide group, Sam was attending several other interventions, was receiving medication, and undergoing one to one therapy. With this in mind, it is possible that the positive outcomes observed are not wholly attributable to his attendance at the homicide group. Therefore, to ascertain the group's specific role in his progress, reliance on his own accounts are observed which may be subject to response bias in the form of desirable responding. However, in order to increase the reliability of this case study, sources of information were varied, and reports by facilitators of the homicide treatment group also support the notion that progress has been observed, and this is at least in part due to his attendance at the homicide group.

9.0 CONCLUSIONS

Sam has demonstrated that he has made considerable progress since he started the homicide group for strangers. His scores on psychometric measures imply clinical gains in improved interpersonal functioning and mental well-being, and changes to his attributional style and attachment style have positive implications for risk. However, the exact links between these

outcomes and reduced risk are unclear and the results not necessarily generalisable to homicide offenders as a whole, on the basis that their outcome may be subject to a number of potential confounding factors such as treatment responsivity and diagnosis.

What does seem to be evident is that the homicide group has the potential to be greatly beneficial to the recovery of the offender, as was the case for Sam. This is a treatment that could run in conjunction with other evidence based interventions for offending behaviour, but unlike anger management or violence reduction programmes has the benefit of considering directly the complexities that are specific to homicide.

10.0 FUTURE DIRECTIONS

For Sam, his progress in the group so far indicates that his attendance has been beneficial and that prolonged engagement, particularly to address some of the ambivalence in his relational style may be helpful.

More generally, the outcomes of this case study indicates that future research must focus on gaining information that can be used to provide clarity in terms of outcomes for homicide offenders following group treatment and their association with risk reduction. Practically this may begin with studies that employ a larger sample, utilising a longer period of time before follow up. A greater sense of the defining characteristics of recovery in forensic patients may also be beneficial, paving the way to focus on precise links between recovery and risk reduction; and to an associated improved understanding of the benefit of recovery for the offender and for the homicide perpetrator population as a whole.

An Introduction to Chapter Four

In chapter four, the experiences of five homicide offenders involved in group treatment are explored. The group treatment under investigation is the same intervention that Sam participated in, as was explored in chapter three. The therapy is based on both recovery and risk reduction principles, designed specifically for people who have killed.

In order to complete the task, Interpretive Phenomenological Analysis (IPA) was used (Smith et al., 2009). Alternative methodologies such as Grounded Theory (Glaser & Strauss, 2009), Discourse Analysis (Potter, 2005), Narrative Analysis (Bruner, 1990) and Thematic Analysis (Braun & Clarke, 2006) were considered less appropriate methodologies with which to achieve the aims of the following chapter, and the reasons will be discussed below.

Grounded Theory (GT) was not employed because the research aim was not directed toward testing ideas as they emerged in the analysis. The sample of homicide offenders was also not large enough to facilitate continuous collection of data as

additional concepts arose to the point of theoretical saturation. Theoretical saturation refers to the researcher being able to reach a point in their analysis where sampling more data will not lead to more information related to their research questions (Marshall, 1996). Whilst IPA and GT are both inductive approaches, IPA is often able to provide a more nuanced and detailed analysis of lived experience in smaller samples of homogenous participants with an emphasis on convergence and divergence between cases (Smith et al., 2009).

With this in mind, IPA is particularly suited to the study of complex individuals and multifaceted phenomena, which research continues to indicate homicide offenders and homicide as an offence to be. Furthermore, a grounded theory study in this area would entail a push for a mid-level theory based on a large sample of homicide offenders and in this instance it was simply not possible to access large numbers of homicide offenders participating in group therapy. This is because such interventions are a relatively new concept, with very few groups in existence. Instead, IPA offered a focus on a detailed examination of the lived experience of homicide group treatment in a small and amenable sample of homicide offenders.

Discourse Analysis (DA) was inappropriate because in discursive psychology it is assumed that what is said by an individual is a contingent upon their social context. Thus, the aim of the analysis is to illuminate the social interactions being performed by the verbal statements rather than to relate them to experience, sense making and cognition, which was the aim in this chapter (Potter, 2012).

Thematic Analysis (TA) as a method in its own right (Braun & Clarke, 2006) was a less suitable alternative than an IPA approach for two reasons. Firstly, TA is not tied to any particular theoretical framework (Braun & Clarke, 2006) and while this means it is flexible by design, it also means that it is not informed by an epistemological position and methodological framework that is concerned with the exploration of lived experience. Secondly, TA is suited to studies that include relatively large data sets because it does not possess an ideographic focus. This makes it far less suited to small sample projects than IPA.

Narrative Analysis (NA) shares an intellectual link with the interpretative phenomenological approach since IPA is

concerned with meaning making, and construction of a narrative is one way of making meaning through the organisation of events into a coherent whole. However, NA was not employed due to fact that most forms of narrative research focus on the structures of autobiographical stories and the constraints and opportunities that these place on experience (Gergen & Gergen, 1988). In particular, the key epistemology and methodological focus is grounded in the way narratives chronologically and conceptually construct meaning rather than how particular phenomena are consciously experienced and made sense of.

Finally, the hermeneutic and ideographic values of IPA lent themselves better to the study aim than did descriptive approaches. Descriptive approaches to phenomenology closely translate Husserl's (1931) original phenomenological method (Husserl, 1997). Therefore, there is a dedicated attempt to temporarily suspend the preconceived beliefs which distort our view of the world in order to gain access to the experience in its purest form and in doing so, describe them more precisely (Langdridge, 2007). However, the limitations and practicality of this as an approach are well documented (Langdridge, 2007; LeVasseur, 2003). IPA acknowledges the existence of the

researcher's preconceived beliefs and draws from a body of existential and hermeneutic literature which ensures a phenomenological approach that is more interpretive, and more widely used.

In short, choosing a method for qualitative investigation is not particularly concerned with choosing the tool for the job, such as deciding upon an appropriate statistical analysis, but is instead a question of deciding *what the job is* (Smith et al., 2009). Different qualitative methodologies possess different assumptions about what constitutes data and what may be inferred or known from such data. Research aims specify epistemological assumptions that are more and less suitable to different methodologies. In the following chapter the aim was to investigate the lived experience of those engaged in group homicide treatment, therefore the interpretive phenomenological approach is favoured for its focus on lived experience and personal meaning making (Smith et al., 2009).

CHAPTER FOUR

ABSTRACT

Background: There is remarkably little research that examines the experiences of individuals receiving treatment following the commission of a homicide offence. **Aims**: This study investigated the lived experience of five homicide offenders in a high security hospital who were involved in narrative group therapy for Homicide. **Method:** Semi-structured interviews were carried out and the data were analysed using the principles of Interpretative Phenomenological Analysis (IPA). Three areas were discussed: (1) the Group (2) Recovery and (3) Risk. **Results:** Recurrent themes reflected that participants benefitted from the group structure and format, finding that it engendered positive relationships with other participants, making it easier to broach emotionally challenging topics. Further themes reflected the importance of shifting narratives and hope for the future, in both domains of recovery and risk, lending support to the utilisation of narrative approaches in Index Offence work. **Discussion:** The results have implications for clinical practice and are discussed in the context of directions for further research.

GROUP WORK ON HOMICIDE: PARTICIPANT PERSPECTIVES ON ITS VALUE AND CONTRIBUTION TO RECOVERY AND RISK REDUCTION

1.0 INTRODUCTION

As discussed in chapter one, homicide is a relatively rare event, with 526 homicides committed in 2013-2014 in England and Wales (ONS, 2015). This is in comparison to the 762,515 offences of violence against the person recorded by the police per year (Sivarajasingam et al., 2010). Amongst these are a number of homicides perpetrated by those with mental illness or disorder. The link between mental illness and violent offending, although historically subject to debate, is now well-established (Hodgins, 1992; Hodgins, Mednick, Brennan, Schulsinger, & Engberg, 1996; Monahan, 1992). For example, Eronen, Hakola, and Tiihonen (1996) calculated that the risk of committing homicide amongst those suffering from schizophrenia is eight times higher than that of the general population, for personality disorders the risk is ten times higher, and this risk is further elevated in instances whereby there is comorbid substance misuse and mental disorder. Indeed, the

prevalence of personality disorders among homicide offenders has been estimated to be over 30% (Eronen et al., 1996). Antisocial personality disorder is the most common personality disorder among homicide offenders, with estimates of prevalence ranging from 11% (Eronen et al., 1996) to as high as 35% (Hodgins et al., 1996). However, this could be reflective of how anti-social personality disorder is defined; as the incorporation of risk taking, hostility, irresponsibility and impulsivity (American Psychiatric Association, 2012) could be characteristic of the act of homicide itself.

1.1 Treatment of Homicide Offenders

Given the apparent rarity of homicide as an event, it is a difficult area to access for research. Historically studies have focussed on homicide rates or victims rather than focussing on the treatment of homicide offenders themselves (Adshead et al., 2008). This study therefore aims to examine the experiences of those who have engaged in a group intervention designed to explore precursors to homicide, and its impact on their mental health; maintenance of the latter being a key feature in onward risk reduction strategies.

A sub-set of homicide offenders are mentally ill and are transferred as required to secure psychiatric hospital beds to enable them to access treatment for their mental disorder and to reduce their risk of future offending (Adshead, Ferrito, & Bose, 2015). This treatment usually involves both medication and psychological therapies. Secure forensic services, like many others nationally, are recovery oriented in practice, which ensures that each patient is placed at the centre of their care pathway and are ideally able to exercise some autonomy in relation to their access to treatment.

There are few groups designed to address homicide specifically. This is particularly noteworthy given that many homicide offenders do not usually have a history characterised by violence or other offences (Blackburn, 1986; Brookman & Maguire, 2003; Brunning, 1982), which, as discussed in chapter one, suggests that their needs may not be met in violent or other offender behaviour programmes. Brunning (1982) described a group for male offenders in a category B prison, which utilised a psychodynamic approach. He defined the structure as semi-closed, with only designated prisoners allowed to attend weekly. The prisoners were responsible for deciding on each weekly topic, and the group was facilitated

with a co-therapist and an officer. He noted that the prisoners who had killed experienced a sort of bereavement, and viewed the group as helping the prisoners to adjust, although this finding was anecdotal, rather than supported empirically.

Given the levels of trauma expected to be found in this population, it is pertinent to consider trauma focussed therapies when considering intervention. Existing research advocates for the use of individual trauma-focused cognitive behavioural therapy (TF-CBT) and eye movement desensitisation and reprocessing (EMDR) in the treatment of PTSD. TF-CBT is a form of cognitive behavioural therapy (CBT), which involves a number of techniques to help a person overcome a traumatic event. By changing the way a person think and acts, TF-CBT helps an individual come to terms with a trauma through exposure to memories of the event (Bisson et al., 2007). EMDR is a psychological therapy which aims to help a person reprocess their memories of a traumatic event. The therapy involves bringing disturbing trauma-related images, beliefs, and bodily sensations to mind, whilst the therapist guides eye movements from side to side (Bisson et al., 2007). More positive views of the trauma memories are acknowledged, with the aim of replacing the traumatic memories that are causing problem. A

meta-analysis by Bisson et al. (2007) identified that there was evidence that individual TF-CBT, EMDR and non-TFCBT are equally effective in the treatment of PTSD. However, TF-CBT and EMDR were found to be superior to non-TFCBT between one to four months following treatment. EMDR, CBT and TF-CBT and TF-CBT are more effective than other therapies (Bisson et al., 2007).

Regarding the interventions explored in this study, there are two homicide groups at the study site. Research indicates that between 21% and 27% of homicides are committed by strangers and between 73% and 79% are committed by offenders known to the victims (Harrell, 2012). In line with this profile; one group is for participants who have killed strangers and one for those who killed people they know. The groups are narrative in nature and address what the offender thinks about himself; his account of his offending; his emotions (in the present and past, and often in relation to offending), and how to establish and maintain the sort of changes that may be necessary to keep him and others safe in the future (Adshead et al., 2015). The aim is to instil hope and pro-social attitudes, regain agency and ownership over the offence and reduce risk for the people in their lives and other potential victims (Adshead

et al., 2008). This study will involve interviews with offender patients who are members of the Homicide treatment groups to explore their perspectives of treatment, the impact of the treatment, and how they feel their engagement has influenced their recovery pathway and risk status.

1.2 Recovery as a Service Orientation

Recent Department of Health directives in England suggest that 'personalised care' should be at the forefront of healthcare provision (Department of Health, 2009). This emphasis on increased service-user focus and choice is also voiced in other recent publications from the government, such as The Darzi Review (Darzi, 2008) which made clear that mental health services should address the views and aspirations of all involved, including service commissioners, mental health professionals, service-users and carers. The UK Government has been in support of recovery as a movement over the last decade with international support and energy located in empowering recipients of care to engage with and comment on the quality of the service they receive.

With regard to mental illness or disorder, Warner (2010) found that a substantial number of people affected with psychotic

illness recover completely or return to a 'good' level of functional capacity and mental health. In these studies recovery principles have further enhanced quality of life, improved self-esteem, enhanced functioning (including return to work) and expanded social networks (Liem, 2013; Warner, 2010). Meanwhile there is only emerging thought about how the concept of 'recovery' in mental health might be best defined in forensic settings, and similarly, how best operationalised or measured (Slade, 2009). Some of the inherent tension in measuring something that is unique to each person is relevant here (Anthony, 1993).

Recovery from a mental health problem differs in some important ways from recovery from a physical health problem. One concept of recovery is that posited by 'The Recovery Paradigm' (Simpson & Penney, 2011). It is about the individual staying in control of their life despite experiencing a mental health problem. Putting recovery into action means focusing care on supporting and building the resilience of people with mental illness or disorder. It is not just about treating or managing symptoms. In this study, the focus is on whether it is possible for someone to regain a meaningful life, despite serious mental illness and despite committing a serious offence.

A central theme of the recovery approach is the empowerment of the service user (Repper & Perkins, 2003). Empowerment is facilitated by increasing the autonomy of the individual and is conceptualised as hope, opportunity and control (Green et al., 2011). This is particularly relevant in forensic services, as there is a dual task: recovery from mental illness and the recovery task of re-building of an identity post offending (Drennan et al., 2013). There is always a dual focus for the treatment targets in forensic settings to cover mental state, behaviour and the interaction between the two (Drennan et al., 2013).

In addition, there are extra challenges inherent where there are complex needs such as co-morbid personality disorder. Personality Disorder is highly prevalent in offending populations (Blackburn & Coid, 1999). Personality Disorder could be conceptualised as a disposition with a different aetiology from Mental Illness, the onset of which occurs at a specific time in an individual's life, thus meaning that a return to a previous level functioning is possible. In contrast, for the individual with Personality Disorder, the aim would not necessarily to be to return to previous functioning but rather to promote pro-social

behaviour and long-term relationship maintenance (Green et al., 2011).

Other factors affecting the concept of recovery within Forensic Mental Health services is the idea that patients have been incarcerated, often against their wishes, and may feel coerced into so called 'recovery oriented' therapies. This is an area which has received limited attention in the literature. Until recently, research has focused on staff attitude toward care, rather than speaking to those to whom it applies (Green et al., 2011).

The homicide treatment groups at the study site are attended by those with a variety of mental disorders, mental illnesses and substance misuse disorders, and by exploring their experiences of treatment, greater insight into recovery following homicide can be forged.

1.3 The Impact of Group Therapy on Risk Reduction

The Homicide groups within the study site are non-directive and take a 'narrative' approach. The idea being that before homicide patients can leave the hospital, the group members have to

fundamentally alter their offender identity. They arrive with a narrative of themselves and their offences, and it is this 'cover story' that needs to change (Adshead, 2011). As described in chapter three, offender narratives, contain 'neutralisation techniques' which are employed as defences of responsibility. One aim of the Homicide Groups therefore is to increase a person's sense of agency, or ownership of the offence, thus working towards rehabilitation of the offender. If the offenders can, through their changing narrative, and through a lessened reliance on neutralisation, 'own' their offender identity, then this identity can be thought about and worked on in the group so that change can be established (Adshead, 2011).

Group work is the main psychological intervention offered to offenders, frequently in the form of psycho-educational groups, or groups that set out to change the cognitions, beliefs and values of the group members. Narrative groups such as those in this study have only been available comparatively recently (Adshead, 2011), and there are concerns that conversation in open format groups may become criminogenic in nature (Timmerman & Emmelkamp, 2005), or that dynamic therapies would not work since offenders do not experience the same sort of distress as the rest of the population (Andrews et al., 1990).

However, the idea that offenders do not experience psychological distress is disputed (Eronen et al., 1996; Hodgins, 1992; Hodgins et al., 1996; Monahan, 1992), and Adshead (2011) states that levels of childhood maltreatment and adversity are higher in the prison population than the general population; and in secure psychiatric settings are as high as 80%. There is also the aforementioned evidence to suggest that offenders, including homicide offenders, can experience trauma or bereavement responses as a result of their offence (Brunning, 1982; Curle, 1989; Fraser, 1988; Gray et al., 2003; Kruppa, 1991; Kruppa et al., 1995; Papanastassiou et al., 2004; Pham & Willocq, 2013; Pollock, 1999b). With this in mind, it is argued that dynamic approaches can enhance the offender's capacity for narrative intelligibility, leading to an integration of dissociated thoughts and emotional affect, and to an associated cessation of violent behaviour (Renn, 2002).

Adshead (2011) asserts that there are further reasons why psychodynamic group therapy is indicated for offenders. First, shame and guilt may best be addressed in groups because they are emotions of self-assessment that imagine an audience. Second, group processes such as shared disclosure, listening,

and supporting others is in itself a pro-social activity, which challenges the antisocial, anti-group state of mind. Third, many patients in secure settings do not have secure experiences of being alone in a room with another person in an authority/caretaker role and thus individual therapy could be anxiety provoking or counterproductive.

In summary, there are inherent difficulties with researching risk reduction in homicide offenders and this is laden with complexities when taking diagnosis and treatment responsivity into account. Moreover, the idea of recovery in a Forensic population is multifaceted, made challenging by the dual treatment concept of managing both disorder and offending behaviours and the debate concerning approaches to treatment. In light of this, this study aims to explore participant perspectives on the value of narrative group homicide treatment and the contribution it makes to recovery and risk reduction for offenders in a high security setting.

1.4 Purpose of Research

Offence-related work is central to risk reduction and is the basis of treatment programmes in prisons as well as secure psychiatric services (Perkins, Moore, & Dudley, 2007).

Exploring offender patient perspectives potentially adds information to our knowledge base about how interventions are experienced and some of the barriers to change. Moreover, only the perpetrator themselves can know how they feel about their offending behaviour and subsequent treatment, and it is by exploring this that the overall goal of recovery can be better informed. By aiding recovery for forensic inpatients, there may be a greater likelihood of patients living an offence free life. The premise here is that rather than centring on reducing risk, the focus is on increasing positive aspects of an individual's life – such as increased quality of life, improved self-esteem, enhanced functioning and expanded social networks (Green et al., 2011). The idea that offending behaviour can be reduced via increasing positives in an individual's life is similar to that posited by the 'Good Lives Model' which is also a strength based approach to offender treatment (Ward, Mann, & Gannon, 2007).

The field of research for this area is limited and lacking in good quality studies that follow a rigorous methodology. The challenges faced by researchers include the inability to conduct longitudinal follow up studies to assess treatment success. This is due to the length of time of imprisonment for homicide

offenders, the inaccessibility of these individuals, and the implications of allowing homicide offenders the freedom in the community to test whether the treatments have been successful. Still, offence specific work is a demand of most medium security or step down units, and in order to meet this need, high security facilities must provide a therapy that aims to reduce the risk of homicide reoffending in the future. At present there is a paucity of research that informs us about exactly what is involved with this treatment and how it affects those who receive and deliver it, and this study aims to contribute toward this question.

An in depth qualitative research investigation will attempt to explore the group and its processes, from the perspective of those at the heart of treatment. This may then highlight undiscovered areas of potential importance, the results of which will inform ideas about recovery and risk reduction, and act as a starting point for future research in this area.

1.5 Interpretive Phenomenological Analysis

As discussed in greater detail in the preamble to this chapter, Interpretative Phenomenological Analysis (IPA) (Smith, 2007; Smith et al., 2009) was used as the methodological approach

in this study. This is because IPA is fundamentally hermeneutic in its attempt to access a participant's personal world albeit dependent on the analyst's own assumptions (Smith & Osborn, 2008). IPA involves a double-hermeneutic where the analyst endeavours to make sense of the participant's attempts to make sense of their world (Smith & Osborn, 2008, Cited in Smith, 2015). IPA emphasises the value of the individual as a unit of analysis, while becoming more iterative in its focus where multiple cases are used, in order to arrive at more general findings (Smith et al., 2009). This is well suited to the study of homicide offenders undergoing group treatment because the offenders are a homogenous group although each individuals' offence and experience of treatment will have differences worthy of exploration. Therefore, the ideographic emphasis of IPA supports its use within this study. Nevertheless, IPA is subjective by design. It aims to conduct an investigation that enables lived experience to be expressed in its own terms, situating people in their particular contexts and exploring their personal perspectives (Smith et al., 2009). The focus was therefore not to propose a theory, but to generate in depth information about how offenders experience group treatment for homicide.

2.0 METHOD

2.1 Sampling and Inclusion Criteria

There are no firm rules about what should be the optimal sample size for an IPA study (Smith et al., 2009). However, it is usually accepted that smaller samples, studied in greater depth, are favoured (Reid, Flowers, & Larkin, 2005; Smith et al., 2009). Samples are small, well-defined and purposively-selected with three to five being recommended to be able to understand the individual's lived experience and to be able to draw generalisations from across the group (Smith et al., 2009).

Participants were male mentally disordered Homicide Offenders who attend the Homicide Treatment Groups, aged between 18 and 65. Participants had to have been members of the homicide groups for at least six months in order that treatment effects can be observed. It is difficult to ascertain the length of time required to observe treatment effects, especially given the lack of research into homicide treatment as a group therapy. However; Adshead et al. (2008) observed that after a six month period the homicide group had become more settled. This could perhaps indicate that interviewing patients prior to this time

would not be reflective of the group in general because the level of acting out and resistance is still high (Adshead et al., 2008). Participant's whose mental health was considered by their Responsible Clinician as too unstable for interview, or considered unable to consent to participation were not included in this study.

2.2 Ethical Considerations

Ethical Approval for the study was granted by the National Health Service (NHS) National Research Ethics Service (NRES). The following ethical guidelines were applied: right to withdraw during data collection, responsible data control, informed consent, debriefing and anonymity and were in line with the British Psychological Society (BPS) Code of Human Research Ethics (BPS, 2006).

2.3 Procedure

The research took place in a high security mental health hospital. Participants were recruited via access to the centralised group work database at the study site in order to identify those who satisfied the inclusion criteria. Prospective participants were approached by a member of their clinical team not involved in the research project, and were provided with an

information document outlining the research, interview, right to withdraw and data management measures. No participants were made aware of who else was taking part in the study. Five participants of an initial eleven expressed an interest and were interviewed. The six who did not participate chose not to on the basis that they had either left the group and did not want to talk about it, or had left the hospital and been transferred to a less restrictive environment. Participants were interviewed in a private room in the centralised group work service, away from their wards. This was to provide a quiet environment in which the participant felt comfortable and could give their responses confidentially. Interviews were tape recorded. A debrief was conducted following the interview in order to monitor participant experiences including adverse effects should they have been present. Potential sources of support were provided in all cases to increase access to help in the event that adverse effects were delayed, and the clinical team involved with each participant were made aware of their involvement in the research project, though their specific responses remained confidential. Following interview, the recordings were transcribed and anonymised. Once transcribed the original recordings were deleted. Please see appendix six for a copy of the participant information sheet, appendix seven for the

consent form, appendix eight for the debrief form and appendix nine for the clinician information sheet.

2.4 Participants

The age of participants ranged from 22 to 39 years old. All were convicted of homicide offences. Four participants killed someone they knew, and one killed a stranger. All had a previous offending history, three of the five being violent, and all were known to mental health services at the time of the offence. Table 16 within the results section provides more detailed participant information.

2.5 Interview

A semi-structured interview schedule was used, as shown in appendix ten. This was designed to facilitate a comfortable interaction with participants which in turn enabled them to provide a detailed account of their experience of treatment. The interview was developed collaboratively with two other members of the research team and focused on areas of interest relative to the lived experience of group homicide treatment. These were (1) General beliefs and opinions about homicide group work, (2) opinions of recovery and how the group impacts on this, and (3) opinions of their future beyond high security

hospital, including their perspective of risk. It is noteworthy that while comments on risk were included in the analysis of the interviews, they are interpreted with caution due to the possibility of response bias within this population. However, participants were made aware that their involvement in this research would not affect their clinical progress, and instead was a forum within which to speak openly about their experiences of treatment.

2.6 Data Analysis

The original impetus for the study was born out of noting a lack of studies following a rigorous methodology concerning the treatment of homicide offenders. Much of the existing literature is narrative in nature or provides a commentary on homicide group treatment (i.e. Brunning, 1982), rather than yielding findings grounded in scientific methodology, though there are relatively new examples that counter this (Adshead et al., 2015; Ferrito et al., 2012) .

The author was not involved with the delivery of the homicide group, this ensured an unbiased analysis of the information collected. Neither was the author involved in any therapeutic work with participants interviewed, with a view to avoiding

arriving at the process with preconceptions about the men as individuals, or an agenda about the findings. The disadvantage of this is that the author was not aware of whether the reports provided by participants were reflective of their group behaviour. In order to counter this, and as a form of triangulation, discussions were held with members of the participants' clinical teams as a form of validity check.

It is unavoidable that the author arrives at the investigation with existing clinical knowledge and experience to bear on the data, and the results reflect this. It is also important to note that the author and the study, together with the limited research on this topic, are located within the recovery literature. Hence, the author possessed value-laden motivations toward transmitting this perspective, particularly through focusing on topics which inform the concept of recovery for the offender. Moreover, because the author is a young white British female, with a good standard of education, and without the same life experiences as the men in this study, a considerable 'gap' exists between the researcher and participants. Although similar in age to the participants in the study, a gender, social, and cultural gap is apparent. The author therefore brings their own assumptions to the research and there are positive and negative

aspects to this. In some respects the author is able to take an objective stance toward the research, and view each individual from a 'distance'. In other ways this is a disadvantage as the author does not have their own lived experience of the sorts of traumas, social deprivation, and mental illnesses that are found in this group of individuals. It could therefore be argued that the researcher will have difficulty interpreting the true essence of what is being communicated by participants.

Self-reflection throughout analysis was pertinent, in order that the author's preconceptions and how these influenced the case-by-case analysis could be tracked. Reflections were noted in a diary (appendix eleven). The presence of self-reflection demonstrates analytical rigour (Yardley, 2000). For example, in the 'Wayne' interview lines 535 -542, Wayne talks about personal responsibility and being a victim of circumstance. Here, it is important to be wary of how invasive the influence of 'clinical attitude' on the data can be. The author's initial responses were side-tracked somewhat by the idea that the individual lacked insight into the severity of his offence, evidenced by his reluctance to accept responsibility for it. However, by staying true to the process of engaging more openly with personal meaning, it seemed that Wayne was not

doing this, but instead was trying to make sense of his own culpability. This example illustrates the general influence of self-reflection and the diary on the analysis, in that it enabled the author to become aware of their professional and personal position and preconceptions and how these influenced their interpretation of the data. In addition to this, regular research supervision was undertaken with other members of the research team, and interview recordings along with transcripts were listened to and read by others in order to check for validity as an ongoing process.

A 6-step guide to data analysis provided by Smith et al. (2009) was employed:

1. The verbatim transcript was read three or four times to ensure familiarity with the case.
2. Descriptive, linguistic and conceptual comments were made in the column on the right side of the text. In making descriptive comments the data was engaged with at face value and acronyms, figures of speech and emotional responses were identified. Linguistic comments focused on the function of language, such that the participant's specific use of words and metaphors were examined to provide further meaning. Conceptual

comments aimed to be more interpretive. These comments involved delving deeper into the participants' lived experience of homicide group treatment.

3. Emergent themes were developed and noted in the left hand column of the transcript.
4. Super-ordinate themes were identified through a process of grouping the emergent themes which were similar in meaning.
5. The process was repeated with each case
6. Conceptually similar themes between cases where identified.

An example of the analysis is provided in figure 3.

Figure 3: Example of Analysis

Emerging Themes	**Transcript: Trevor**	**Initial Notes**
Recovery from painful emotions Sharing – recovery	76. you have. Um…with homicide <u>you've got a lot Inside</u>. Y<u>ou've got to live with what you've done and it's quite painful</u>. But with other people, they talk about what they did and they're going through the same experience as you have. It's very very helpful.	*With homicide you have <u>a lot inside</u> – painful emotions* Homicide is painful, you have to live with what you've done <u>Helpful to share that feeling</u>

Key: *Linguistic Comments,* <u>Conceptual Comments,</u> Descriptive Comments

The process of IPA does not necessarily have to follow such a pattern, although it should follow an iterative and inductive process (Smith et al., 2009). As a result, IPA can be characterised by a set of procedures including: moving from what is distinctive about a case to what is shared among cases, transitioning from the descriptive to the interpretative, commitment to an understanding of the participants point of view, and a focus on personal sense making (Reid et al., 2005). Due to the length of the interview transcripts, they are not included here, although can be made available upon request.

For a full list of themes and evidence in the form of excerpts from the interviews, please refer to appendix twelve. Appendix thirteen then includes a full list of the final super-ordinate themes from each interview.

2.7 Validity

In an attempt to ensure validity of the following phenomenological account, an effort was made to achieve the validity criteria outlined by (Yardley, 2000). According to Yardley (2000) validity in qualitative research may be demonstrated by four essential principles; namely, (1) sensitivity to context, (2) commitment and rigour, (3) transparency and coherence and (4) importance and impact. The first of these may be achieved by remaining sensitive to the context of the raw data (Smith et al., 2009) and this was evidenced by using verbatim extracts to support all themes (appendix twelve). Yardley's second principle was upheld not only through rigorous selection of participants, but adherence to an IPA protocol which included use of a reflexive diary and an independent audit by a second investigator as a form of triangulation that ensured confidence in the plausibility of the interpretations by the author. In order to achieve Yardley's third principle, information about the five participants, the author,

the analytical process and the phenomenological account derived has been provided for its coherence and plausibility to be determined. Finally, Yardley's fourth validity criterion will be a continuing appraisal by the reader and their opinion about the results to convey something interesting and purposeful.

3.0 FINDINGS AND INITIAL DISCUSSION

The findings are presented according to the three topics that were discussed during the interviews: (1) General opinions of the group itself (2) Recovery and (3) Risk.

Table 16 shows an overview of information about each participant. Table 17 illustrates a summary of the findings.

Table 16: Information about participants

Pseudonym	TREVOR	MICHAEL	WAYNE	BENJAMIN	ALEX
Age					
At time of interview	37	22	30	29	39
At time of offence	27	18	22	20	17
Diagnosis: Mental illness (MI)/Personality Disorder (PD)/Learning Difficulties (LD)	MI & PD	MI	MI	MI	MI & PD Mild LD
Psychopathy according to PCL-R Criteria	No	No	No	No	No
Ethnicity	White other	Black African	White British	Mixed Ethnicity	White British
History of Substance misuse	Yes	Yes	Yes	Yes	Yes
Victim known to offender	No	Yes	Yes	Yes	Yes
Under MH services at time of offence	Yes	No	Yes	Yes	Yes
Offending history	Non-Violent offences Arson	Drugs related offences Violent Disorder Criminal damage Car offences	Assault Arson	Assault Property offences 1X Drugs offence	GBH
Prev. exp. of Victimisation	Yes	Yes	Yes	Yes	yes

To protect the identity of participants, pseudonyms are used and information about the specific offences are deliberately vague. In table 2, recurrent themes are grouped by topic, with associated themes also listed. Within each topic, the superordinate themes from across the interviews are divided into over-arching themes, numbers in brackets denote how many of the participants cited that particular theme, which gives an indication of how common that theme is, which offers insight into its particular relevance to the group members.

Table 17: A Table Showing a Summary of recurrent themes

HOMICIDE GROUP WORK	RECOVERY	RISK
Group Bond (3) Homicide Support Group (1)	**Emotional recovery** Recovery from difficult emotions through sharing them (4)	**Understanding** Developing understanding of the offence (5)
Unstructured group (5)	Conflicted about own right to recover (2)	Risk Reduction (5)
A challenging group	Guilt (2)	**Agency** Acceptance of responsibility (2) Making sense of culpability
Homicide group is challenging (2)	**Identity**	**Schemas** Patients challenge other patients (2)
Would like more support	Re-humanising (4)	
Slow disclosures	Recovery of identity as more than a homicide offender (3)	
Homicide is traumatising	Becoming normal	
Apprehension starting the group (1)	A changed person(2) Improving as a person (3)	
	Hope for the future Recovery of hope for the future (5)	
	Reparation (2)	
	Mental Well-being Negative impact of mental illness (4)	

3.1 HOMICIDE GROUP WORK

Throughout the following section, emerging themes are conveyed, and supporting quotes are reported as evidence. Quotes are followed by the corresponding pseudonym of the participant in brackets, and numbers refer to the lines in which that quote can be found in the original interview transcript.

Regarding the way the group is operationalised, all participants described the group as unstructured, or as semi-structured. Adshead (2014) argues that this is a common misconception because in actuality, groups such as this one are highly structured in terms of time, boundaries and focus. However, these participants experienced the narrative group as without structure, especially when compared to manualised groups that have pre-set topics for discussion. This is important because it separates the group from other therapies and emphasises how it enables the participants to talk freely:

That's the beauty of it. The facilitators will sit back and they'll listen and they'll encourage us to speak amongst ourselves. But if it goes quiet and that, the facilitator will bring in a topic and say what about this or that? And they'd offer insight, and that would encourage more of the patients to speak about other things. (Trevor, 206-211).

We're not following a book or anything. And mostly I would say the Index Offence, all these things are relevant things you know (Michael, 725-727)

I understand it's a psychodynamic group and as far as I can tell, that means that basically people are free to talk about whatever they want. (Wayne, 28-130)

You're encouraged more to talk among yourselves rather than theories and ideas from facilitators. (Benjamin, 15-17)

I actually preferred it to structured groups cuz you can talk about what's going on, talk about your crimes, how your weeks been, things like that. (Alex, 38-40)

All participants found this format to be of some benefit, and in particular, Benjamin and Wayne felt as though it enabled the discussion of topics that may not immediately have seemed connected to the Index Offence:

So… people are free to chip in whatever they want at any time. I found that immensely helpful for myself personally. I know we'll get onto this in a bit, but I found it very helpful because I felt like I could talk about things which might not immediately seem to be related to homicide but actually in my own mind they form part of the larger issues which were going on for me, at the time and also now in relation to who I am and where I fit in the world and what the point of my life is now that I've killed someone. (Wayne, 151-160)

I dunno, I think… it's good in some ways and it's not good in some ways. In some ways it's good cuz the conversations might lead to places that they might not of been able to predict (Benjamin, 105-107)

In the above statement, Benjamin notes that the group enables discussion to move in directions not necessarily predictable by the therapists. As discussed earlier, we know very little about homicide as an offence as much existing research is based on studies of homicide rates rather than focussing on homicide as a phenomenon (Lim, Bond, & Bond, 2005) or the specific treatment of homicide offenders themselves (Adshead et al., 2008). In this sense, the group allows for the participants to be perceived as experts of their own offence and thus has the

scope to explore topics that may not yet have been considered by theorists as important in the act of homicide.

3.1.2 Group Bond

The idea that a firm group bond is developed during this group is recurring. There were a number of sub-themes that comprised this over-arching theme. Firstly, there is a shared offence so there is less scope for judgement than would perhaps be experienced in a group where there is an assortment of offences. Secondly, and perhaps as a result of this, participants can come and be open and honest about their feelings. Thirdly, participants provide a unique sense of support for one another:

So there's a bond, a bond you have with other members of the group and that can be quite strong (Wayne, 351-353)

Realising that you have a support network when you need it. Realising that this group is going to be here and you have somewhere to vent your views. (Trevor, 585-586)

Everyone in the group has done the same offence that I've done, but not in the same way. Our Index Offence is the same so that gave me a bit of a like, like not being able to be judged (Michael, 116-121)

In the group someone who's say, a hard case on the outside, they come in the group and they open their hearts and say this this and this and they show their cards really. That is the close bond. (Trevor, 284-286)

So there's a bond, a bond you have with other members of the group and that can be quite strong (Wayne, 351-353)

Realising that you have a support network when you need it. Realising that this group is going to be here and you have somewhere to vent your views. (Trevor, 585-586)

The group bond becomes particularly important because offenders are often especially socially isolated. For humans, breaking social rules leads to social exclusion (Adshead, 2014). When a person breaks the rules, they are doing something to their social identity as well as to their personal identity. Adshead (2014) states that when that rule break involves violence, they not only drop out but are pushed out, and it is for this reason that criminal law states that a criminal offence is an offence against the 'whole body politic' (Adshead, 2014). The offence is against society (the group) as a whole, not just the victim alone. For these isolated individuals then, returning to 'the group', starts with forming bonds within a therapy group such as this.

3.1.3 The Group is challenging

Participants seem to find the group challenging. The challenge in this instance doesn't seem to stem particularly from the group structure, but from the nature of what is being discussed:

I would say it's better to ease someone into a group that's full scale like that. (Michael, 157 -159)

For some people it's harder than others, because some people are a lot more ashamed for what they've done. (Benjamin, 40-41).

On one level, talking about offending in front of others is incredibly difficult. Participants expose themselves to the

opinions of their peers and clinicians. To talk about the offence means that all post hoc justifications or rationalisations will be exposed and potentially challenged by others, and by saying the words out loud, the offence becomes real, as Wayne articulates below:

Umm because once, I mean, you can tell your story to yourself however many times you want, and it will change each time, but once you've told your story to someone else, someone else has an understanding of it, and that doesn't change until you give them new information, so what you've got is a situation where by telling your story to other people you're making it real and more concrete, instead of something that is just something in your own internal dialogue (Wayne, 501-509).

Beyond the challenge of making their stories real, is that homicide itself has been traumatising for them as perpetrators. Trevor spoke about how prior to one-one therapy aimed specifically at recalling his memory, he had forgotten many of the details of the offence. He discussed having an idea that he had done it, but that his brain was unable to fit the pieces together into a coherent story of what had taken place. Recalling the offence was traumatic and distressing, but joining the group did alleviate some of this.

Erm... when I finished the one to one therapy, when I had time by myself, all that was going through my mind was all that I did, and what happened, and it was eating me up inside. And when I came to this group, I learned how to deal with that by other people said about how they had dealt with it and I'm a much better person. (Trevor, 607-613).

Drennan and Alred (2012) describe offender recovery as the personal experience of coming to terms with having offended, perceiving the need to change one's attitudes and beliefs that gave rise to offending in the past and which support the future risk of re-offending, and accepting the social and personal consequences of having offended. However, what Trevor's and Michael's cases indicate are that the acceptance of the social and personal consequences of a homicide offence can be particularly difficult to cope with (Adshead, 2014).

The group makes me think a lot about my Index offence, and others' Index Offence, so sometimes I think I think too much you know (Michael, 430-432).

3.2 RECOVERY

Recovery in this study appeared to have four key components, (1) Emotional recovery (2) Recovery of identity (3) Hope for the future and (4) Mental well-being. The key findings from participants are discussed below.

EMOTIONAL RECOVERY

3.2.1 Recovery from difficult emotions by sharing them

The emotions described by the participants in this study are painful. Four of the five men spoke explicitly about how the process of sharing these emotions made them feel better. For Trevor, the homicide itself was traumatising, but in the group he was able to talk about this and in his words, 'recover', and he hopes that by sharing his feelings that others will have the same experience.

…and we talk about such painful things and I see that they're going through the same things that I'm going through, it's very very helpful, and hopefully the other way around. That when I talk about things, and I say that I am recovering and that I am getting better, that they can draw from that as well. (Trevor, 1059-1065)

Alex also found the process of talking about his emotions helpful:

Well, if you're stressed you want to talk to someone about it be it your doctor or your primary nurse or whoever, and the more you talk about it, the less stressed you get (Alex, 74-78).

For Michael such discussions were sufficiently difficult that he felt as though he needed extra support between sessions:

…it might be something the group could do in the future, if they think that, maybe some time, they could come and check up on how you're feeling, once …. Not even a one to one session…. Just check up on how they're feeling if they wanna talk about something further you know. (Michael, 252-256).

Adshead et al. (2015) recognised that people who have killed are at increased risk of PTSD, suicide and complicated grief, and highlighted the importance of therapists and clinicians being mindful of this when working with this group of offenders. Part of emotional recovery entails that over time, the offender is able to incorporate their story into their self-narrative such that it causes less psychological disturbance. Below, Benjamin describes how when he started the group he found it difficult to cope with some of the things that had happened in his life. He mentions the 'things he had done' affecting the way he thought about his future, but by using the past tense, indicates that this has changed.

When I first started the group, you know I found it hard to deal with things that had happened in my life. And I dunno… I look back at that time now and see it scarred me a bit mentally, it scarred the way that I … I can't really explain it but in a certain way, the things that I've done they really affected, in the past it really affected the way I thought about my future and that (Benjamin, 143-151)

3.2.2 Conflicted about the right to recover

Through sharing difficult emotions, the homicide offenders in this study appear to be 'coming to terms' with what they have done, and in doing so, are starting to move forward from it. However, they, like many others in society have doubts about whether this is acceptable:

It sounds a little bit selfish to say that we want to get over it (Trevor, 145-146)

So I was like… it brought me back down to earth. Like why do I deserve a future? And I started asking myself all these things cuz I thought, know what I mean, um… I've taken someone's life away from them you know. (Michael, 207-210)

While a recurrent theme for Trevor and Michael, it was not reflective of how the group felt as a whole. For Wayne, rather than feeling conflicted about his own right to recover, he viewed his disposal to high security as unjust:

And I certainly had this period in the group where I was saying, well this isn't right and why have I been brought here…What's the rationale behind it when there are people who do things similar to what I've done but they go straight to medium security? And they're sort of back out within two or three years. And there wasn't really an answer to it (Wayne, 822-828).

3.2.3 Guilt

Wayne's comment about feeling that his treatment has been unjust raises the question as to whether he understands what he has done, and whether he has remorse for it. He believes he does.

Um. Yes and no. In that, I still feel guilty for what I've done, and erm… but I've had members of the group say to me that they don't think I've done anything wrong. But I don't necessarily agree with that, I think I have done something wrong. But it's very hard to sort of identify where personal culpability ends and just being a victim of circumstance begins. And I still haven't fully managed to do that. (Wayne, 535-542).

Wayne appears to be trying to make sense of his own culpability and doesn't really seem to have reached a conclusion. This has impacted on whether or not he feels guilt. He uses the word 'guilt' explicitly, although it feels devoid of meaning given that he speaks about his incarceration being unjust. Wayne's perception is that the group have told him he hasn't done anything wrong, which given the nature of his offence is perhaps surprising. One concern of psychodynamic group treatment for offenders has been that they may generate criminogenic discussion or ideas (Timmerman & Emmelkamp, 2005), and it could be argued that this an indication of this.

However, Wayne does not deny his responsibility or agency, he *questions* it. He is an outlier in this sense because the other group members appear to have incorporated their offence into a story which defines them as responsible and in charge of their act, while learning how to manage the emotional backlash that comes as a result of this. Either way, Wayne's view was not reflective of the group as a whole. On the contrary, part of the recovery process was intrinsically linked to the participants conflicted beliefs about their own right to recover, and the guilt they felt for their offences. In this study, dealing with the offender's guilt is paramount and formed a recurrent theme.

Um, I felt guilty for what I done, I got reasons for why I did it, but it doesn't give me the right to go and do what I did. I felt guilty about it; I tried committing suicide a few time. (Alex, 161-167).

I still feel that the pain that you feel inside after taking someone's life is the punishment. Cuz nothing that the government can throw at you is gonna be worse than what you're feeling. (Trevor, 146-149)

IDENTITY

3.2.4 Re-humanising

A number of dimensions of offender recovery have been proposed (Ferrito et al., 2012). The first is making sense of the offence and the effect it has on self-identity. Coming to terms with the reality of a serious offence requires full acceptance, where the person recognises and develops a sense of their own agency and responsibility. Cox (1976) describes the process of taking responsibility after the event, and how this is closely linked with the development of insight and the capacity to sustain emotional disclosure. The idea being that following homicide there is the task of incorporating the offence into the individual's sense of self.

For the men in this study this process appeared to begin with a complete rebuilding of the self from something sub-human, to becoming human again and this is indicated in the language they use, referring to themselves as 'freaks' or 'monsters'. Only

when the person has become a human being can they start to think about what sort of person they may now like to become (and may continue to be):

being told that you're a murderer and a monster this is that, and your identity changes, you start to believe that you're evil and you're this and you're that. Over the years you realise that, this is what happened; I didn't set out to kill somebody. I'm not an evil person (Trevor, 884-888)

it's about being accepted in my views and my position. Not just because of what I've done, but because of myself as a human being. (Wayne, 292-294)

When you come into high security, you feel strange, you feel like a freak or whatever (Benjamin, 163-164)

3.2.5 Recovery of identity as more than a homicide offender

Once humanity is established within the individual and they feel like a person again, the task becomes about discovering who they are after killing someone, and this appears to be facilitated within the group therapy process. For Trevor, the journey to becoming '*more than a killer*' involved discussion about the attributes of himself and other group members. There is no one who has killed, who has only killed, and part of the recovery process for him is about remembering that, and allowing other positive qualities to form part of his identity:

your identity becomes a killer...that's how everybody sees you as. In the group, we talk about, we talk about your identity isn't as a monster, there's more behind it like some of my friends in the group talk about how they're making music, or how good they are at football, or the relationship they have with friends and family and that, it's more in depth (Trevor, 99-107)

Echoing this, Michael makes a comment about how he is viewed as 'just that', indicating the role of others in labelling him as 'just' a killer:

Just um… I dunno… I just think that people think I'm incarcerated, like ooh I've committed a homicide, just that, someone who's committed homicide and that …you know what I mean

3.2.6 A changed person

Once the offender has rebuilt themselves and established themselves as someone who has killed (but not just killed), they feel changed, like a new person. About the therapy groups that Trevor has attended, he had the following to say:

They rebuild a person who can go into society, who has got the aspirations of becoming greater than they used to be (Trevor, 750-753).

The changes that an offender goes through during homicide group treatment are not simple however. It is also about learning how to negotiate the world as someone who has killed and is therefore considered to be dangerous. During the interview Wayne spoke about how acts he perceived to be harmless could be seen as indicative of his risk, so a big part of his recovery is learning to live as someone who has killed, and being able to act in accordance with this. The following statement refers to his writing, and sending, of aggressive rap

lyrics to a member of the community, who subsequently reported this to the staff at the hospital due to their concern.

I mean things that have happened in the last 6-9 months that have demonstrated how my identity has changed, and they've been experiences that I've learned from, umm as a result of what's happened in light of my offence. (Wayne, 683-687).

However, for Wayne as with the other men, there is an acknowledgement that recovery and change must be about *improving.* He does not want to go back to where he was before:

erm… it's about doing very well, and kind of thriving in the future despite what's happened in the past. And… for me recovery is about actually kind of advancing myself and not going back to where I used to be, because I wasn't too happy with where I used to be. It's actually about going forward into a new place which is much more kind of fulfilling and kind of good for me really (Wayne, 962-969).

Benjamin also defines recovery to be about improvement:

It could mean getting back to a place where you can function… on the level of a normal person. I mean don't ask me what a normal person is! Um… you know… being able to look after yourself after being dependent on other people, or getting yourself to a point where you can say to yourself that you're no longer getting better, you're improving. (Benjamin 220-227).

These statements indicate the difference between recovery in mental health settings to recovery in forensic mental health settings. For in Forensic settings the task is about advancing, rather than returning to where they were before (Ferrito et al., 2012). Benjamin attributes his change to a number of factors:

Um, my medication got changed, and after that it was a journey, you know, a process of doing everything that I needed to do to be the person that I wanted to be. (Benjamin, 435-438).

While Benjamin has credited the group for some of his progress, it is important that the change he achieved was due to his own action, as he has taken responsibility for his own care. This is consistent with research that advocates that recovery is contingent on developing a sense of agency and control (Maruna, 2001) and places the offender at the centre of their care pathway (Drennan & Alred, 2012).

…changed over time… Not as much as it could have… if I wouldn't have taken control of my situation as far as RSU's, and doctors and medication and things like that (Benjamin, 597-600).

This was a sentiment also echoed by Alex:

Oh I help myself as well...Cuz I go to work, I do my therapy, I see a doctor every now and then, that's about it. (Alex, 231-236).

HOPE

3.2.7 Hope for the future

I think the group helps toward making sure that never happens again, and that there is a future, and that you can make something of your life even after you've taken someone's life. (Trevor 123-126)

Finding hope for the future is an important part of recovery for these individuals and in a very basic sense is about regaining a

life after taking someone else's. For the men in this study this was about having a purpose in the future, such as a job, some form of independent living and travel or relationships.

And I have other goal like getting involved in charities when I get out, and working for charities (Michael, 513-516)

I think that what's realistic is more me to live in the community and to have an alright life. A pretty good one actually. (Wayne, 1013-1015)

and it's quite easy for me to go into teaching, I mean I have a degree, I have a masters, and I can get funding to do a PGCE and I can go into teaching, but I don't know (Wayne, 1027-1030)

I mean… people… I wanna travel and I wanna meet people, I wanna experience life without the constraints of addiction and you know, lack of, you know, understanding. (Benjamin, 270-273)

a job, me own flat, be able to go fishing again (Alex, 159-160)

Benjamin summarises the importance of having hope for recovery in his statement:

In a place like this, if you lose hope, it's really not conducive with recovery (Benjamin, 290-291)

The question raised here is, how realistic are these hopes for the future, and what role has the group played in forming these? For example, Wayne talks about how he once thought that travel to the United States would be impossible, but now feels differently as a result of his attendance in the homicide group:

…but um just talking in the group to the facilitators I've realised that it was possible [to go to the USA], as long as you don't have a drugs conviction

then they tend to be ok about letting people in. So that's something I'd like to do in the future and that's something we talked about in the group, and seems quite feasible so… (Wayne, 1227-1232).

It feels important in examples such as this to manage expectations, and perhaps the difficulty lies in finding the balance between allowing hope to develop, but ensuring this is realistic for the participants, for as much as hope may be beneficial in the short-term, we know very little about the possible impact of unrealised dreams in the long-term. For example, in the case of Wayne, murder is an offence that would entail he would not be granted permission to enter the United States, and that in itself is contingent on his eventual discharge into the community, which, if possible would almost certainly involve a restrictive supervision order.

However, Adshead et al. (2015) emphasise that one of the roles of the facilitators of this group is to be frank and realistic about what the future may look like for these individuals. In support of this, not all participants' expectations were unrealistic, in fact Alex spoke about wanting a nursing team for support and he does not strive for total independence.

Um… to get out. To have a nursing team for me when I do get out. (Alex, 142-143)

While Trevor sought to make plans that he felt were realistic despite wanting something different, indicating that he had reappraised his initial plans:

Because I have so many plans, and so many goals and ideas, that I can fall back on, I'd love to go to university and get a PhD, do research properly… but… realistically I'll probably go to college and become a lab technician (Trevor, 1141-1148)

Studies exploring recovery in forensic settings have found that patients emphasise hope in their search for meaning as an antidote to hopelessness, and the persistent risk of depression and despair (Hillbrand & Young, 2008), so it would seem that attention needs to be given to how to help patients forge achievable, hopeful, goals.

3.2.8 Reparation

Two of the men spoke candidly about their desire to make reparations as important to recovery:

I feel that I have taken something from society. I feel that society, I feel that I need to pay society back, I need to do what I need to do whenever I'm out. (Trevor, 702-704)

And erm… there's no way I can repay that you know. I can try. But there's no way I can physically repay that and say look I want to erase what I've done and give them their son back. You know, I can't do that. So what I thought I could do, is erm… I can't erase my past, but I can do something to er… something to err overshadow it. (Michael, 287-293)

Making reparations seems to be a way to seek 'redemption', to pay back, make amends, and get relief from their guilt. For

Trevor, this includes being able to 'show the world' through these reparations that he is changed, that he can do good, and this in turn is validating, for it is one thing for an offender to say he is changed, but quite another for this to be believed by others:

It's that drive to show the world that I'm not a screw up (Trevor, 711-712)

3.2.8 Mental well-being

Mental well-being is the final component of recovery found in this study, and participants talked about the negative impact of mental illness on their lives:

I do realise that because of my illness, I've slept in fields, I've run away a lot, I've just been paranoid and my quality of life is non- existent really. (Trevor, 772-775)

Cuz everything was sort of very surreal on the lead up to my offence and I was suffering from psychotic illness as well. (Wayne, 656-658)

I think it's hindered my insight, and it's hindered my understanding of people (Benjamin, 309-310)

Cuz when I was not taking my meds I know I'm unwell, cuz there's that horrible feeling. (Alex, 220-222)

Part of recovering from the symptoms of mental illness is about remaining stable, learning how to ask for help, and taking the right medication:

Most recently, the thing I've been doing is asking for help when I'm down or which is still extremely hard for me. (Trevor, 990-992).

It was a long process, and a learning curve, learning about myself, my mental illness, my Index Offence, everything, all put together makes for a better understanding of the whole situation you know. (Michael, 636-639)

Um… errr and I would say that I'm happy to comply with the anti-psychotic medication. I'm on a very low dose, I don't get any of the side effects, I'm very fortunate and it works very well for me. (Wayne, 1169-117)

*It does… as long as I keep on taking my medication, because I've been level headed now for about *pause* 10/11 years (Alex, 204-206)*

Only Benjamin hoped to be free of medication entirely, with sobriety being a key theme for him throughout his interview, not just from prescribed medication but from all substances, legal or illegal, including alcohol and caffeine. This ties in to how much he feels he has changed as a person, and how he is shedding his former self. Benjamin is also an outlier in that for him mental illness was not an entirely negative experience because it gave him the motivation to change:

Um… it changed me for the better in that it's given me the motivation to everyday do things that I want to improve on, like learning Japanese, things like that…that I never thought I'd be able to do. (Benjamin, 322-336)

Benjamin feels similarly about his Index Offence in that the homicide has also given him an opportunity to change:

When I look at the alternative to what I did, I know it might sound you know, careless or whatever, but if I didn't do my Index Offence then I wouldn't be in the position where I'd be able to think even about my Index Offence or about the things that I've done. I wouldn't be in the position to … I wouldn't be in the position to change. (Benjamin, 520-527).

3.3 RISK AND RISK REDUCTION

The superordinate themes from across the interviews that related to risk were grouped into three over-arching themes (1) Understanding of the offence (2) Agency and (3) Schemas. These will be discussed in turn below.

3.3.1 Understanding the offence

All participants felt that by attending the group they gained a better understanding of their offence. Trevor believed that it was helpful to hear other people's understanding of his offence in order to better understand it himself.

This group is the key to all that, before this group I had some understanding of the Index Offence but it's how I understood it, with this group, I have other people's understanding of it. I have with people that are thinking exactly how I am thinking, with facilitators it's designed to help you think it in a way (Trevor, 1196-1201)

Michael also felt that he learned more about his offence. He moved from a narrative that suggested that killing his victim was an accident to realising that he deliberately killed someone:

You know, and it felt like an accident because everything happened so quickly. But erm… when I went into detail about my Index Offence, and others, said "look, you know what was your thoughts at the time, what were you thinking?" you can't just… I dunno… the feedback they were giving me was that maybe it wasn't an accident. (Michael, 36-41).

Michael had struggled to understand his offence because it happened quickly. He had developed a story whereby he had accidentally harmed someone in a struggle, fatally wounding them. During his attendance at the group this changed and he developed an understanding of his offence as a decision not an accident, it was 'their life or his' and it was feedback from other group member's that aided Michael's realisation:

They made me think about it you know, and after a while, I realised that you know what? I have done what I done (Michael, 64-65).

Michael's pre-group narrative had served a protective purpose, because believing the offence was an accident helped him to deny his responsibility. With Michael's increased sense of responsibility for the offence and changed narrative came emotional distress. He felt conflicted about whether he had the right to recover and move on. But over time, he 'came to terms' with the offence and was able to start moving forward.

it's very difficult for me to word that you know, and for me to come to terms with that. But when I did I felt better about myself you know. (Michael, 71-73)

Wayne also changed his narrative of his offence, though he does state that he had been trying to understand his offence for some years prior to attending the group. His pre-group offence narrative involved believing that he had just '*done loads of*

drugs and gone crazy', but later he arrived at a different understanding:

Well it certainly has, um… in that when I first started the group I believed, well I've just done lots of drugs and gone crazy and killed someone and that was it. And actually as a result of exploring what I have in common with other people in the group, I've come to realise that there's a lot more to it than that. (Wayne, 435-440)

Wayne felt like his offence was a result of a number of factors, namely, he has gained an understanding about how his life trajectory culminated in his offence: his difficult childhood, his drug use and his experience of mental illness.

and in getting your story straight, you draw upon all these elements in your life that have led up to your offence, and you start to recognise how things that have happened to you in childhood or things that were going on for you at the time of your Index Offence contribute directly to things that you did. (Wayne, 522-528).

But for Wayne this doesn't necessarily lead to a greater sense of responsibility. As aforementioned, he is still trying to understand his own culpability. For some clinicians this would be concerning with regards to risk. On the one hand, someone who views themselves as a 'victim of circumstance' has less control over their world, and those who purport that 'internal locus of control' is integral in reducing future risk would not be satisfied with this as an account of offending. However, research has indicated that locus of control theories are overly

simplistic in their conceptualisation of neutralisations, and suggests a broadening of understanding to other dimensions of attributions, such as stability, globality, intentionality, and controllability (Maruna & Copes, 2005).

In addition, there is very little evidence to suggest that offenders who accept full responsibility for their offence are less likely to re-offend, taking full responsibility for every personal failing does not make a person "normal," it makes them extraordinary, and possibly at risk of depression (Maruna & Copes, 2005). Making justifications and rationalisations for behaviour is human, and usually socially rewarded (Maruna & Mann, 2006). Moreover, there is evidence to suggest that if someone makes sense of themselves as a pro-social individual, then they are less likely to offend than someone who believes they are a criminal and that's 'just the way it is' (Maruna & Mann, 2006). For Wayne, there are elements of this in his words. Specifically, there was a sexual element to his offence which he finds very difficult to accept. In order to understand why he did what he did, he has to conceive himself as 'disturbed' at the time:

And I find that quite uncomfortable and quite difficult. Umm because actually there is a sort of sexual component to my offence, in terms of I undressed my victim and was going to have sex with her and didn't, but could have

done, and I still find that quite difficult because that sometimes sends out messages about myself that I don't feel completely at ease with, because I don't feel that I'm actually that sort of person, and I feel that one of the reasons I did that because I was very disturbed (Wayne, 1253-1262).

Continuing the theme that the group aids learning about the offence, Benjamin too felt as though he had learned more, specifically that there are reasons why people act in the way they do:

And when I went to the group, and people said certain things to me, I guess it made me realise that sometimes people do things because of reasons, they don't randomly do it. (Benjamin, 151-155)

And he applied this to his own offending:

It's made me realise the reasons I did what I did. And it made me understand and homicide a little bit more. (Benjamin, 482-484).

For Alex, explaining to other people helped him to open up to others, come to terms with his offence, and understand why he offended and why he shouldn't:

Learning to open up, learning to come to terms erm… whys and why nots of reoffending (Alex, 87)

The finding that attendance at the homicide group helped participants to understand their offence more is an important one, as Maruna (2001) states, in order for offenders to maintain abstinence from crime, they must make sense of their lives.

This sense making commonly takes the form of a personal narrative and through these the offender confronts ambiguity, change and contradictions. Those who are unable to reconstruct their personal narrative to incorporate the past, present and anticipated future are vulnerable to depression, anxiety and other problems, including re-offending (Maruna, 2001).

3.3.3 Risk Reduction

All participants talk about their hope to avoid re-offending in the future. However, perhaps surprisingly not all are wholly confident. This is noteworthy as one criticism of research reliant on offender perspectives is that this is a population likely to employ impression management in their responses (Bernasco, 2013). With this in mind, one would expect participants to at least say that they were confident they would not re-offend, but this was not the case for all the individual's in this study. Michael and Alex said that they hope not to re-offend, but they have concerns:

I can't be too certain, because you never know what will happen, but I like to think that I'm, what I'm hoping for is going to happen. (Michael, 67-70).

I hope I won't reoffend. But I can't tell until I get there. I could say to myself now, I'm not going to reoffend when I get out, in the same way I can say I'm not gonna drink when I get out, but I got to be there, I can't say yes or no. (Alex, 110-114)

Wayne is certain that he will not violently reoffend, largely due to the repercussions, but is undecided with regards to drugs related offending:

Um… yeah… er…. Certainly in terms of offending I mean, different people have said different things to me, but the one thing that seems to be absolutely clear is that any kind of trouble with the police, for any kind of offence, a violent offence or a sexual offence would lead to me being recalled, probably immediately, to conditions of security. Umm… er… which is fine, because I don't intend to commit any sort of offence of a violent nature or of a sexual nature in the future. So that's alright. Um what is more difficult is things like drugs offences, in that I have sort of quite liberal views about drugs and wouldn't mind experimenting with whether I could get away with taking them again or not (Wayne, 1295-1297)

In support of this, Wayne articulates something that may serve as protective in terms of future violent recidivism, namely his understanding of relationships and their effect on him and how this has developed through attendance at the sexual offending group.

And I mean one of the things that's come out of the work I've been doing in the SOG is that relationships are very important to me, and sort of having lots of relationships, or slightly fewer relationships but more satisfying ones, is very kind of central to my life. And it's quite interesting that at the point that I kind of suffered a break down and became very depressed and then acutely psychotic I had very few relationships in my life, in fact practically none. (Wayne, 994-1002)

Only Trevor and Benjamin said that they knew they would not offend again:

I don't even think I'm a risk to people who are a risk to me. You know, I think it's different. I'm not gonna get involved in any of this tit for tat knife crime, gang culture, or anything like that, I mean, that's where I come from, but at the same time it's … I did what I did you know, and I don't want it to be a crazy cycle of you know, you hurt me, I hurt you again and again and again you know (Benjamin, 623-631).

My idea of recovery is my team knowing 100% that my Index Offence will never happen again, that I will never get unwell again (Trevor, 667-670)

As well as describing how he doesn't wish to use violence to '*take control of his life again'* Benjamin describes the factors that he believes reduces the risk of him offending in the future:

It's lots of things, it's no one thing, I had a change in my medication, I stopped drinking coffee, ahh I changed my diet, I went to the gym more, you know, I've taken up past times and skills and it's a lot of things. I don't talk to my family and friends. Which has made a lot of difference. (Benjamin 671-677)

While Trevor largely believes that his prolonged mental stability will serve as protective in the future:

Um.. completely stable since about 2008/2009…(Trevor, 793)

Michael and Alex's uncertainty about their future speaks of a surprisingly passive self-narrative. Surprising in that it contrasts so vastly with their other statements that feel more optimistic and determined. With regard to risk this could be telling; for if life is a series of chance events *(*I can't be too certain, because who knows what will happen?) then what motivation is there to play by the rules? If good fortune is a lottery, then why desist from offending? Maruna's (2001) Liverpool Desistance Study examined the narratives of persisters and desisters of crime and also reported similarly passive accounts delivered by persistent offenders.

Wayne's openness about his 'liberal attitude toward drugs' and his lack of commitment to avoiding related offences in the future is reflective of findings found in the literature. The risk of homicidal reoffending in homicide offenders is low, with none of the 336 homicide offenders in the Roberts et al. (2007) study committing a further killing during the course of the longitudinal study. However, they found that recidivism for new violent or drug crimes occurred in their 'felony homicide' offenders to be over 33%, 27% in their 'altercation precipitated' offenders, and 10% in their 'domestic violence' homicide offenders. However, Roberts et al. (2007) only followed their sample for 5 years so this may not necessarily reflect desistance from homicide and may instead point to a break in offending, begging the question as to how long an offender has to desist from offending before they are considered 'reformed'. A review by Liem (2013) found that recidivism in homicide offenders ranged from as low as 1% to as high as 83%, perhaps reflecting some of the inherent complexity in defining desistance.

AGENCY

3.3.4 Acceptance of responsibility

Within the over-arching theme of 'Agency' was the superordinate theme of 'Acceptance of Responsibility' which occurred in 4 out of 5 of the interviews:

I done this, and I took somebody's son away from them and their parents. I done that and I done this. I was very plain with myself. (Trevor, 507-510).

I admit to it, and I have done that you know? (Michael, 22-23)

but I'm glad that I, you know, held my hands up in the beginning (Benjamin, 344-345)

I just come to terms with what I did. (Alex, 375)

With this acceptance of responsibility appears to come a sort of 'badge of honour' in that the individual allows himself some reprieve because they have owned their offence, and this is difficult. Benjamin articulates that this in turn separates him from the 'others' who presumably are viewed to be worse, or at least 'less reformed' than him.

But going to the group and hearing people talk about, you know, their experiences, being similar to my own and other people who have done very bad things, and also there are people who don't really take any responsibility for what they've done, and people who don't face up the fact that they did what they did (Benjamin, 551-557)

With this in mind, the role of acceptance of responsibility in this study appears in some ways to be redemptive, while also

signposting that the offender is on the route to reform. For these men, admitting culpability was the first step in learning about their offence, discarding their rationalisations and neutralisations and beginning their new narrative as someone who has killed, but is trying to change.

Research indicates that when an environment is excessively controlling, overly challenging or rejecting, the individual has a propensity to act defensively, or employ self-protective processes, but this has not been the case here (Barker, 2012). From this one could conclude that the group environment has allowed participants to accept their offender identity.

Historically, there has been much clinical emphasis on the offender accepting responsibility for their offence, although this has since been disputed (Maruna & Mann, 2006). Here the word 'agency' is used as the over-arching theme because the finding that participants accepted their responsibility was not just related to taking responsibility for their past offence, but was much more about acceptance such that they can continue to take responsibility for their future. This is evidenced within the earlier theme of 'hope for the future' and also illustrated in the following:

So it isn't set in stone, it's how you make the future (Trevor, 748).

and some people gave me advice like don't let your past determine what you do for the future, and stuff like that you know. It's like a learning curve for me anyway you know (Michael, 226-229)

because I don't intend to commit any sort of offence of a violent nature or of a sexual nature in the future. (Wayne, 1201-1203)

SCHEMAS

3.3.5 Patients challenge other patients.

Intrinsically linked to the theme of 'understanding the offence' but worthy of mention in its own right due to the frequency with which it was noted is the process by which patients within the homicide group are constantly challenging one another and this functions as a catalyst for the individual to arrive at a new understanding of their offence, without rationalisations or neutralisations:

*like I might have been thinking a certain way about my Index Offence or a little… or someone gives me an opinion and it makes me think… so erm… more times it's helped me be *pause* be brave enough to say that I admit to… you know what I mean? I admit to it, and I have done that you know? (Michael, 18-23)*

Being able to talk to other people and being able to sense that they may agree or disagree with what I'm saying (Wayne, 294-296)

It's about understanding the offence, by other people asking, and telling their opinions, so it's about getting insight into your offence. (Benjamin, 29-31)

What appears to be happening in the homicide group is that the offenders arrive with a 'story' (narrative) of their offence, but it

is laden with their own rationalisations or 'excuses'. These then change during the course of treatment. This is important because it indicates that the offenders in this study don't have 'offence supportive attitudes' per se. Offence-supportive attitudes and beliefs are defined as stable, on-going, non-situation-specific (Blumenthal, Gudjonsson, & Burns, 1999) attitudes which justify or support offending. In this study, the rationalisations for offending seem to be dynamic and changeable. During homicide group therapy, the participants seem to oscillate between the role of therapist and patient. They challenge one another's 'cognitive distortions' or offence schemas which in manualised groups is often the role of the clinician. One could hypothesise that in this instance, it is even more effective, because there is less of a social gap between group members than in the clinician-patient relationship.

4.0 GENERAL DISCUSSION

Using an interpretative phenomenological method, this study has explored the lived experience of group treatment for homicide offenders by interviewing a group of mentally disordered homicide offenders within a high security setting. The qualitative data was rich and informative providing insight into experiential phenomena which may help our understanding

of homicide offenders and their experience of psychodynamic group therapy. The analysis also incorporated an ideographic focus and with this an attempt has been made to provide nuanced explorations of particular instances of lived experience and highlight detailed variations in the sense making which appeared during analysis.

4.1 The Group

Something that appeared common to all participants was that the perceived open format of the group was beneficial which runs counter to the aforementioned concerns about criminogenic thinking that could result in such a group format. Indeed, describing this intervention as psychodynamic is a misnomer in the sense that the facilitating therapists employ mentalising, supportive, cognitive, and psychotherapy techniques to help group members to arrive at more coherent narratives of their index offence (Adshead et al., 2015).

Groups that emphasise mentalising differ from psychodynamic therapy in that there is more direct activity by therapists in the process of the group, and a clear focus on the theme of mentalising (Karterud & Bateman, 2012). However, mentalising groups are similar to traditional group techniques in that

therapists allow the dialogue in the group to be led primarily by the patients, not the therapists, and there is no agenda to the group process (Adshead, 2014).

Mentalising techniques target the development of the capacity to reflect on one's own mind and are evidenced to be more effective than 'treatment as usual' in the treatment of personality disordered offenders (Bateman & Fonagy, 2004). This is especially pertinent in the study of homicide offenders for which the number of personality disordered offenders is estimated to be over 30% (Eronen et al., 1996), and is even higher within this study due to the environment from which participants were selected.

Finally, the challenging of cognitive distortions and offence schemas noted in this study are often strategies employed in CBT based programmes for offender treatment, for which there is a large body of supporting research (Allen et al., 2001; Andrews et al., 1990) however the mode in which these are operationalised within the homicide group differs vastly from manualised interventions.

4.2 Recovery

Recovery for these offenders was a multi-faceted process that involved (1) the sharing and exploration of difficult emotions such as guilt (2) a reformation of a personal identity that incorporated the offence but allowed for (3) hope for the future, and (4) recovery from mental illness.

The idea that offending leads to difficult emotions is not a new one, and Spitzer et al. (2001) found that in a sample of 53 mentally disordered forensic in-patients, 56% met lifetime criteria for PTSD. However, this followed exposure to different types of trauma including childhood physical abuse and so whether their offence was the specific cause is questionable. That said, 9.4 % of their offenders were homicide offenders and this was found to be the second most common trauma resulting in PTSD (Spitzer et al., 2001).

Moreover, existing research indicates that homicide, particularly if very violent, is highly traumatic, and can lead to symptoms consistent with PTSD (Curle, 1989; Gray et al., 2003; Harry & Resnick, 1986; Papanastassiou et al., 2004; Pham & Willocq, 2013; Pollock, 1999b; Rynearson, 1984). Within this study, attendance at the group was supportive in

overcoming some of the difficult emotions such as guilt and conflicted thinking about recovery, and facilitated the process of incorporating the homicide into a self-narrative that resulted in a reduction in emotional disturbance.

The narrative identity can be understood as an active information processing structure, a cognitive schema, or a construct system that is both shaped by and later mediates social interaction. People construct stories to account for what they do and why they do it (Ward et al., 2007). Maruna (2001) studied the narratives of recidivist offenders and compared them with narratives of those who desisted from offending and found that those who desisted from offending talked about themselves in different ways than those who persisted in their offending. The desisters provided reflective commentary with a temporal element comparing how they used to see themselves to how they see themselves now.

For the men in this study, a key element of recovery was the belief that they are now a changed person, and Maruna's (2001) findings indicate that this may also have implications for future risk as well as for offender recovery. The homicide group played a role in helping the offender to transition from a 'monster' to a

person with a new identity, yielding improvements to self-perception and their mood concurrently. Within this, were veins of 'hyper-morality' which Lofland (1969) describes as a process whereby 'transformed deviants' don't just become moral, they become hyper-moral. This is similar to the theory of Generativity, which is defined as a concern for and commitment to promoting the next generation, through teaching and mentoring, generating outcomes that aim to benefit others (Maruna, 2001), and this was supported by the redemptive hopes of the homicide offenders to make reparations for their offences in the future.

Hope for the future was prominent in this study with regards to recovery. However at times, whether these hopes for the future were realistic were questionable. This is similar to a finding by Maruna (2001) of recidivist versus reformed offenders. He noted that offenders displayed an exaggerated sense of control over their future and an inflated 'almost missionary' sense of purpose in life. They did not perceive their offending to be a shameful failing, instead viewing it as a necessary prelude to a 'newfound calling' (Maruna, 2001). What is surprising, is that these results came from the group of offenders who were 'reformed' not those who persisted in criminal activity. In

Maruna's (2001) study, the active offenders were realistic in their appraisal of their situation and their chances of achieving success in the world without resorting to crime. This would indicate that there is some value in having dreams for the future, irrespective of their achievability or realism. How true this holds for this sample is subject to debate however, as there was some evidence of 'reality checking' amongst these participants. This is perhaps evidence of the therapeutic process whereby offenders are encouraged within the group to think realistically about what their life will be like post-homicide (Adshead et al., 2015)

Unsurprisingly, of recurrent importance within the realm of recovery for these men is the ability to maintain sound mental health. The ways in which this is made possible goes beyond attendance at the homicide group, to include finding the right balance of medication and learning to ask for help. All of the men had had terrible experiences of mental illness and attributed causality of their offending partially to their mental state at the time. They did not seem to 'blame' the mental illness however, which is remarkable given that it is a mitigator of responsibility in law and is usually the main reason that group members have been sent to hospital instead of being sentenced

to prison (Adshead et al., 2015). That said, all participants told a story that reflected that this was a process that had occurred over time, originally viewing their mental illness as causal in an almost linear fashion, before gradually arriving at a different understanding that allowed for multiple contributory factors to the offence alongside a sense of personal responsibility or agency.

For two members of the group, the experience of mental illness had been given a positive slant, in that it spurred them to fight to improve themselves. Maruna (2001) describes this as 'making good from the bad'. Redemption narratives such as this seldom involve just 'getting by' in the future, but rather call for the individual to operate at exemplary levels (Maruna, 2001). The recurrence of 'self-improvement' and 'reparation' as themes within this study lends support for this concept. In this sample this seems to be a way to live with the fact that many years of their life have been wasted since their admission to hospital and in this sense, two lives are lost as a result of the homicide. They emphasise how facing a life sentence makes one look at life through a different lens and by conceptualising these events as purposeful, the offender is not in a position where they have 'nothing to show' for themselves. Rather, it can be a

turning point from which to create positive change, not just for themselves but for others too. Encouragingly, Maruna (2001) found these redemptive narratives in 70% of his desisting offenders, indicating the importance of being able to assimilate a terrible act into a positive self-story with a 'happy ending'.

4.3 Risk

Each of the individuals felt that attendance at the group had helped them to understand their offence in greater detail. They arrived at the group with a narrative or story that explained their offence and this changed over time to allow for a greater sense of agency and deeper insight into the contributory factors for the offence. Reflected in the narratives of the men in this sample is the arrival at an explanatory style that is consistent with literature that supports a changed narrative as important to desistance from offending (Berglund; Bushway, Piquero, Broidy, Cauffman, & Mazerolle, 2001; Gadd & Farrall, 2004; Giordano, Cernkovich, & Rudolph, 2002; King, 2013; Laub & Sampson, 2001; Maruna, 1997; Maruna et al., 2004; Sampson & Laub, 2005; Vaughan, 2007).

With regard to this, three cognitive processing biases are considered: (1) 'internality' (I am solely responsible for the

good/bad event versus the event is someone else's fault/responsibility), (2) stability (the cause is going to last forever versus the cause will be short lived) and (3) Globality (it is going to affect everything I do versus it is only going to influence this) (Maruna et al., 2004). This is related to work on depression. For non-depressives, failure events tend to be external, temporary, and specific, but good events are personal, permanent and pervasive. 'If it's bad, you did it to me, it'll be over soon, and it's only this situation. But if it's good, I did it, it's going to last forever, and it's going to help me in many situations.' (Seligman, 2011).

Maruna (2004) found similarities with offending behaviour in that negative-internal attributions are associated with persistence in criminal behaviour. This finding suggests that an individual might be more likely to reoffend dependent on the extent to which negative events are viewed as originating from internal sources (This is just the way I am), especially when these are stable (I've always been this way) and global (I fail at everything I do, no matter where I go) (Maruna, 2004).

The individuals in this study attributed their offending behaviour to be a result of a combination of personal, social and

situational circumstances, not indicating a bias toward internality or externality, but leaning toward the view that the causes for the offence were dynamic (i.e. not stable) and specific to that particular situation alone (i.e. not global). These offenders did not convey a sense of passivity and helplessness in their own lives, and did not view themselves as 'bad people' with no hope of change. From this, one could hypothesise that with a greater sense of agency and self-belief, they are less likely to offend in the future.

That said, this wasn't a stable finding, and was noted to fluctuate even throughout the course of the interview. Two of the participants were concerned that they couldn't be certain about whether they would reoffend in the future, hinting at helplessness, before quickly oscillating to a more positive stance with a determination not to reoffend. This indicates that explanatory style is subject to change and a revised self-narrative is not a stable construct, but something that can fluctuate over time. With this in mind, Paternoster and Bushway (2009) have suggested that offender identity is made up of narratives that include at least three components: the 'working' self, the 'future/possible' self and the 'feared' self. One possible explanation for this shift to passivity from agency in this sample

therefore maybe that the 'feared self' is triggered. This is probably a common occurrence in conditions of high security where the focus is so frequently on the individual's Index Offence and the potential risk they pose to others.

Despite this, the overarching themes adhered to by these offenders were those that utilised language of personal agency, and they described ways in which they could effect and maintain change for their future. One process by which this was achieved was by offenders challenging one another and questioning their neutralisations, almost undertaking a therapist role in their ability to create dissonance.

Ward et al. (2007) proposed that the current process of corrective intervention works in a manner that means that rehabilitation is 'done to' the offender, rather than 'by' the offender, a process long disputed for its efficacy in motivational interviewing research that suggests that the decision to change must come from the individual, otherwise defences and denial may be activated (Miller & Rollnick, 2012). An explanation for the efficacy of patients challenging one another, as opposed to the clinician taking this role, is that the experience of the shared offence (and perceived lack of judgement) lowers the

participant's defences, allowing them to hear an opposing view even if this causes emotional disturbance, lending support for the use of narrative therapies within offending populations.

5.0 LIMITATIONS OF THE STUDY

It is important to note that the views expressed in this research come from a very small sample of offenders who volunteered to participate. This could have provided a skewed interpretation of the value of group treatment. It would have been helpful to have heard the opinions of those who had dropped out of the group, or those who refused to participate, as it is possible that these individuals would have a different account of the therapy and its efficacy.

6.0 REFLEXIVE CONSIDERATIONS

There are several aspects of this study that may require reflexive consideration. Firstly, there is the potential for the author to interpret the data with the influence of pre-existing frameworks of reference (Willig, 2013). In an attempt to address this, verbatim extracts are provided to support the credibility of the analysis. The author also kept a reflexive diary, which, in addition to tracking the analytic process also

encompassed a course of self-reflection that allowed for conscious monitoring of preconceptions. One such preconception was an outdated impression of locus of control as a bilateral process, which influenced the way in which certain statements were interpreted. The reflexive diary encouraged a critical evaluation of such preconceptions and their influence in order to avoid missing important avenues of meaning.

The second reflexive consideration is the way that the validity of the results may have been affected by the fact that the participants had been purposely selected due to their length of stay and therefore their commitment to homicide group treatment. Within this we are only able to access the experiences of those who have found the group to be of some benefit to them, and know very little about the experiences of those who have dropped out of the group or refused to join, as aforementioned.

Thirdly, an inherent difficulty with IPA itself lends itself to consideration. IPA is concerned with lived experience, and the medium in which we access these experiences is language (Willig, 2001). The difficulty with this is that there is a possibility that the language used may differ from what the participant

truly meant to transmit and researchers will not always be able to detect this. The researcher attempts to make sense of the participants' words within the context of their own linguistic repertoire and background of beliefs. This is noteworthy particularly given the difference between the participants and the researcher. One could argue that it is challenging for a male, who has killed, with mental health difficulties, in a high security hospital, to be fully understood by a female who hasn't faced such obstacles. One possible improvement in this detail would have been further triangulation, particularly through carrying out a respondent validation (Langdridge, 2007). Similarly, impression management may have impacted on the responses given by participants, who may have sought to 'please', impress, or give 'correct' responses to the researcher (Paulhus, 2002). Again, triangulation of evidence, possibly via consultation with involved clinicians, may help to address this.

Finally, it could be argued that the sample was too small thereby hindering the transferability of the results to a wider population. However, IPA is committed to detailed appraisals of small samples with the aim of producing nuanced analyses of personal experience and as such, the sample size used within this study is within the bounds suggested (Smith et al., 2009).

Nevertheless, future research may benefit from using narratives from larger samples.

7.0 CONCLUSIONS

In summary, the findings of this study demonstrate that there is room for narrative therapies within the realm of 'Index Offence' work, and according to the individuals in this study the homicide group played a significant role in aiding their recovery. Recovery is defined here as maintaining mental well-being, recovering or 'getting over' the difficult emotions caused by the offending, and by the individual having confidence in their ability to avoid offending in the future, thus integrating the 'dual' task of recovery in an offender population (Drennan & Alred, 2012). The part the group played with regards to risk reduction is more complex, largely because it doesn't just affect the offender, but has an impact on society as a whole. One can never say with certainty that an offender will never re-offend again. Risk is a dynamic concept subject to change over time and influenced by different contextual, social and relational circumstances; even for some of the participants in this study, uncertainty (or fear) about the risk of re-offending was persistent. What was apparent however, was that the participants demonstrated a shift in narrative identity which

research indicates is consistent with reduction in risk (Berglund; Gadd & Farrall, 2004; King, 2013; Laub & Sampson, 2001; Maruna et al., 2004; Vaughan, 2007).

7.1 Clinical Implications

There are several clinical implications of the findings of this study. Firstly, group members felt that the intervention had an impact on recovery and risk reduction, and as such supports the use of such narrative therapies. There also seems to be support for groups which are open and dynamic in format, as the participants found this particularly advantageous. There was scope for a group bond to form and for individuals to help one another to disclose and discuss difficult topics. That said, the participants were clear in that there were a multitude of factors that led to their improved well-being including; medication, other therapies, one to one work, and self-motivation, and as such homicide group treatment forms only part of a wider treatment plan for individuals.

Secondly, with regard to assessment; risk assessment in hospitals is only partially accounted for by actuarial risk assessment, with clinical judgement playing a significant role. With this in mind, understanding the personal narrative of

offenders appears important in the process of making informed clinical judgements, particularly given that there is an emerging body of research that challenges preconceptions about explanatory style and theories of 'criminal thinking'. The themes emerging in this study assist in the understanding of the experiences of the homicide offender following their offence, and their thought processes during treatment.

7.2 Suggestions for Future Research

Given the complexities of homicide as an offence, dedication to painstaking and meticulous case analyses should play a key role in future research. It would be particularly helpful, as aforementioned, to explore the experiences of those who had dropped out of homicide treatment, or even those who had moved on from high security hospital, to assess if and how their experience of treatment had assisted in this process.

It may also be of value to compare this approach with other intervention types. For example, given the levels of distress in this sample, and trauma experienced by homicide offenders more generally (Curle, 1989; Gray et al., 2003; Papanastassiou et al., 2004; Pham & Willocq, 2013; Pollock, 1999b), one to one therapy for trauma or CBT for PTSD may be of value, and it

would be interesting to compare the efficacy of these different treatment modalities for homicide offenders specifically.

An Introduction to Chapter Five

Psychologists use validated instruments and tests to provide measurements of a range of psychological domains including: intellect, personality, emotional state, well-being, literacy and risk. The results of such tests are a useful means from which to make recommendations for treatment. Often, psychometric assessment informs forensic psychological reports for courts, tribunals, or parole boards which offer an opinion on the individual's likelihood of further offending. Such reports may be used in mitigation for sentencing or release purposes and as such, a critical approach involving an awareness of the reliability, validity, and scope of application is crucial.

The following chapter involves a critique of the Inventory of Complicated Grief (ICG) (Prigerson, Maciejewski, et al., 1995). Certain symptoms of grief have been shown to be both distinct from bereavement-related depression and anxiety, and to predict long-term functional impairments. Prigerson, Maciejewski, et al. (1995) termed these the symptoms of 'complicated grief' and developed the Inventory of Complicated Grief (ICG) to assess them.

The ICG was used as an assessment measure in chapter three in the case study of Sam, and is a pre and post assessment tool used in the facilitation of the homicide group explored in chapter four. As such, the reliability and validity of this tool is critiqued, with specific reference to its applicability within an offender population, for which the bereaved are culpable for their loss.

Chapter Five

A CRITIQUE OF THE INVENTORY OF GRIEF

Abstract

Certain symptoms of grief have been shown to be distinct from bereavement-related depression and anxiety, and to predict long-term functional impairments. These have been identified as symptoms of 'complicated grief' and the Inventory of Complicated Grief (ICG) was designed to assess them. Studies increasingly indicate bereavement responses in homicide offenders, a group of individuals who are culpable for their loss. Psychological adjustment within this population is imperative when considering recovery and risk reduction, and increasingly measures such as the ICG are being used within this population. In this critique, the ICG is compared with other measures of grief and is considered to be a scale with demonstrated internal consistency, and convergent and criterion validity, and provides an easily administered assessment for symptoms of complicated grief. Its use within a forensic population is discussed.

1.0 INTRODUCTION

1.1 Grief

As discussed in previous chapters, grief is a normal reaction to loss and refers to the distress resulting from losing someone. Research has shown that certain symptoms of grief form an integrated component of emotional distress that is clearly distinguishable from the symptoms of depression and anxiety (Prigerson, Maciejewski, et al., 1995). Symptoms which cannot be accounted for by anxiety or depression diagnoses include: preoccupation with thoughts of the deceased, searching and yearning for the deceased, disbelief about the death, crying, being stunned by the death and not accepting the death. These symptoms are also thought to predict long term dysfunction such as impairments of global functioning, sleep, mood, and self-esteem at 12-18 months following the loss (Prigerson, Maciejewski, et al., 1995).

Grief is multi-faceted with physical, behavioural and meaning/spiritual components and is characterised by a complex set of cognitive, emotional and social adjustments that follow the death of a loved one (Lobb et al., 2010). Individuals differ in the way they experience their grief, particularly with

regard to intensity and duration, and the way that grief is expressed (Field & Behrman, 2003). Despite this, most people who are grieving demonstrate similarities of experience including distress, anxiety, yearning, sadness and pre-occupation, with these symptoms gradually decreasing over time (Field & Behrman, 2003). Most individuals will be able to resolve their grief feelings, and most do not experience adverse grief related health effects (Allumbaugh & Hoyt, 1999).

1.2 Complicated Grief

Complicated grief is discussed in chapter two, but is explored fully here with a view to examining its credibility as a discrete syndrome. According to Prigerson, Maciejewski, et al. (1995) complicated grief involves experiencing functional impairments as a result of prolonged bereavement symptoms. At six months following bereavement, the bereaved is expected to still experience some residual symptoms of grief, but should have integrated these into their life, such that they no longer impact on their ability to function on a day to day basis (Shear et al., 2011). 'Pathological' symptoms may include survivor guilt, bitterness over the death, jealousy of others who have not experienced a similar loss, distraction to the point of disruption in everyday activities, and lack of trust in others as a

consequence of the loss (Prigerson, Maciejewski, et al., 1995). Symptoms suggesting shock or debilitating intrusive thoughts about the deceased differentiate grief from complicated grief (Prigerson, Maciejewski, et al., 1995).

In the deliberations over the DSM-5, there were a number of suggestions that it should specifically address the minority of bereaved individuals for whom their grief is crippling (Boelen & van den Bout, 2014a; Horowitz M., 1997; Lichtenthal, Cruess, & Prigerson, 2004; Prigerson et al., 2009; Zisook & Shear, 2009). Some argued that this severe reaction to grief could be handled by including diagnoses such as 'complicated grief disorder' or 'prolonged grief disorder' recognising that while most people have grief reactions within a typical range, 10 to 15 percent of grievers have severe reactions to the loss of a loved one and thus may need treatment that includes prescription medication and counselling (Prigerson & Jacobs, 2001).

The DSM-5 committee believed there was no consensus for the addition of prolonged grief disorder and complicated grief (American Psychiatric Society, 2013). Instead, the committee removed the "bereavement exclusion" from both depression

and adjustment disorders. This means that a person who is grieving a loss potentially may be diagnosed with depression or an adjustment disorder (Zisook et al., 2012).

This is problematic since complicated grief is distinguished from non-impairing grief and other disorders such as PTSD, Depression, and Anxiety. Complicated grief disorders may include symptoms such as intrusive images, severe pangs of emotion, denial of implications of the loss to the self, and neglect of necessary adaptive activities at work and at home (Horowitz, 1997). Major depressive disorder does not adequately cover this symptom picture; adjustment disorder is too nonspecific to serve as the relevant additional category and can be distinguished from complicated grief by the specificity of the etiologic event, as well as grief-specific symptoms. The event criterion for PTSD excludes some common loss-induced reactions and does not adequately describe the phenomenon of complicated grief (Horowitz et al., 1997).

In contrast to the view taken by DSM-5, ICD-11 is proposing a separate diagnosis that recognises complicated grief and terms the condition 'prolonged grief' (Maercker et al., 2013). This recognises that individuals experiencing complicated grief

experience a sense of persistent and disturbing disbelief regarding the death and resistance to accepting the painful reality. Intense yearning and longing for the deceased continues, along with frequent pangs of intense, painful emotions. Thoughts of the bereaved remain preoccupying often including distressing intrusive thoughts related to the death, and there is avoidance of a range of situations and activities that serve as a reminder of the loss (Byrne & Raphael, 1994; Middleton et al., 1996; Prigerson & Jacobs, 2001). In support of this, recent studies have used confirmatory factor analysis to replicate earlier findings that complicated grief, depression, and anxiety are distinct syndromes (Boelen & van den Bout, 2014a).

1.3 Complicated Grief in Homicide Offenders

Adshead et al. (2008) state that perpetrators of homicide can develop PTSD, complicated grief and clinical depression in response to their offences, and require treatment for those conditions. There is a lack of literature to support this however, with most focussing on the impact on the victim's families. However, Brunning (1982) describes the similarity of psychological responses between those who have killed and those who have been bereaved by killing. He described a group he facilitated for male homicide offenders in a prison setting and

outlined how they had experiences following the act which were symptomatic of grief. Brunning (1982) reported that they went through an initial phase of disbelief, reliving the trial, denial, and depression.

Fraser (1988) also described cases of homicide offenders suffering grief after killing someone close to them and demonstrated several reasons why a murderer may be expected to suffer from difficulties in the process of grieving. Firstly, there will have been significant relationship difficulties and ambivalence of the relationship and secondly the unusual circumstances of a person being responsible for the death of another might in itself lead to abnormal grief. Thirdly, they noted that a previous complicated grief reaction may predispose them to further difficulties in bereavement and that the initial abnormal grieving may have in itself been a factor in the subsequent killing. Indeed, Parkes and Prigerson (2013) has described how some patients suffering atypical grief had experienced aggressive outbursts as symptoms of their complicated grief, and furthermore, someone suffering such a grief reaction may have cognitive distortions about death, which justify further killing, such as 'If it was okay for them to die, then why shouldn't you' (Parkes & Prigerson, 2013).

Fraser (1988) also emphasised the importance of personality factors which may make someone more vulnerable to complicated grief. For example, an individual who is unable to tolerate extremes of emotional distress is more likely to suffer a complicated grief reaction. Furthermore, grief is described as a social as well as a personal process, such that there are likely to be problems if the circumstances of a death make it uncomfortable for others (i.e. suicide) or if the bereaved does not have access to a social support network (Fraser, 1988). These personality and social factors which predict complicated grieving will almost certainly be relevant to those who kill, as the actual offence will often be an extreme reaction to stress to which the individual was unable to find a suitable response (Fraser, 1988). Additionally, the act of homicide is almost universally deplored, and a typical reaction in our society is one of shock and disgust. Therefore the offender will have to encounter a hostile rejection by society, including members of the deceased's family.

As discussed in chapter one, Parkes and Weiss (1983) explored why some people do well after bereavement while others do not. They identified risk factors to identify who, after

bereavement, were at risk of problems later. They also noted the characteristic reactions that followed sudden, unexpected, and untimely deaths, the deaths of partners for whom the bereaved person had been very dependent and the conflicted grief of people whose relationships were highly ambivalent (Parkes & Weiss, 1983). Factors that predispose the individual to pathological grief reactions include (a) modes of loss in which the death is; sudden, unexpected, multiple, violent, or for which the bereft feels responsible and disenfranchised losses (b) personal vulnerability in which the bereft was dependent on the deceased (or vice versa), had an ambivalent relationship with the deceased, persons lacking in self-esteem/trust, and with psychological vulnerability, and (c) lack of social support; i.e. no supportive family and/or social isolation (Parkes & Prigerson, 2013; Parkes & Weiss, 1983).

Against this background, it seems plausible that homicide offenders suffer complicated grief, with symptomology not too different from those bereaved in other scenarios. Therefore, it makes sense that complicated grief is measured in homicide offenders, particularly if one is focussed on a dual recovery agenda which includes both reduction in risk, and the recovery of the individual (Drennan & Alred, 2012). However, at the

present time there is no literature that supports the use of the ICG within a forensic population, and this remains an area that warrants further exploration. In this critique, the value of the ICG is explored, before examining its application to forensic samples.

2.0 MEASURING COMPLICATED GRIEF

Psychometric measures of complicated grief include; the Texas Revised Inventory of Grief (TRIG), the Hogan Grief Reaction Checklist (HGRC), the Grief Evaluation Measure (GEM), the Revised Grief Experience Inventory (RGEI), the Core Bereavement Items (CBI), the Parkes Bereavement Risk Index (BRI) and the Inventory of Complicated Grief (ICG). A brief description of these measures is followed by a comparison of their utility with that of the ICG.

2.1 The Texas Revised Inventory of Grief (TRIG)

The Texas Revised Inventory of Grief (Faschingbauer, 1981) is a 21-item scale that relates to two points of time: past (immediate or shortly after the death) and present (the time of data collection). The Texas Revised Inventory of Grief—Present scale (TRIG–Present) is one of the most widely used grief

measures. The TRIG was initially regarded as a measure of unresolved grief (Faschingbauer, 1981) but more recently, it has been conceptualised as a measure of normal grieving (Futterman, Holland, Brown, Thompson, & Gallagher-Thompson, 2010).

2.2 Hogan Grief Reaction Checklist (HGRC)

The HGRC is a 61 item instrument structured as a five-point Likert-type scale (Hogan, Greenfield, & Schmidt, 2001). The instrument consists of a list of thoughts and feelings that the bereaved person may have experienced since their loved one has died. Respondents are asked to consider their feelings in the previous two weeks.

2.3 Grief Evaluation Measure (GEM)

The GEM is an instrument designed to screen for the development of a complicated mourning response in a bereaved adult (Jordan, Baker, Matteis, Rosenthal, & Ware, 2005). The instrument is comprised of seven sections using quantitative and qualitative questions to assess risk factors, including the bereaved person's loss and medical history, coping resources before and after the death, and conditions surrounding the death.

2.4 Core Bereavement Item (CBI)

The CBI is a 17 item tool which was developed using qualitative data from a longitudinal study of three groups: bereaved spouses, bereaved adult children and bereaved parents (Burnett, Middleton, Raphael, & Martinek, 1997). It included three subscales (images and thoughts, acute separation, and grief) forming the basis of a single measure, labelled the Core Bereavement Items (CBI).

2.5 Revised Grief Experience Inventory (REGI)

The RGEI has 22 six-point items and includes the subscales: Depression (six items), Physical Distress (seven items), Existential (six items), and Tension/Guilt (three items) (Lev, Munro, & McCorkle, 1993). The RGEI is adapted from the GEI and originally consisted of 9 factors that measured despair, anger, guilt, and social isolation, loss of control, rumination, depersonalisation, somatisation, and death anxiety. The RGEI does not contain items that describe sadness or crying, which are usually considered normal reactions to bereavement (Lev et al., 1993).

2.6 Bereavement Risk Index (BRI)

The BRI (Parkes & Prigerson, 2013) was initially used to assess spousal bereavement and is able to differentiate those that will experience high levels of psychological disturbance following loss. The BRI is a 4-item assessment of complicated grief which is simple and easy for nurses to use and requires minimal training (Kristjanson, Cousins, Smith, & Lewin, 2006).

2.7 Inventory of Complicated Grief (ICG) and the ICG Revised (ICG-R)

The Inventory of Complicated Grief (Prigerson, Maciejewski, et al., 1995) is a 19 item self-report instrument that allows for the dimensional assessment of the severity of complicated grief symptoms. Scores of 25 or higher (over a range of 0 to 76) indicate a high likelihood that the syndrome is present. The ICG-R is a short version of the ICG originally consisting of 19 items. The ICG-R has 4 fewer items and demonstrates similar psychometric properties to the ICG (O'Connor, Lasgaard, Shevlin, & Guldin, 2010). For the purpose of this report, the original ICG will be the focus of this critique, due to the fact it is widely and freely available, and has the largest evidence base from which to discuss its properties.

2.8 Comparing the ICG with other measures of grief

The ICG is most aligned with the literature that confirms the distinction between complicated grief, anxiety and depression (Prigerson et al., 1995). The TRIG (Faschingbauer, 1981) includes benign symptoms of grief that would not be expected to be associated with enduring illness and asks the respondent about crying in three separate statements, a procedure that seems redundant for the assessment of a unique set of indicators of complicated grief. The GEM (Jacobs et al., 1986) includes symptoms associated with anxiety and depressive disorders such as statements about a dread of impending doom, fear of losing control of one's feelings, and feeling tense, nervous, and fidgety. The literature suggests that items that signpost depressive illness should be extracted from a specifically grief-focused scale (Kristjanson et al., 2006).

The other psychometric measures of complicated grief described here include other superfluous symptoms which could confound the assessment of complicated grief by including measures of general grief, depression, and anxiety. In addition, existing grief scales also fail to incorporate some measures of symptoms found to be specific to complicated grief such as survivor guilt, bitterness over the death, jealousy of others who

have not experienced a similar loss, distraction to the point of disruption in the performance of one's normal activities, and lack of trust in others as a consequence of the loss (Kristjanson et al., 2006).

The TRIG also does not include auditory and visual hallucinations, and neither the TRIG nor the GEM contains an item to assess the 'identification' symptoms associated with a grief related facsimile illness such as pain in the same parts of the body as that experienced by the deceased (Kristjanson et al., 2006). These foreboding grief-related symptoms included in the ICG seem more likely to reflect greater difficulty accepting the death and to predispose the bereaved to enduring maladjustment to the loss of another and would therefore seem like a more representative assessment of a pathological form of grief such as that posited by the definition of complicated grief (Prigerson, 1995).

3.0 PRACTICAL EVALUATION

The ICG is an easy to administer, self-report tool consisting of 19 items which can be scored on a scale of 0-4 (0 Never, 1 rarely, 2 sometimes, 3 often and 4 always). Asking respondents

to report the frequency of an emotional or cognitive state has been found by Horowitz et al. (1979) to be an effective means by which to assess the impact of events. The ICG was developed to isolate the symptoms of complicated grief, and avoid being over inclusive of symptoms which could signal other disorders such as anxiety or depression (Prigerson, Maciejewski, et al., 1995). In short, the rationale was to identify grief-related symptoms that could help to discriminate between uncomplicated and complicated grievers. A brief overview of the items in the ICG are displayed in table 18.

Table 18: Overview of ICG items

1. Preoccupation with the person who died	11. Avoidance of reminders of the person who died
2. Memories of the person who died are upsetting	12. Pain in the same area of the body
3. The death is unacceptable	13. Feeling that life is empty
4. Longing for the person who died	14. Hearing the voice of the person who died
5. Drawn to places and things associated with the person who died	15. Seeing the person who died
6. Anger about the death	16. Feeling it is unfair to live when the other person has died
7. Disbelief	17. Bitter about the death
8. Feeling stunned or dazed	18. Envious of others
9. Difficulty trusting others	19. lonely
10. Difficulty caring about others	

4.0 THE DEVELOPMENT OF THE ICG

The ICG was piloted with 97 widowed elders as part of a program of research that was designed to study physiological sleep changes in major depression and bereavement, and there was also a bereavement and a healthy control sub study. Eligibility criteria for the original study specified that only individuals with medical problems that were well controlled and

appeared to be stable could be accepted into the study, participants on medication were screened for affective disorders and subjects found to have had a personal history of psychiatric disorder other than minor depression or anxiety were excluded. Subjects were not permitted to be receiving psychiatric treatment outside of that administered as part of the protocol (Prigerson, Maciejewski, et al., 1995).

In addition to the ICG, participants also completed the Beck Depression Inventory (BDI; Beck, 1967), the TRIG, and a socio-demographic questionnaire. The comparison subjects were 27 elderly persons who were free of mental and physical impairment. All of the healthy comparison subjects completed the ICG and its related materials, along with the ongoing follow-up self-report assessment battery. Most of the comparison subjects had not been widowed recently (mean 15.3 years compared to 2.8 years of the bereavement study), and as such they provided a reasonable reference group that enabled exploration of levels of grief expected to be reported at times further removed from the bereavement.

Prigerson et al. (1995) found that the average level of complicated grief symptoms in the bereavement study was

significantly higher than that for the healthy comparison subjects who had been widowed. Furthermore, 20% of the bereaved subjects met their criteria for 'syndromal' levels of complicated grief, whereas not a single member of the comparison subject group met these criteria. In conclusion, a significant minority of the bereavement sub-study participants were complicated grievers, while none of the healthy comparison subjects were found to have clinically significant levels of complicated grief. Results were not affected by gender, racial composition, depression (BDI total scores), religiosity, or percentage distribution of Protestants, Catholics, and Jews (Prigerson, Maciejewski, et al., 1995).

Within this study, seven symptoms were found to load highly on the grief factor and these were: 1) preoccupation with thoughts of the deceased 2) crying, 3) searching and yearning for the deceased 4) disbelief about the death 5) being stunned by the death and 6) not accepting the death (Prigerson et al., 1995). Later the following were also added: 1) preoccupation with thoughts of the deceased that would make it difficult to do the things one normally would do 2) anger over the death 3) distrust and detachment from others as a consequence of the death 4) pain in the same parts of the body as that experienced

by the deceased before the death 5) avoidance of reminders of the deceased 6) feeling that life is empty without the deceased 7) auditory and visual hallucinations of the deceased 8) survivor guilt 9) loneliness 10) bitterness about the death and 11) envy of others who have not lost someone close (Prigerson et al., 1996).

The data obtained from the 97 subjects was used to explore the underlying factor structure of the items that made up the ICG (Prigerson et al., 1995). An exploratory factor-analytic technique was used to determine whether the ICG items formed one or several components of complicated grief. For example, if the symptoms suggestive of PTSD were found to load on one factor, while those suggesting psychotic features of grief were found to load on another factor, then this would help to clarify the underlying dimensions of complicated grief.

Aside from determining the underlying factor structure of items in the scale, Prigerson et al. (1995) also set out to determine whether specific items proved to be indicators of the emergent factors. Items that were not pure to complicated grief were then excluded, creating a scale that enabled a differential diagnosis of complicated grief from other bereavement-related emotional

disorders such as depression. Any item, which when removed, increased the scales overall internal consistency was considered for deletion. Item discriminability (the extent to which the item was associated with having high levels of complicated grief) was examined using each item's correlation with the ICG total score and factor loadings resulting from the exploratory factor analyses.

5.0 PSYCHOMETRIC PROPERTIES

5.1 Reliability

The term reliability refers to the extent to which an assessment tool measures a construct and produces reliable outcomes. A number of factors which relate to reliability will be explored. An assessment tool is deemed reliable if it is able to produce similar results if used again in similar circumstances.

a) Internal Consistency Reliability

Internal Consistency Reliability refers to correlations between different items on the same assessment tool and determines the stability of results across items on the same assessment. For example, when a question on an assessment tool seems to

be similar to another test question, it may point towards the questions being used to determine reliability. Because the two questions are similar and designed to measure the same thing, the participant should answer both questions similarly, which would indicate that the assessment tool has internal consistent reliability. An alpha coefficient of at least .70 is said to confirm good internal reliability (Kline, 2013). The ICG has high internal consistency (Cronbach's alpha coefficient of 0.92 – 0.94) (Prigerson, Maciejewski, et al., 1995).

b) Test-retest reliability (temporal stability)

The test-retest reliability method is a way of testing the stability and reliability of an assessment tool over a period of time. Correlation analysis determines whether similar results are yielded for an individual on more than one occasion, and a minimum level of .70 must be achieved in order to satisfy a good standard and be seen as test-retest reliable (Kline, 2013). In order to control for confounding variables, and because all subjects who provided repeat assessments for the ICG were those who were receiving treatment for their depression, Prigerson et al. (1995) used only those subjects in a state of stable remission to examine test-retest reliability and found

that the ICG received a test-retest correlation score of 0.80 (Prigerson et al., 1995).

5.2 Validity

The term validity refers to whether an assessment tool measures what it is supposed to measure. There are various types of validity which relate to psychometric properties of measurements.

a) Face validity

Face validity refers to the common sense understanding of the item and simply means that an assessment tool superficially looks like it is should be measuring what it is intended to. Qualitative findings by Prigerson et al. (1995) indicated that the ICG appeared to have good face validity, with 85% of participants favouring the ICG to the TRIG. ICG questions were thought to be more comprehensive and easier to understand and respond to. However, face validity is subjective and lacks scientific evidence so it is necessary to measure other areas of validity.

d) Criterion Validity

Criterion validity is the extent to which a measure is related to an outcome and is often divided into concurrent and predictive validity (discussed below). Concurrent validity refers to a comparison between the measure in question and an outcome assessed at the same time. A randomised controlled trial by Shear, Frank, Houck, and Reynolds (2005) to compare the efficacy of complicated grief treatment with a standard psychotherapy, used the ICG to measure improvements in complicated grief symptomology over time, providing evidence of its validity.

b) Concurrent Validity

Concurrent validity refers to the extent to which an assessment tool correlates with other validated measures testing the same concept. The ICG total score correlated well with measures of depressive symptoms and a general measure of grief providing evidence for the validity of the tool.

The ICG total score showed a fairly high association with the BDI total score (0.67) the TRIG score (0.87), and the GMS score

(0.70). Individuals with ICG scores greater than 25 (i.e. those in the top 20%) had significantly worse scores on nearly all of the MOS quality of life measures than those with ICG scores of less than 25. Those with ICG scores greater than 25 had significantly worse scores on the general health, physical health, social functioning, and bodily pain measures

c) Predictive Validity

Predictive validity refers to the amount in which an assessment tool is able to predict other measures of the same construct at a point in the future.

In a study of the ICG by Guldin, O'Connor, Sokolowski, Jensen, and Vedsted (2011) it was possible to identify a combination of the BDI scale and a single item from the ICG (*Even while my relative was dying, I felt a sense of purpose in my life)* answered at eight weeks post loss to assess the propensity of bereaved individuals to develop a complicated and prolonged reaction of grief after six months. It was therefore possible to develop a screening tool to identify people at risk of suffering complicated grief six months after bereavement and divide the risk of a pathological grief reaction of bereaved individuals into three

distinct groups defined by scores on the BDI and on the single item, referred to as C:

Risk group 1: a BDI score of 0-9 and item C score of 1-4

Risk group 2: a BDI score of 10-19 or a BDI score of 0-9 and item C score of 5-7

Risk group 3: a BDI score of 20-63 or a BDI score of 10-19 and item C score of 5-7

This model allowed the detection of 85.2% of bereaved patients with complicated grief, defined by a score of 10 or above on the BDI or a score of 5 or above on the Item C. Sensitivity (true positive rate) was 0.852, specificity (true negative rate) was 0.694, with positive predictive value (PPV) of 40.4% and negative predictive value (NPV) of 95.1%. Specificity was improved to 0.964 with a score of 20 or above on the BDI or a score of 10 or above on the BDI and a score of 5 or above on the Item C at the expense of sensitivity (0.407). This points to increases in depressive symptoms as being predictive of complicated grief and lends support to the predictive validity of the ICG (Guldin et al., 2011).

e) Content validity (logical validity)

Content validity, sometimes called logical or rational validity, is the estimate of how much a measure represents every single element of a construct.

The ICG was developed based on research that found certain symptoms of grief to be distinct from the symptoms of depression and anxiety, and when experienced in combination would predict several types of enduring functional impairments (Prigerson, Maciejewski, et al., 1995). The seven symptoms that were found to have loaded highly on the grief factor were: preoccupation with thoughts of the deceased, crying, searching and yearning for the deceased, disbelief about the death, being stunned by the death, and not accepting the death (Prigerson, Maciejewski, et al., 1995; Prigerson, Frank, et al., 1995). To these symptoms, the authors added other grief-related symptoms based on research undertaken with bereaved populations, to characterise potentially maladaptive aspects of grieving. These symptoms were: preoccupation with thoughts of the deceased, anger over the death, distrust and detachment from others, pain in the same parts of the body as that experienced by the deceased before the death, avoidance of reminders of the deceased, feeling that life is empty without the

deceased, auditory and visual hallucinations of the deceased, survivor guilt, loneliness, bitterness about the death, and envy of others who have not lost someone close (Prigerson, Maciejewski, et al., 1995). The inclusion of these additional symptoms would indicate that the ICG measures all aspects of complicated grief.

f) Construct Validity

Construct validity is the extent to which the measure measures what it intends to; and is comprised of convergent validity (measures of constructs that should be related to one another are) and discriminant/divergent validity (measures of constructs that should not be related to another are not).

The results of an exploratory factor analysis revealed that the ICG items were best characterised as one factor. When the results of models with more than one factor were examined and compared with those that had forced the model to have all items load on a single factor, the findings indicated that all of the items loaded highly on the first factor. A scree plot provided further evidence in support of a single underlying construct within the scale to measure complicated grief, with almost all

the variance in the data being accounted for by the first factor (Prigerson, Maciejewski, et al., 1995). These results strongly suggested that the ICG was measuring a single underlying construct - one intended to measure complicated grief.

6.0 APPROPRIATE NORMS/POPULATIONS

To achieve an accurate interpretation of a psychometric measure, normative information is an important requirement and provides information about how a respondent compares with others in a particular normative sample. The sample from which these criteria were derived for the ICG is not a clinical one, was relatively small (n=291) and included almost exclusively older (average age 62) white (95%) widows (84%), the majority of which were female (73%) with 60% educated beyond high school and not necessarily generalisable to people with complicated grief who are younger, less educated, from diverse backgrounds and bereaved of other close friends or relatives (Shear et al., 2011). With this in mind, the ICG should be used with other populations and indeed, forensic populations, with caution.

Moreover, only 28 of the participants were judged to have complicated grief. This small sample size limits the ability to explore any symptom patterns for determining diagnostic criteria. The methodology used to derive criteria was also problematic. Data used were from study subjects bereaved from 0–6 or 6–12 months, yet the authors (Prigerson et al., 1995) propose that complicated grief should not be diagnosed before six months, and others have judged it more appropriate to wait 1 year (Shear et al., 2011). The question remains then as to whether data from individuals considered ineligible for the diagnosis should be used in assessing for the presence of complicated grief.

That said, since the development of the ICG, it has been used with a range of populations including men and women of various ages from 18-85 years, lending support to its credibility as a measure than can be used more widely (Boelen & van den Bout, 2014b; Guldin et al., 2011; Hall, 2006; Horowitz M., 1997; Lobb et al., 2010; Mitchell, Kim, Prigerson, & Mortimer-Stephens, 2004; Prigerson, 2004; Prigerson, Maciejewski, et al., 1995; Shear et al., 2005)

7.0 ICG USE WITH HOMICIDE OFFENDERS

There are several contentious issues concerning the use of the ICG within a forensic population. First of all, the concept of 'complicated grief' is not without disagreement, as evidenced by the DSM omitting it as a proposed disorder for the DSM-5 (American Psychiatric Association, 2013). With this in mind, one could argue that the limits of normal grief following bereavement and the conceptualisation thereafter of complicated grief are subject to debate, and it may be better to focus on symptoms indicative of depression or trauma (Kristjanson et al., 2006). This may be especially important for the population of homicide offenders, where the level of PTSD is high (Curle, 1989; Papanastassiou et al., 2004; Pham & Willocq, 2013; Pollock, 1999b), and as such a focus on grief may be misleading.

Secondly, if homicide offenders do experience grief in response to them killing someone, it is possible that their experience of grief will be different to someone who has, for example, lost a partner to illness. With this in mind, it would be more appropriate to use a tool which is designed specifically for measuring grief in that context, though no such tool exists at present. Moreover, the ICG is validated for use within an elderly

population of middle class women, which is not representative of the majority of homicide offenders, who tend to be younger men of lower economic status (Santtila, Häkkänen, Canter, & Elfgren, 2003). That said, Fraser (1988), Brunning (1982) and Kruppa (1991) all noted signs of bereavement in their subjects, which were not dissimilar to a 'normal' grieving process.

Lastly, socially desirable and defensive responding has been documented as a confounding factor in self-report assessment tools (Paulhus, 2002), and as aforementioned, caution should be used when administering the ICG to forensic populations. Forensic studies using self-report assessment tools have regularly been criticised for both the validity of the tool used and the analysis of its findings, in particular when the purpose of such assessment tools are clear to the offender (Hanson & Bussiere, 1998; Mills, Loza, & Kroner, 2003). It is possible that an offender may exaggerate symptoms in order to receive a diagnosis of complicated grief. A limitation of the ICG is that it does not contain any type of validity scale, though this makes sense when considering that it was developed for detecting complicated grief in bereaved individuals from the general population.

8.0 CONCLUSION

The Inventory of Complicated Grief (ICG) is a 19 item self-report instrument that allows for the dimensional assessment of the severity of complicated grief symptoms. Scores of 25 or higher (over a range of 0 to 76) indicate a high likelihood that the syndrome is present. The ICG-R (Jacobs, 2000; Prigerson, Maciejewski, et al., 1995) is a short version of the ICG originally consisting of 19 items. The ICG-R has 4 fewer items and demonstrates similar psychometric properties to the ICG (O'Connor et al., 2010).

A review of complicated grief measures by the Australian Department of Health concludes that The TRIG and the ICG appear to be theoretically grounded and empirically sound instruments that have potential for use in assessment, research and clinical practice. However, the ICG meets some of the deficits identified in the TRIG and is the recommended tool for assessing for the presence of complicated grief (Kristjanson et al., 2006).

The ICG was developed to assess a distinct cluster of symptoms that have been found to predict long-term dysfunction and is

based on literature that confirms the distinction between complicated grief, anxiety, and depression (Prigerson et al., 1995). Prigerson and colleagues developed and tested this 19-item inventory with elderly bereaved men and women and found that it measured a single underlying construct of complicated grief, had high internal consistency (Cronbach's alpha coefficient of 0.92 – 0.94) and test-retest reliability estimates (0.80). The ICG total score correlated well with measures of depressive symptoms and a general measure of grief providing further evidence for the validity of the tool. Respondents with ICG scores greater than 25 were significantly more impaired in social, general, mental and physical health functioning and in bodily pain than those with ICG scores less than or equal to 25. The inventory demonstrated good convergent and criterion validity and appears to be an easily administered tool to assess for complicated grief.

However, it would be beneficial to conduct longitudinal research to determine the extent to which the ICG is able to predict individuals at risk for complicated grief responses over time and further evaluative research using other populations is required. Finally, caution must be taken when using self-report assessment tools with a forensic population, particularly when

the purpose of such measures is transparent to the offender (Hanson & Bussiere, 1998; Mills et al., 2003). An offender may malinger in this scenario in order to engender sympathy, to appear more favourable by demonstrating remorse for the offence, to obtain additional medications, or to gain inclusion into therapy groups which may assist discharge from hospital. If it is suspected that a respondent is providing a biased response, then it may be appropriate to also use a measure to test for distorted responding.

CHAPTER SIX

GENERAL DISCUSSION

This thesis has aimed to provide a broad and varied enquiry into the field of psychological treatment for homicide offenders. The importance of this field of investigation is paramount. The criminal justice system and forensic mental health services invest huge amounts of public health resources for those detained as a result of homicide, and the hope is that future victims will be spared as a result. It is therefore necessary to establish by the best scientific methods possible to what extent treatment for homicide offenders can contribute towards creating a safer society, and which modalities of treatment are the most appropriate for this purpose.

In completing this thesis, a contribution has been made toward the limited pool of research in this field by use of diverse methodologies. It has systematically explored the presence of trauma within the homicide offender population, provided a contextual example of a case with clinical change data, reported on the lived experience of a sample of homicide offenders who were receiving treatment, and provided a critical evaluation of

a measure of bereavement considering explicitly its use within a population who are the responsible for their loss. This is important because of the shift in thinking toward recovery in mental health services and rehabilitation in the criminal justice system, both of which focus on increasing positive experiences in an offender's life.

Summary of Findings and Implications

The systematic review in chapter two aimed to bring together the small pool of existing quantitative psychological research examining PTSD, grief, and other trauma responses in adult homicide offenders as a direct result of their offence. Examining the factors involved in increased levels of PTSD amongst this population is important if interventions contributing toward recovery and rehabilitative pathways are to be better informed.

Systematic reviews are increasingly replacing traditional narrative reviews and expert commentaries as a way of summarising research evidence, as they attempt to bring the same level of rigour to reviewing research evidence as should be used in producing the actual research (Hemingway & Brereton, 2009). On the whole, systematic reviews should be based on a peer reviewed protocol so that they can be replicated

if necessary, and this was the case here. Staying true to the notion of a high quality systematic review (Hemingway & Brereton, 2009) the review in chapter two sought to identify all relevant published and unpublished research, select studies or reports for inclusion, assess the quality of each study, synthesise the findings from studies in an unbiased fashion, and present an interpretation of the findings in a balanced and impartial summary, taking into due consideration any flaws in the methodological rigour of the included studies.

The review did find evidence to suggest that homicide offenders suffer a range of traumatic responses, particularly PTSD, following the commission of their offence. The high levels of reported trauma symptoms therefore suggest that recovery oriented treatments for this population, focussing specifically on their experience of the offence and how to move forward may be warranted. This is particularly pertinent given that PTSD has been shown in a number of studies to be linked to future violence (Beckham et al., 1997; Collins & Bailey, 1990; Fehon et al., 2005; Vaughan, 2007; Watson, 2013), so in treating trauma in the homicide offender, risk may also be addressed.

However, the above findings were not without controversy. Just six studies met the strict inclusion criteria for this review, and this is a reflection of the lack of research in this area. Randomised controlled trials, investigating the effect of an intervention are usually the focus of systematic reviews, however this was not the case here. Most of the studies did not employ randomisation in their selection of participants, and were generally cross sectional by design. This is justifiable on the premise that the review was not examining the efficacy of a treatment or intervention, but sought to establish the presence of a phenomenon, within a particular population, within a specific context. It is therefore acceptable for observational or cross sectional studies to be used to routinely identify and quantify potential adverse events, such as the presence of homicide induced trauma as is the case in chapter two (Reeves, Deeks, & Higgins, 2008).

Of the six studies collated, two were rated 'good' and four rated 'satisfactory', which is an indication of the quality of existing research in this field. Sample sizes were small, with an unequal representation of men and women and power analyses were largely overlooked. However, this is partially explained by the difficulty in accessing this population for research. Restrictions

imposed by the prison regime often curtail the best efforts of investigators and there are ethical considerations when recruiting mentally ill participants, particularly concerning their capacity to provide informed consent. The methods used to measure trauma within the studies were varied, although generally researchers favoured reliable and valid instruments. Confounding variables were only partially accounted for however, with little mention of the impact of gender on the findings, and one study encompassed attempted homicide offenders into their sample of killers (Pham & Willocq, 2013). The included studies did control for other traumatic experiences though, lending support to the findings overall. Due to the small sample sizes, the scope for statistical analysis was limited, creating challenges to the wider applicability of the findings and increasing the risk of type II errors.

It is acknowledged that there is a selection of qualitative studies, case studies and commentaries available on the topic of trauma in homicide offenders and these have been explored throughout this thesis. While providing a valuable contribution to the field as a whole, these were not included here. This is because systematic reviews aim to establish whether scientific findings are consistent and can be generalised across

populations and settings (Mulrow, 1994), the sample sizes in the aforementioned being too small to meet this requirement. In short, improvements must be made to the scientific designs that are employed to evaluate the psychological effects of homicide for the perpetrator, otherwise there stands to be a continuing lack of clarity about this as a phenomenon. This is crucial when designing and implementing treatments for this population, not least because of the implications of expending public resources on interventions where the treatment need is ambiguous.

In chapter three, the case of Sam, a young male homicide offender, is explored. A range of treatment needs were identified for him, however, only his progress within the homicide group was explored due to the specific relevance to this thesis. Sam made considerable clinical gains through attendance in group treatment within a high security hospital. From a personal recovery perspective, he experienced a marked decline in alexithymia symptoms and his complicated grief scores reduced from being clinically present as a syndrome, to no longer meeting the criteria. From a risk reduction perspective Sam demonstrated an increase in secure attachment style, and an increase in guilt feelings related to his

offence. However, there were some contradictory findings which indicate that the road to recovery will not be a straightforward one for Sam. He also experienced a decline in mature, desirable attachment styles indicating difficulties in the way he relates to others. In addition, because some of his scores fell far outside of norms, it could be concluded that he did not necessarily understand the measures, impacting on the conclusions that can be drawn from these findings.

The case study provides a detailed picture of what homicide group treatment is like for the offender, and Sam's individual story provides a context for the group treatment under exploration in chapter four. The type of intervention that this case study described is subject to debate (Allen et al., 2001; Andrews et al., 1990) however Sam's case provided some support for the use of more dynamic based interventions, and challenged the notion that forensic clients don't experience psychological distress, one of the arguments employed against using such therapies within this population (Andrews et al., 1990).

Furthermore, the findings from this case study reinforced the outcomes of chapter one, namely that homicide offenders can

experience trauma as a result of their offence. For Sam, trauma was evidenced in his high levels of pre-treatment complicated grief, though it is noteworthy that other potential causes of his bereavement symptomology were not controlled for. Nevertheless, his symptoms improved markedly at six month follow up. Of course, the applicability of the findings from a single case to the wider population of homicide offenders is limited. Future studies that employ a larger sample, utilising a longer period of time before follow up are therefore recommended.

In chapter four, an interpretative phenomenological method was used to explore the lived experience of group treatment for homicide offenders by interviewing a group of mentally disordered homicide offenders within a high security setting. Group processes, such as the open format and the challenging of ideas between participants seemed to help individuals to gain an increased understanding of their offence, and the changing narratives were akin to those linked to desistance (Berglund; Laub & Sampson, 2001; Maruna et al., 2004; Vaughan, 2007). A number of factors were relevant for recovery. A conceptualisation of the self as someone who had killed but was not just a killer was important, alongside the maintenance of

mental stability and hope for the future. Hope for the future included the 'hope' that they would not reoffend, indicating that the notion of 'recovery' for these offenders incorporates desistance from offending alongside the maintenance of mental health. The findings lend support for the use of dynamic, narrative therapies in Index Offence work, but again, the findings were not without controversy.

IPA is obviously inherently interpretive. It is not possible to 'get inside the minds' of whomever is interviewed, and thus the researcher brings their own conceptualisations and experiences to the analysis. That said, it has been argued that our subjective worlds are not primarily mental, or 'hidden inside', because the very nature of our being is to 'be there' out in the world, located and observable in our relatedness to some meaningful context (Larkin, Watts, & Clifton, 2006). This implies that our personal experiences can be communicated to others through suitable expression. It is nevertheless important to qualify this prudently. An account can be used to reveal something about a person, but only that person's current positioning on the matter. In other words, we can only glimpse a person's current subjective mode-of-engagement with some specific context or

aspect of the world, and that is what IPA tries to achieve (Larkin et al., 2006).

In addition to this, it is important to note that taking 'the insider's perspective' is only part of the analytic process. The analyst in IPA is doing more than this; they are also offering an interpretative account of what it means for the participant to have such thoughts, beliefs or opinions, within their particular context (Larkin et al., 2006). In doing so, the analyst moves beyond a descriptive approach to analysis, and as such researchers will arrive at different interpretations of meaning. However, Smith et al. (2009) state that one of the major criticisms of novice IPA studies is that they have a tendency to be too cautious, entailing that the analysis is simply too descriptive for the outcomes to be described as interpretive. In this study, every effort was given to move beyond the descriptive, while also aiming to deliver information not overly subjective by design. In order to achieve this, a number of strategies were employed; such as the maintenance of a reflective diary, and second author opinion about the interpretation of transcripts as a form of triangulation. Overall, phenomenological approaches were valued here as they allowed the researcher to engage meaningfully with both the

cognitive and constructionist traditions (Larkin et al., 2006), arriving at a dependable account of homicide offenders experience of group treatment.

Considering the thesis as a whole, it is apparent that more research is required, employing rigorous methodologies. This thesis originally aimed to investigate the experiences of homicide offenders generally, however the focus has largely been within a mental health setting. This is true even in chapter two, where there was the scope to explore trauma in homicide offenders more generally, however only one of the studies used a sample from within the criminal justice system. This has serious implications for the generalisability of these findings, and the thesis as a whole has thus focussed largely on the small number of homicide offenders who are mentally disordered.

Considering group treatment for homicide offenders, there does seem to be a rationale and evidence base for this, and the method explored in chapter four is one means by which to meet this need. It would now be helpful to explore in depth which treatments would be most effective for this population. As is the case for sex offenders and arsonists, CBT group treatments are widely used, and these are increasingly incorporating a good

lives, strengths based approach (Ward & Brown, 2004). This is perhaps something that would be also appropriate for homicide offenders. Alternatively, we have seen in chapter two that there are high levels of PTSD in homicide populations, so the value of trauma interventions, such as EMDR or CBT for PTSD for this population cannot be ignored. That said, such interventions would not necessarily take into account issues such as offender identity and shame, found to be important to the offenders in chapter four, thus signalling a potential need for narrative therapies within the realm of Index Offence work.

In closing this thesis, it can be said that a variety of information has been provided and that this has been helpful in contributing to the small corpus of research available in the field. However, for those questions which it has helped to answer, it has identified a number of further questions which require exploration. This thesis has demonstrated that there is much work to be done both in terms of understanding homicide offenders and evaluating the psychological treatments used within this population. As with most things which are not accurately understood, more and better research with intuitive enquiry is most likely to be the answer. In the future, it is recommended that far greater sample sizes are utilised for a

wider range of homicide offenders, as thus far research has been impeded by the sampling bias that arises from the way in which the criminal justice system deals with such offenders.

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Appendix One: Critical Appraisal Proforma

An adaption of the Critical Appraisal Skills Programme (CASP)

Screening or threshold questions		**Comments**
1. Are the aims of the research clearly stated?	**Yes (3)** **Partially (2)** **No (1)** **Undecided (1)**	
2. Was the stated method appropriate to answer the research question?	**Yes (3)** **Partially (2)** **No (1)** **Undecided (1)**	
3. Were participants recruited in an acceptable way?	**Yes (3)** **Partially (2)** **No (1)** **Undecided (1)**	
4. Were the measures used appropriate and accurately measured to reduce bias?	**Yes (3)** **Partially (2)** **No (1)** **Undecided (1)**	
5. Were confounding factors taken into account or acknowledged?	**Yes (3)** **Partially (2)** **No (1)** **Undecided (1)**	
6. **FOR COHORT STUDIES ONLY**: Was follow up of participants complete and long enough?	**Yes (3)** **Partially (2)** **No (1)** **Undecided (1)**	
7. Were the methods of analysis appropriate?	**Yes (3)** **Partially (2)** **No (1)** **Undecided (1)**	
	Yes (3) **Partially (2)**	

8. Was the data analysis sufficiently rigorous?	**No (1)** **Undecided (1)**	
9. Are the results precise? Is there a clear statement of findings?	**Yes (3)** **Partially (2)** **No (1)** **Undecided (1)**	
10. Can the results be applied to the local population?	**Yes (3)** **Partially (2)** **No (1)** **Undecided (1)**	
11. Do the results fit with the existing research?	**Yes (3)** **Partially (2)** **No (1)** **Undecided (1)**	

Other Comments:
Overall Quality: **Overall Score**

Notes for Critical Appraisal Questions

1. Are the aims of the research clearly stated?

Are the study issues clearly focused in terms of populations, measures, outcomes etc.

2. Was the stated method appropriate to answer the research question?

Did the methods address the study question appropriately?

3. Were participants recruited in an acceptable way?

LOOK FOR SELECTION BIAS: is the sample representative of the wider population? Was there a reliable selection system? Are there any special characteristics about the sample? Is the sample size big enough? Is a power analysis included? Was everyone included who should have been (eg. for this population those who can't read)? Were response rates discussed?

For case control studies think about both the cases and the controls.

4. Were the measures used appropriate and accurately measured to reduce bias?

LOOK FOR MEASUREMENT BIAS: are the tools which have been used reliable, valid and objective? Have they been standardised for use with this client group? If no, has this been acknowledged or a rationale given? Do the tools accurately measure the stated outcome?

5. Were confounding factors taken into account or acknowledged?

Were confounding factors taken into account at the design or analysis stage? Which important ones have not been accounted for?

6. FOR COHORT STUDIES ONLY: Was follow up of participants complete and long enough?

Are sufficient details included in the study to make a judgment?

7. Were the methods of analysis appropriate? What are the results? How significant are they? Does the analysis appear appropriate to the aims of the study?

8. Was data analysis sufficiently rigorous?

Is there an in-depth description of the analysis process? Is enough of the data presented to support the findings? How were missing values managed?

9. Are the results precise? Is there a clear statement of findings?

Are the findings are explicit? Is there an adequate discussion of the evidence both for and against the researchers' arguments?

Has the researcher discussed the credibility of their findings or the limitations? Are the findings are discussed in relation to the original research questions? Are the results believable?

10. Can the results be applied to the local population?

Are the participants in the study significantly different enough to the population to cause concern? Do the participants differ to those of the local population?

11. Do the results fit with the existing research?

Does the researcher discuss the contribution the study makes to existing knowledge (e.g. do they consider the findings in relation to current practice or policy, or relevant research-based literature)? Have the researchers discussed whether or how the findings can be transferred to other populations?

Appendix Two: Data Extraction Template

General Information	**Notes**
Date of data extraction: Author: Source of origin: Reviewer ID:	
Specific Information	**Notes**
Study Characteristics: Re-verification of study eligibility (tick if correct): **Population** ☐ **Outcome** ☐ **Context** ☐	
Introduction	**Notes**
List the specific objectives: Study design:	

Setting location and date: Participants:	
Method	**Notes**
Variables measured: Tools used to measure variables: Statistical methods:	
Results	**Notes**
Attrition and reasons for attrition:	

Basic descriptive statistics from the study: Main results (Note both significant and non-significant findings):	

Data Extraction Template Notes

	Recommendation
I**ntroduction**	State specific objectives, including any pre-specified hypotheses
Methods	
Study Design	Present key elements of study design early in the paper
Setting	Describe the setting, locations, and relevant dates, including periods of recruitment, exposure, follow-up, and data collection
Participants	(a) Cohort study—Give the eligibility criteria, and the sources and methods of selection of participants. Describe methods of follow-up Case-control study—Give the eligibility criteria, and the sources

	and methods of case ascertainment and control selection. Give the rationale for the choice of cases and controls Cross-sectional study—Give the eligibility criteria, and the sources and methods of selection of participants (b) Cohort study—For matched studies, give matching criteria and number of exposed and unexposed Case-control study—For matched studies, give matching criteria and the number of controls per case.
variables	Clearly define all outcomes, exposures, predictors, potential confounders, and effect modifiers. Give diagnostic criteria, if applicable Data sources/ measurement
Data sources/Measurement	Give details of each different measure used and state whether valid, reliable etc.
Statistical methods	(a) Describe all statistical methods, including those used to control for confounding variables (b) Describe any methods used to examine subgroups and interactions (c) Explain how missing data were addressed (d) Cohort study—If applicable, explain how loss to follow-up was addressed (e) Case-control study—If applicable, explain how matching of cases and controls was addressed (f) Cross-sectional study—If applicable, describe analytical methods taking account of sampling strategy
Results	**Participants:**

	(a) Report numbers of individuals at each stage of study—eg numbers potentially eligible, examined for eligibility, confirmed eligible, included in the study, completing follow-up, and analysed (b) Give reasons for non-participation at each stage **Descriptive Data:** (a) Give characteristics of study participants (eg demographic, clinical, social) and information on exposures and potential confounders (b) Indicate number of participants with missing data for each variable of interest (c) Cohort study—Summarise follow-up time (eg, average and total amount) **Main Results:** (a) Give unadjusted estimates and, if applicable, confounder-adjusted estimates and their precision (eg: 95% confidence interval). Make clear which confounders were adjusted for and why they were included (b) Report category boundaries when continuous variables were categorised (c) If relevant, consider translating estimates of relative risk into absolute risk for a meaningful time period.

Appendix Three: Table of excluded studies – Systematic Review

Study	***Reason for exclusion***
1. Mental illness in people who kill strangers: longitudinal study and national clinical survey (Amos et al., 2004)	Outcome measure was not trauma response in homicide offenders. Study examined characteristics of perpetrators of homicides according to whether victims were strangers or not.
2. A case report of treatment of offence related PTSD (Lad, 2013)	Case Study Design
3. Women Who Kill Their Mates (Bourget & Gagne, 2012)	Study about homicide rates: does not examine trauma in perpetrators.
4. The prevalence of post traumatic stress disorder in a special hospital population of legal psychopaths (Kruppa et al., 1995)	Not homicide specific – does include homicide offenders but doesn't report trauma rates for this group, instead puts homicide offences in with other offences such as arson. Reports rates of trauma related to the 'Index Offence'.
5. Offence-related posttraumatic stress disorder (PTSD) symptomatology and guilt in mentally disordered violent and sexual offenders (Crisford, Dare, & Evangeli, 2008)	Population not homicide offenders but violent offenders more generally. 'Serious offenders' include homicide, rape and serious assaults so diluted as an outcome measure.
6. What violent offenders remember of their crime: empirical explorations (Evans, 2006)	Trauma not measured directly as an outcome. Review about amnesia in violent offending. Link between amnesia and trauma uncertain as amnesia can also be caused by other factors, i.e. alcohol consumption.
7. Correlates of Posttraumatic Stress Disorder in Forensic Psychiatric Outpatients in the Netherlands	Not homicide specific – only 3 homicide perpetrators

	(Henrichs & Bogaerts, 2012)	Trauma caused by homicide not explicitly discussed
8.	Does PTSD occur in sentenced prison populations? A systematic literature review (Goff, Rose, Rose, & Purves, 2007)	Examines PTSD in a prison population generally and not in homicide offenders specifically.
9.	Intrusive memories in perpetrators of violent crime: Emotions and cognitions (Evans, Ehlers, Mezey, & Clark, 2007)	Population are juveniles
10.	On killing. II: The psychological cost of learning to kill (Grossman, 2001)	Examines legally sanctioned killing, e.g. in war rather than by homicide.
11.	Posttraumatic stress disorder in murderers (Harry & Resnick, 1986)	Case study design
12.	Depression and homicide (Hirose, 1979)	Case study design
13.	Mortality among homicide offenders: a retrospective population-based long-term follow-up (Lindqvist, Leifman, & Eriksson, 2007)	Trauma not measured
14.	Applying a psychodynamic treatment model to support an adolescent sentenced for murder to confront and manage feelings of shame and remorse (Marriott, 2007)	Case study design
15.	Eye movement desensitization and reprocessing (EMDR) for post-traumatic stress disorder (PTSD) following homicide. (Pollock, 2000)	Case study design
16.	Behavioral Treatment of PTSD in a Perpetrator of	Case study design.

Manslaughter: A Single Case Study. (Rogers et al., 2000)	
17. The Treatment of Juvenile Homicide Offenders (Neihart, 1999)	Population are juveniles
18. Posttraumatic Stress Disorder and Appetitive Aggression in Rwandan Genocide Perpetrators (Schaal, Heim, & Elbert, 2014)	Not just homicide offences – but rape and other violence.
19. Mental health 15 years after the killings in Rwanda: imprisoned perpetrators of the genocide against the Tutsi versus a community sample of survivors (Schaal, Weierstall, Dusingizemungu, & Elbert, 2012)	Not just homicide offences – but rape and other violence.
20. The self-traumatized perpetrator as a "transient mental illness" (Young, 2002)	Commentary: not a quantitative design.
21. Their dark materials: narratives and recovery in forensic practice (Adshead, 2012)	Not a quantitative design
22. Responses to violence and trauma: the case of post-traumatic stress disorder (Adshead, Bartlett, & Mezey, 2009)	Not a quantitative design
23. The grief process in those admitted to regional secure units following homicide (Hambridge, 1990)	Case Study Design
24. Bereavement in those who have killed (Fraser, 1988)	Commentary – not a quantitative design
25. Bereavement after homicide: A descriptive study (Rynearson, 1984)	Not a quantitative design

26. The Group Psychotherapy of Murderers (Brunning, 1982)	Not a quantitative design Trauma not measured
27. The Perpetrators Suffer Too (Kruppa, 1991)	Not a quantitative design Case study design
28. PTSD by psychiatric murderers (Senninger & Laxenaire, 1995)	PTSD not caused by homicide
29. Trauma, PTSD, and Resilience A Review of the Literature (Agaibi & Wilson, 2005)	Not homicide related
30. Interpersonal violence and its correlates in Vietnam veterans with chronic posttraumatic stress disorder (Beckham et al., 1997)	Legally sanctioned violence – not homicide
31. Traumatic stress disorder and violent behavior (Collins & Bailey, 1990)	General violence rather than homicide under examination
32. Posttraumatic stress disorder and criminal violence: Basic concepts and clinical-forensic applications. (Miller, 2012)	Exploration of PTSD as a legal defence – PTSD is not measured as an outcome of homicide.

Appendix Four: Participant Informed Consent – Case Study.

THE UNIVERSITY OF NOTTINGHAM

DOCTORATE IN FORENSIC PSYCHOLOGY (D.FOREN.PSYCH)

CLIENT CONSENT TO COURSE WORK ASSIGNMENTS

I understand ALISON BROMLEY, hereafter referred to as 'the trainee' would like my permission to use information about me to complete a course work assignment (oral case presentation and a written case study).

I understand that the work will not contain any information that would reveal my personal identity i.e. my name or address; rather I will be referred to via a pseudonym or case number.

I understand that the work may be discussed in the trainee's supervision and personal development group or looked at by other trainees to help their learning.

I understand that the work will be checked by the trainee's supervisor and The University of Nottingham to see that my anonymity and confidentiality have been safeguarded.

I understand that course work assignments (and material relating to these) are kept in securely locked premises and are not available for public access.

I understand that the final **anonymised** article will be used as part of a doctoral thesis and give my permission for this to be published in an academic journal upon completion.

I understand that I do not have to allow information about me to be used in this way. I can change my mind and refuse my consent at any stage and this will have no effect on the treatment offered to me.

Name of Client:

Client's signature:

Date:

Appendix Five: Client information sheet

Group Work on Homicide: Participant Perspectives on its Value and Contribution to Recovery and Risk Reduction

Name of Researcher: Alison Bromley

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 the study?
The purpose of this study is to explore your views on the impact of the homicide treatment groups, and how you feel it has affected you.

Why have I been invited?
You have been invited to take part because you are a member of the homicide group and we would like to discuss with you your opinions about the group. We are inviting 11 participants like you to take part.

Do I have to take part?
It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form If you decide to take part you are still free to withdraw at any time and without giving a reason. This would not affect your legal rights will not affect the standard of care you receive.

What will happen to me if I take part?
You will be asked to participate in an interview to obtain your feedback on the homicide group and discuss from your experience, what you feel its impact has been. Interview sessions will be audio taped to allow us to record your responses to make full use of your experiences. Before the interview you will have the opportunity to discuss in full the purpose of the study and what will happen with the information you provide, if

you decide to continue with the study then you will be given forms to sign to give your consent to participation.

You will be interviewed in a room on your ward that allows for confidentiality. A time will be arranged that is suitable for you and does not impact on any of your other activities. The interview length will be decided by you- but is not expected to last more than two hours maximum.

You will only be asked about your experiences of the group with regard to your recovery pathway and future. You will not be asked to directly disclose any offence information. You do not have to answer any questions that make you feel uncomfortable.

After the interview you will have a conversation with the interviewer to discuss any concerns you may have, this is called a debrief. You will be offered support should you need it.

We will also ask for permission to access your case file information and collect information about your referral for the group. This is so we can gain a better understanding of who is being referred by their teams for homicide group work.

Expenses and payments
You will not be paid to participate in this study.

What are the possible disadvantages and risks of taking part?
You may be asked questions which make you think about your past behaviour and this may be of a sensitive nature. It is important to note however that we will not be asking direct questions about your past offending. It is entirely up to you how much personal information you disclose throughout the interview - we are interested primarily in your experiences of therapy within the group.

If a question is asked that makes you feel uncomfortable you do not have to answer it. If you experience any difficult feelings from participating in the interview, a researcher will give you a debrief and discuss with you how best to manage these feelings. The length of the interview will be dependent upon how much you have to say about the homicide groups, and as such will be directed by you. This is expected to take between 1-2 hours, although you can stop at any time, and can take breaks where required.

What are the possible benefits of taking part?
We cannot promise the study will help you but the information we get from this study may help us to develop therapy groups so that they bring maximum benefit to those involved. You have the opportunity to discuss how you feel about the group, and will have the chance to comment on anything that you believe could be improved. You will also have the opportunity to reflect on your progress through therapy, and think about how it has impacted on you.

What happens when the research study stops?
All information will be secured safely. The study will be written up for publication with all identifiable information removed to ensure your participation remains anonymous and confidential. Specific feedback will be given to you if you request it.

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. The researchers contact details are given at the end of this information sheet. If you remain unhappy and wish to complain formally, you can do this through the NHS Complaints Procedure. Details can be obtained from the hospital nursing staff.

Will my taking part in the study be kept confidential?
All the information about your participation in this study will be kept confidential. The procedures for handling, processing, storage and destruction of data are compliant with the Data Protection Act 1998.

Data will be collected with only a participation number to identify it. Information linking participation numbers and patient names will be locked away and only researchers will have access to this for the purpose of collecting file data (patient files are recognised through identification numbers). Data will be stored at Broadmoor until the study has been completed and the educational degree awarded.

The only time that confidentiality may be breached is if you discuss any issues that indicate a specific risk to yourself or others. This can include risk of self-harm, violence or disclosures of abuse. If this occurs it is part of our duty of care to forward this information to your clinical team to ensure your safety and the safety of others.

We will follow ethical and legal practice and all information about you will be handled in confidence.

If you join the study, some parts of the data collected for the study will be looked at by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty.

All information which is collected about you during the course of the research will be kept **strictly confidential**, stored in a secure and locked office, and on a password protected database. Any information about you which leaves the hospital will have your name and address removed (anonymised) and a unique code will be used so that you cannot be recognised from it.

Anonymised research data will be kept securely for 7 years. After this time your data will be disposed of securely. During this time all precautions will be taken by all those involved to maintain your confidentiality, only members of the research team will have access to your personal data.

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 this information may still be used in the project analysis.

Involvement of the responsible clinician (RC) and clinical team

Should you wish to participate in the study, your responsible clinician and team will be made aware of this. They will not have access to the information you give during the interview and your care will not be affected. Your team need to be aware of your involvement in the study in order that they can continue to provide the best possible care for you before, during and after the study.

What will happen to the results of the research study?

It is intended that the research might be written up and published, and presented in a Care Professional Development forum. Participants will not be named during this.

The research will also contribute to an academic degree but as stated above all information you consent to be used will be used in confidence and anonymously.

Who is organising and funding the research?
This research is being organised by the University of Nottingham and is being funded by Alison Bromley, the researcher.

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. This study has been reviewed and given favourable opinion by the Bromley Research Ethics Committee, London.

Further information and contact details
If you should wish to contact us regarding the research please ask a member of nursing staff to contact Alison Bromley on 4492.

The chief investigator overseeing the research is Simon Duff who is based at the University of Nottingham within the institute of Mental Health.

Appendix Six: Consent Form

CONSENT FORM

(Final version 1.0: 30.7.13)

Title of Study: Group Work on Homicide: Participant Perspectives on its Value and Contribution to Recovery and Risk Reduction

REC ref: 13/LO/1376

Name of Researcher: Alison Bromley

Name of Participant: **Please initial box**

1. I confirm that I have read and understand the information sheet version number ……dated..... 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 agree to take part in the above study. ☐

_____ _____

_____

Name of Participant Date
Signature

_____ _____

_____

Name of Person taking consent Date
Signature

3 copies: 1 for participant, 1 for the project notes and 1 for the medical notes

Appendix Seven: Participant Debrief

Group Work on Homicide: Participant Perspectives on its Value and Contribution to Recovery and Risk Reduction

Study Debriefing Schedule

This study was aimed toward getting to know more about your opinions of the homicide group.

Thank you for your participation and help with this. By taking part you will have contributed toward the field of research in this area, and this may help to inform future treatments. Your contributions are therefore much valued.

Before we begin this discussion, do you have any questions or concerns you would like to talk about?

How did you feel about the interview process?

Were there aspects of the interview that you found it easy/comfortable to discuss?

Talking about offending is a sensitive issue; it is understandable that it may bring up memories that are painful or difficult. How are you feeling following the interview?

Discuss and offer support.

What support system typically assists you when you are distressed and how can you use these now that the interview has finished?

E.g. Primary nurse contact, link psychologist, individual therapist, member of staff from the multidisciplinary team

If you found that the conversation led you to feel distressed now or later we can take a number of steps in order to support you:

If you feel that you need further advice or support, your clinical team have been informed that this interview has taken place and they can be approached for assistance. They will not know the details of the interview.

Do you have any further thoughts or questions?

Conclusion

In this study, you were asked to talk about the homicide treatment groups, their impact on you and how this may have affected your recovery pathway and future. All participants will be asked to discuss the same issues. We hope to find out more about patient perspectives about what is useful in treatment, and what isn't useful.

This is important because there is very little research into the area of homicide treatment. Health services are increasingly trying to help patients work toward recovery, and it is important to learn more about how we can make this possible.

If you would like to know more, you are welcome to the results of the study when they are available.

Appendix Eight: Clinician Information

Clinical Team Information Sheet

Study title:

Group Work on Homicide: Participant Perspectives on its Value and Contribution to Recovery and Risk Reduction

Invitation paragraph

Patient XXXXXXXXXXX has been invited to take part in a research study.

This sheet summarises the purpose of this study and what will happen should they consent to participation.

Purpose of study

The purpose of this study is to explore patient views on the impact of the homicide treatment groups, and how they feel they have been affected by it in terms of their recovery and risk reduction.

Participation

The patient will be informed that it is their choice whether or not to take part in the study. If they do, they will be given a consent form to sign stating that they fully understand everything that is expected. They are informed that they are still free to withdraw at any time and without giving a reason, up until the point their data has been anonymised, and that this will not affect the standard of care they receive.

Procedure

Patients will be asked to participate in an interview to obtain their feedback on the homicide group and discuss from their experience, what they feel its impact has been. The research team will also be requesting permission to access case file information and collect information about their initial referral for the group.

Potential risks to the participant

In order to minimise distress to the participant they will not be asked to disclose specific details of their offence. In order to facilitate this, questions in the interview will be open and non-directive. The purpose of the study is to gain an understanding of patient perspectives of treatment, not to explore the offence itself.

The patients will participate in a full debrief following the interview, and any concerns will be relayed to the clinical team. Extra support will be offered where required.

Capacity

If you have any concerns about the named patient's capacity to consent, then please alert Alison Bromley, the principal investigator, Centralised Group work Service, Newbury Therapy Unit.

Results of the research study

It is intended that the research might be written up and published, and presented in a Care Professional Development forum. Participants will not be named during this.

The research will also contribute to an academic degree but all information used will be used in confidence and anonymously.

Study review

This study was given a favourable ethical opinion for conduct in the NHS (or private sector) by the XXXXXX Ethics and the Research and Development Team.

Contact Details:

If you should have any concerns to be addressed then please contact Alison Bromley on 4492.

Thank you for taking time to read this sheet

Appendix Nine: Interview Schedule

Group Work on Homicide: Participant Perspectives on its Value and Contribution to Recovery and Risk Reduction

Semi Structured Interview

Introduction

The interview is semi-structured, and is focussed on your opinions of the homicide group. There are no 'right' or 'wrong' answers: this is an exploration of the therapy group and what you feel its impact has been. The interview falls into three sections. These include 1) general exploration of the group and your experiences and opinions of it, 2) Your beliefs about your recovery pathway and the group's contribution toward this and 3) ideas about how the group impacts on your thoughts and feelings about your homicide offence and the future.

Part One: General beliefs and opinions about homicide group work.

Firstly, it would be helpful if you could tell me about your opinions of the homicide group. Please describe for me as completely and as fully as you can your thoughts, and feelings about the group and how you experience it.

- What does the group do?

Possible prompts: what does it address? How?

- What is it like to speak about homicide in a group setting?

Possible prompts: How does this compare to 1:1 work?

- What were your expectations of the homicide group prior to attending?

Possible prompts: How do you feel about these now?

- How has it impacted on you?

Possible prompts: Is it helpful/ unhelpful? How does it compare to other groups?

- How has it affected the way you think about your offence of homicide?

Possible prompts: how, if at all, has your account of the offence changed since being part of the homicide group? How has this been helpful or unhelpful?

- How, if at all, have your emotions changed with regard to your offence over time?

Possible prompts: How has the group impacted on this?

- Does being part of the homicide group impact on your mental well-being?

Possible prompts: Has the group impacted on your ability manage distress? How?

- Can you describe to me the positive and negative aspects of the homicide group?

Possible prompts: what has been helpful/ unhelpful?

Part Two: Beliefs about recovery and how the group impacts on this.

Please begin by describing your experience of recovery, and how, if at all, you believe the group has impacted on this.

- What does recovery mean to you?

Possible prompts: how do you view your quality of life? How do you feel about the future?

- What does a meaningful life mean for you?

Possible prompts: what are your hopes for the present and future?

- How are you affected by mental illness?

Possible prompts: How has it affected you in the past? How does it affect you now?

- How has having an offence of homicide affected you?

How has it affected your past and present? What are the daily issues you are dealing with? How do you feel it will affect your future?

- What has your recovery pathway been like?

Possible prompts: What is it like living with a mental illness? Do you feel in control of your life? Do you have support?

- What do you think you would need to further help you work toward recovery?

Possible prompts: How can you move forward? What would it involve?

- How does having an offence of homicide affect your recovery pathway?

Possible prompts: Does having an offending history as well as mental illness make recovery more challenging? How?

- How, if at all, has the group itself impacted on your recovery pathway?

Possible prompts: Has it been helpful or unhelpful? How?

- What changes have you experienced, if at all, as a result of the group?

Possible prompts: Any changes in thoughts, feelings or attitudes that would be beneficial?

Part Three: Beliefs about the homicide offence and future offending, and how the group impacts on these.

Please begin by describing to me your thoughts and feelings relating to your homicide offence, and what the impact of the group has been in relation to this.

- How did you feel about the homicide offence before starting the homicide group?

Possible prompts: what were your thoughts, feelings and emotions? What were your feelings toward the victim?

- How have your feelings about the homicide offence changed over time?

Possible prompts: How has the group impacted on this, if at all? What else has affected your feelings toward the offence?

- Has your understanding of the offence changed? How?

Possible prompts: what has been the group's role in this process (if it has occurred?)

- What are your hopes for the future with regard to offending?

Possible prompts: How do you intend to manage your feelings and behaviours?

- How do you feel about moving forward from the homicide offence?

Possible prompts: What are the challenges? How will you manage these?

Appendix Ten: Reflective Diary

Research Diary: Analysis.

Thoughts and reflections of the researcher during analysis of the text

Trevor

1. Trevor didn't recall his offence for many years. He talks about how the homicide offence helped him to process this. He arrived at the group with the memory of what he had done, but the group then helped him to understand it. He understood it from the perspective that professionals might – a collection of risk factors and missing protective factors – this could be helpful in terms of future risk.

2. The amount of pain that Trevor talks about is akin to the notion that he is both a victim and a perpetrator.

I'd say it's a… Dickens has said … you have a chain. You're dragging a huge chain behind you that the homicide is the biggest link in the chain. As I mentioned earlier, it's a very hard thing to live with. It's your punishment that you have to live with what you've done, being told that you're a murderer and a monster this is that, and your identity changes, you start to believe that you're evil and you're this and you're that.

3. Trevor feels guilty thinking about whether he has the right to recover – this is perhaps mirrored in how professionals and lay persons feel. It is common to hear people wanting offenders of horrendous crimes to suffer as a form of redemption.

4. Isolation is a key theme here – part of his recovery was learning that he is not alone. When you commit an offence you transcend the group – you are alone. Being with others in the group setting seems to help to regain that sense of belonging (to a group – to humanity). G. Adshead discussed themes of isolation when one if either prey or predator.

5. Trevor talks about regaining his identity as someone more than just a killer, i.e. someone with interests and

thoughts and hopes. But he also talks about something more than this – he talks about how after having committed a murder he is a monster, he is evil. He calls himself a monster, the language he uses means he doesn't just need to regain his identity from being 'a person who has killed' to 'a person who does other things too and has also killed', but he needs to become a human first. I have labelled this notion re-humanising which feels like another layer to regaining an identity and is perhaps linked to the low self-worth he later discusses.

6. Hope is important: *Once you're rebuilt, it's about the future. The beautiful thing about the future is that it hasn't happened yet.* But he also has to come to terms with the idea that life in the future will be really difficult: *That the future's going to be nothing, you do this to get out of hospital, but you're going to be stuck on the DSS, it's going to be horrible. You're going to be branded a murderer*

7. Unique group bond – because of the shared experience? What exactly is this experience? Is it the feeling of killing someone? The trauma?
8. Learning about the offence appears key. Understanding more about your own offence when challenged by other patients – what is being challenged? Are patients taking on the therapist role – challenging cognitive distortions that minimise/post hoc justifications?

9. Trevor talks about slow disclosure – examination of his words indicates that he is not just talking about a fearful slow admission from the side of the teller, but the idea that it is a sort of 'graded exposure' for the other participants such that they are not shocked by hearing about someone else's offence.

10. The group helps him to process the trauma and the pain.

11. Reparation is important – putting something back for others, as well as for himself.

Michael

1. It seems to be a key theme for Michael that he developed a new understanding of the offence – he moved from

believing that it was an accident to believing that he chose to kill someone. A significant shift –

They made me think about it you know, and after a while, I realised that you know what? I have done what I done

2. The theme 'recovery from difficult emotions by sharing them' was difficult to name – because it was quite dynamic. It was initially named sharing of difficult emotions is helpful, but was later changed to cover a recovery topic as it was highlighting how sharing the difficult emotions helped him to move forward.

Reading through the interviews for analysis helps the researcher to see where more follow up questions could have been asked. In 'the moment' it is challenging because there are time restrictions for interview and you have to think quickly to keep the interview flowing. Having the semi-structured interview helps because you can go back to it and stay on course, but sometimes this is also a hindrance as it pulls the interviewer away from exploring a topic in greater depth.

3. 'non-judgemental' and 'group cohesion' were combined to make 'group bond' as this seemed to better represent what was being said in the text.
4. It's interesting that Michael is saying that he cannot be sure that he won't offend again. This seems to counter the argument that offenders are untrustworthy and will say what we want to hear in order to better represent themselves.

Wayne

1. Several themes were deleted after consideration that they were not relevant or were better encapsulated by another theme. For example 'not understood by group members' was deleted and incorporated into 'drawing comparisons with the media', as indicated by the quote below:

*"Um… I don't see how it could not have done, I mean yeah. I mean actually I remember one member of the group saying "well I haven't got a clue what you're talking about" *laughs* but certainly some of the things we talked about, particularly when we talked about things we've all got in common, like films, then um.. that was really good for promoting debate really and discussion. So we talked about the sort of torture porn films like saw and hostel, and erm what it's like to watch those, and what*

the experience is like. I haven't actually seen them, I've seen a bit of one of the saw films so I thought I got the idea."

2. 'Minimisation of the offence' was renamed 'justifying the offence' as the themes appeared to be better represented this way. It didn't feel as though Wayne was trying to depict the offence as small or insignificant, but rather that he had reasons to do so and his subsequent treatment has been unfair. It was difficult to conceptualise what Wayne was saying in the below quote. He appears to be hinting at outside forces being at play during the offence, indicating an external locus of control. It was considered that this could be a theme in its own right, however on reflection did seem to fit with the idea of justifying the offence. Later in the interview he talks about his life and all the events which led up to the offence, some beyond his control, which appeared to justify why he ultimately offended.

"…and my memory of it is me sort of sitting there and talking and talking about sort of moral philosophy and like the sort of situations you find yourself in in your life, and whether you have free will to act at any point, in accordance with how you desire or whether you're subject to other forces acting upon you" --- Questioning his own agency and sense of control.

3. 'Substance Misuse' emerged as an interesting theme. It is broadly termed substance misuse rather than saying something specific about substance misuse as he talks about it in many different ways. He talks about how it formed the basis of debates, and whether he felt substances should be legalised. It didn't feel like the context in which this was delivered gave a direction i.e. is he saying drugs caused him to commit the offence? Or is he talking about drugs more generally? Later in the interview he talks about how he didn't just 'take a load of drugs and kill someone'. He refers to drugs as being present without being causal, which is why the theme was left broadly titled. His discussion of drugs is perhaps best conceptualised as being one of the many factors involved in his offending, but not the cause. Indeed, he would very much like to experiment safely with substances in the future.

4. 'New understanding of the offence' is a multi-faceted theme for Wayne because he is also learning that he was in an imaginary, rather than real, relationship with his victim. He is learning something about the relationship as well as the actual homicide:

"Well my offence is slightly different to most people in the group in that I didn't know my victim that well personally but I had quite a strong kind of imaginary relationship with her. In that I knew who she was and I knew kind of her position and what she did a lot of the time. And… erm… in my mind I kind of had this kind of fantasy relationship with her…"

5. 'Preparing to leaving hospital' only had one quote so it was thought that perhaps it should be encapsulated into another theme, such as one relating to moving forward or hope for the future. However it was interesting in its own right, due to the ambivalence expressed by Wayne, who was struggling with the idea of leaving, while simultaneously feeling more at peace, therefore not easy to fit with other emerging themes, and warranting mention in its own right.

"Yeah I would say so. I mean it's been a bit difficult for me recently because I'm kinda in the process of leaving Broadmoor now. And that can be stressful in its own way, and that makes all sorts of things more difficult rather than less difficult, for me personally anyway. Um, so I've actually been sort of hiding, and spending more time in bed, and sort of waiting for things to end really, umm but certainly like feeling more relaxed makes day to day living more easy really. And… ermm once you start to feel more relaxed and at peace with yourself you can start to talk to other people more, and not just people in the group but friends you may have outside of the group or just on the ward or across the hospital."

6. There is a prominent theme for Wayne about developing his relationships. Relationships played a key part in Wayne's offending – so would it follow that improvements in his relationship skills would mean a reduced risk of reoffending? What skills is he learning in the group, if any, that could lower his risk of offending?

7. There was a process of tweaking words slightly to increase validity of the themes – for example 'minimising offence' was changed to 'feelings of injustice' which more accurately captured what Wayne was saying. The researchers first thoughts were to feel like he is minimising his offence – it feels logical given that the thinks his treatment has been unfair, but closer examination of his words do not evidence overtly that this is how he feels, though perhaps Wayne understands how that would be perceived. However, between his words

there is a covert minimisation, for example, below Wayne talks about people with similar offences to him being out in a few years. What is he comparing his offence too? How can he think that his offence could be similar to an offence that warranted a three year sentence? Is this is a significant lack of insight on Wayne's part? What does this mean in terms of his risk?

"…what's the rationale behind it when there are people who do things similar to what I've done but they go straight to medium security'? and they're sort of back out within two or three years. And there wasn't really an answer to it"

8. 'Hopes for the future': Wayne says that it will be 'quite easy' for him to become a teacher. It seems unrealistic given his offending history, that he would be able to work in a school or university, particularly given where his offence occurred. Is this a concern for the group? The aim is to instil hope, but is it instilling false hope? Or is Wayne implying that it would be easy for him from an academic perspective, given his intelligence? Have I misunderstood what he is implying here? Furthermore, he seems to be under the impression based on group discussion that he can visit the states. Is this helpful?

Wayne's interview was very complex. He was light-hearted and bright throughout which felt incongruous with the subject matter. He could be conceptualised as being glib and superficial, keen to minimise his own responsibility. However it doesn't appear to be as straightforward as this. He appears to be trying to understand his own culpability himself, rather than simply reducing it. This seems reasonable given that such a large part of the group appears to be focussing on understanding the offence, including the multitudes of factors that led to each one. It would be difficult not to have some external focus, given that much discussion is about difficult upbringings and circumstance. Perhaps this is hinting at something that is pertinent to all unstructured, psychodynamic groups. The individual's own personality will hugely influence their learning and development. Someone with a tendency to blame others may find a way for this belief to grow within this group, the challenging of offence schemas is left largely to other patients who may not always be able to challenge others. For other's this may be extremely effective, such as for Michael, who entered the group believing he was not to blame, but found himself with an entirely different perspective. Perhaps then, with regard to issues of risk reduction, the personality of the individual should be considered prior to admission to the group and there is some research to support this i.e. group treatment

for those scoring highly in rates of psychopathy. (How many of the group rate highly in their PCL-R scores?)

Benjamin

Had been in the group for two years (not a theme in its own right but interesting that the patients are expected to join and then participate until they leave the hospital).

1. 'Other people have committed worse offences' – a prominent theme for Benjamin. It is important that he is not the worst offender. This is perhaps indicative of his own need to ease his guilt which may be important for his own recovery.
2. Benjamin had an interesting perspective because he had mixed feelings about the openness of the group:

"I dunno, I think… it's good in some ways and it's not good in some ways. In some ways it's good cuz the conversations might lead to places that they might not of been able to predict and in other ways, sometimes you're just going round in circles".

Benjamin raised the idea that because the group is patient led it could go in an unpredictable direction, this in turn means that we could learn more about homicide, from the perspective of the offender.

3. During analysis of this interview I found myself deleting quite a lot of themes that are better encapsulated into other themes. As a researcher I am having to be careful not to find what I want to find, or find themes that aren't emerging because I found them in other interviews. The process of looking for evidence for themes is helpful. The initial process of labelling themes didn't force me to think as critically. I made some errors in my understanding of the text the first time round. It is challenging to find a balance between being interpretive and still accurately reflecting what each participant is saying.

4. Benjamin does appear to be hinting at the concept of 're-humanising', much like some of the other participants. But he doesn't describe himself in quite the same way so it was difficult to conceptualise this theme in this manner. He talks about becoming more normal and less of a 'freak', which is slightly different, so the theme was retitled 'becoming normal'. Within this however is the idea that he is normalising the offence – he says he feels like

what he did was normal as well, so he is talking about more than just himself, but also his actions.

5. I initially wrote that Benjamin was 'grandiose' but closer examination of the text felt more like he felt he had a rare insight into life now, as a result of the help he has received, which didn't seem as grandiose as I initially assumed. My initial coding error was that I had a tendency toward attributing too many themes to one sentence, which made it difficult to gather evidence for one theme. I gave extra time to thinking about the themes, and trying to ensure that they did not cross over – in order to increase the validity of my analysis through finding mutual exclusivity.

6. Perhaps unexpectedly – Benjamin seems to feel as though he is better for his offence. It has given him a chance to rebuild himself.

There is a conflict between recovery and risk reduction. As a researcher, and possibly a non-offender, there is a discomfort that comes with hearing a perpetrator of a serious offence talk about their own rights and the injustice they feel they have experienced. But this is a moral issue, not a scientific one, as we don't have a great deal evidence to suggest that a sense of responsibility is linked to reduced recidivism, neither do we have evidence that feelings of injustice are linked to higher offending (check literature).

Alex

There was initially not much content to some of what Alex was saying, the interview was difficult and he had a tendency toward short answers. Some themes felt important to keep as themes, because of what they would mean for him, despite there being only a few words or phrases to support them. His responses became lengthier over time, perhaps as a result of becoming more relaxed, greater use of open questions or even just having more to say about the subjects raised later in the interview.

As with the other interviews, moving through the text and extracting evidence for the themes has made me re-think them. I had made the same error of applying too many themes or ideas to one text excerpt, so this process was one of discovering what the text actually means from the perspective of the interviewee rather than what my thoughts were when I first analysed the text.

Alex, like Michael, is unsure about whether he would reoffend again in the future. What does this mean? It could be positive because patients are more aware of their risk factors (in Alex's case, alcohol) which is something that professional's encourage. But at the same time it feels uncomfortable hearing someone admit they are uncertain about whether or not they would reoffend. How can clinicians plan for discharge from hospital, and is it realistic? This aside, Alex says he does not intend to reoffend, and that the group does help support this. Alex talks about how the group manages this, and his perception is that the message is continually repeated not to reoffend, with an emphasis on the consequences of recidivism. This perhaps is a message also strengthened by other group members – As a researcher I need to be wary that my clinical view is interfering with my understanding of the text here.

It's interesting that for Alex, recovery means having a nursing team for him when he leaves hospital. He never envisages independence; this is perhaps a more realistic view of his future than that of some of the other participants.

Alex talks a lot about guilt and learning to live with that guilt. The shared experience of homicide within the group setting helps to break down the sense of shame and social isolation of having committed a homicide – and in doing so helps him to process his narrative and come to terms with what he has done.

The process of IPA entails that the researcher can draw conclusions across the participants such as 'the group helps them to progress' before looking closely at what they are saying to understand how. The researcher can grow to understand more than just an outcome of treatment. The researcher wouldn't get that sort of understanding from a purely quantitative study.

They all talk about the group bond – and this seems important in terms of recovery and overcoming the shame and isolation originally felt by homicide offenders.

Appendix Eleven: Evidence for Themes

Themes and Super Ordinate Themes	Key Words and Phrases	Page and Line Number
Interview 1		
1. Developing understanding of the offence	*but with the homicide group you can sit back and learn*	P2, 32-33
Learning about the offence	*In-depth thought and help from other people that have committed the same crime*	P3, 74-75
Shared knowledge – Learn from others – risk?	*This group is the key to all that, before this group I had some understanding of the Index Offence but it's how I understood it, with this group, I have other people's understanding of it. I have with people that are thinking exactly how I am thinking, with facilitators it's designed to help you think it in a way*	P45, 1196-1201
Realisation of factors leading to offence		
Offence not random		
Understands life events leading to offence		
Not a moment of madness		P20, 511-58
Understands how life led to offence	*With the group, though I have that pain inside I've learned to understand that it wasn't, it wasn't like a, I didn't set out to kill somebody. It was because of life choices, or how I grew up, there was more than one variable. My identity isn't just a killer, there were things around the Index Offence that play a huge part and that play in that event. How their life, How my life, led up to that point and what*	
New understanding of the factors leading to the offence		
Not a good childhood		P45, 1198-1199
Understanding of offence checked out with others		P63 436-441

Hopes to help others Hopes others are motivated by his progress	*happened. It's with the group, I've been able to.* *with this group, I have other people's understanding of it.*	
Offences vary greatly despite being the same Similarities allow perspective taking and sharing of opinions	*I look out for relevance's, things I can relate to, something that I've done, that they've done… some way that they were thinking that I was thinking… and if I see it I say look I was thinking that, that was wrong, so I try and erm make them think, make them understand. Know what I mean?*	P18, 456-459 P18, 481 - 486
Learn from one another's offending/thoughts about offending	*So if someone was saying this is how I feel, and this is how I feel about my Index Offence, then someone else would say during my Index Offence I was doing this or I done that.* *So when someone talks about something completely different about how they've felt or what they did, this is what led up to it, that people can draw from their own perspective and say, yeah that's what I thought about that, or this is what I felt about that. As I said, so everyone is different Index Offence*	

2. <u>Apprehension starting the group</u> Apprehensive about the group being open ended Slow Disclosure Openness over time Initially apprehensive Needed preparatory work before group Talking about homicide is difficult Avoidance	*They suggest that you can do 18 months … and you're sort of given that time date to, but to begin with when you're told "oh it doesn't have an ending to it" you come into the group a little bit wary.* *you've got that slow pace that encourages you* *Yeah I was a little bit nervous*	P 17, 17-21 P2, 34 P13, 325
<u>3. Recovery from difficult emotions through sharing them</u> Sensitive subject matter Recovery from painful emotions Sharing – recovery Learning how to live with guilt Builds strength – recovery Learned how to cope from others in the group	*when we discuss things, it's about painful subjects, we open our hearts up and we're talking about things that really matter to each other* *I seen how much that pained other people, I wasn't just suffering myself When people were talking about what they'd done, I'd sit back and It might sound bad but I got support from that, I got help from knowing that I wasn't alone really* *Certainly, the group's designed for people that have committed a homicide and how not to come to terms with it but how to live with. And it's designed with all the people doing the same thing. That you can get*	P10, 257-259 P4, 82-86 P20, 617-622

Not trying to accept or forget it, but learning how to live with it members with varying degrees of proximity to their offence entails sharing of experience and new hope Help is reciprocal Everyone at different stages of recovery Sharing painful emotions	*support and learn new skills about how other people have learned to deal with it.* *and we talk about such painful things and I see that they're going through the same things that I'm going through, it's very very helpful, and hopefully the other way around. That when I talk about things, and I say that I am recovering and that I am getting better that they can draw from that as well.*	P40, 1059-1065
<u>4. Guilt is punishment</u> Dragging a chain Punishment you have to live with Part of the punishment is being 'haunted' by visions	*I still feel that the pain that you feel inside after taking someone's life is the punishment. Cuz nothing that the government can throw at you is gonna be worse than what you're feeling.* *I'd say it's a… Dickens has said … you have a chain. You're dragging a huge chain behind you that the homicide is the biggest link in the chain. As I mentioned earlier, it's a very hard thing to live with. It's your punishment that you have to live with what you've done, being told that you're a murderer and a monster this is that, and your identity changes, you start to*	P6, 146-149 P34 879-888

	believe that you're evil and you're this and you're that. *Again, just er… learning to live with what you've done. It's not good *long pause* You walk into a room and you see things that aren't there.* *As I said it's part of your punishment learning to live it.*	P35, 922-925 P36, 952-953
5. Conflicted about own right to recover Feelings of guilt about own recovery	*It sounds a little bit selfish to say that we want to get over it* *I feel a little bit selfish when I say that to get over it we should be able to get over it.*	P6, 145-146 P6, 150-151
6. Homicide group is a support group Not alone Support Group The key is realising you're not alone Homicide support group Safe space to share difficult emotions	*there's other people that are in the same boat as you are* *Um it's like a support group actually* *Realising that you have a support network when you need it. Realising that this group is going to be here and you have somewhere to vent your views.*	P3, 71-72 P3, 72-73 P 23, 585-586 P 24, 645-636

Same offence makes it permissible to discuss it Learning to cope with the pain Group is supportive	*It's very very supportive and it's teaching you to teach yourself.* *it's not like if you're outside if you joined a support group. It's with strangers. In here it's a community of 200 people and everyone kind of knows each other. So we already have that bond of knowing each other, and then as I said when the group, when we discuss things, it's about painful subjects,* *When people were talking about what they'd done, I'd sit back and It might sound bad but I got support from that, I got help from knowing that I wasn't alone really.*	P10, 252-258 P 4, 84-86
7. Recovery of identity as more than a homicide offender Recovery of identity More than a monster Recovery of identity (as more than a killer) Identity as more than a killer More than a killer Not black and white Not just a killer Regain identity	*your identity becomes a killer...that's how everybody sees you as. In the group, we talk about we talk about your identity isn't as a monster, there's more behind it like some of my friends in the group talk about how they're making music, or how good they are at football, or the relationship they have with friends and family and that, it's more in depth* *My identity isn't just a killer*	P5, 99-107 P20, 414 P20, 525-527

Not 'a murderer' Murder doesn't define who he is Labelled as a psychopath Labelling/branding makes it harder in the future	*And it's not as black as white that you're the scum of the earth, you done this and you done that, and this is your identity and this is the rest of your life really.* *In the press *pause* they call us psychopaths and they call us this and they call us that, erm… of course you view it differently.*	P34, 899-902
8. Re-humanising Become dehumanised when you kill someone, the group helps to repair that Felt like scum Not human Not a monster Have to rehumanise and learn you're not evil Homicide is Dehumanising	*we're not these monsters that we're pictured in the news. Things like that is very very helpful.* *being told that you're a murderer and a monster this is that, and your identity changes, you start to believe that you're evil and you're this and you're that. Over the years you realise that, this is what happened; I didn't set out to kill somebody. I'm not an evil person* *to show the world that I'm not a monster*	P5, 107-108 P34, 884-888 P27, 711-712
9. Loss of self-worth through homicide		

Loss of self-worth	*you're murderers, you're not worth anything* *I'm not the dregs of the earth*	P5, 115-116 P27, 714-715
10. Recovery of hope for the future Recovery of hope for the future Hope for the future Hope for the future Renewed hope Recovery is the ultimate goal Takes ownership of recovery while acknowledging role of institution Recovery cake Is given the ingredients but makes the cake Hope for the future Recovery Journey Know place in journey	*I think the group helps toward making sure that never happens again, and that there is a future, and that you can make something of your life even after you've taken someone's life.* *But, we all talk together and we realise that we have family and we have friends. That what we did is not going to destroy our future completely* *Realising that the rest of your life isn't up in the air.* *As I say, when I get out I want to do this and I want to do that, I want to put something back into society. Recovery is overall what you're going to be like when you're out. This place is designed to set you on the path of recovery, this gives you all the ingredients, and you make the recovery from the ingredients*	P5, 123-126 P5, 140-142 P23, 583-584 P24, 646-648 P26, 664-667 P28, 741-743

Recovery is on-going Driven to succeed Hopes keep him motivated Future is unspoiled Future possibilities Able to imagine a future Realistic about the future Accepts his need for medication Fears becoming unwell again but doesn't think it is likely Get freedom Have a family and employment Keep the future in mind No control over life in institutions but has hope of this for the future	*Once you're rebuilt, it's about the future. The beautiful thing about the future is that it hasn't happened yet.* *That to me is recovery. That is the road to recovery. This place will say, is like a bus, you're put on a bus and each bus stop is a different group, or something that's designed to help you to recover, and at the end of that road is recovery. So it's knowing at what stop, or what part of that journey you're on.* *It's that drive to show the world that I'm not a screw up* *This place is designed to take all that away and then rebuild you again. Once you're rebuilt, it's about the future. The beautiful thing about the future is that it hasn't happened yet.* *So it isn't set in stone, it's how you make the future, with the groups like the homicide group, with the anger management group, or understanding this or understanding that, is they rebuild you. They rebuild a person who can go into society, who has got the*	P26, 672 – 678 P27, 711-712 P 28-29, 744-749 P 28, 748-753 P29, 757-759

	aspirations of becoming greater than they used to be. *A meaningful life is to have me own family, to have my own job, to have a car, to be free. Just to be able to go to a shop, to be able to lock a door behind me.*	
11. <u>Attendance to get out of hospital, but it will still be hard</u>	*That the future's going to be nothing, you do this to get out of hospital, but you're going to be stuck on the DSS, it's going to be horrible. You're going to be branded a murderer*	P6, 136 - 139
<u>12. Open group, lead by patients and prompted by facilitators</u> Participant guided Centred on homicide Facilitators aide Different to structured groups	*That's the beauty of it. The facilitators will sit back and they'll listen and they'll encourage us to speak amongst ourselves. But if it goes quiet and that, the facilitator will bring in a topic and say what about this or that? And they'd offer insight, and that would encourage more of the patients to speak about other things.*	P8, 206-211 P14, 363-367

	And that's most of the groups in N unit have that structure. With the, with the err homicide group, that structure is there if you want it. But it's mostly open ended where people just come into the group and use the time to talk about frankly, openly and honestly.	
13. New group members changes the group dynamic New people, new ideas Ambiguity over new members New members are not unknown	*they're still fresh in the group and they're bringing new ideas in* *When there was people coming and going, er… that was good because it would offer you new thoughts and new ideas as new people came in.* *It's not bad and it's not good, we're very adaptive.*	P10, 244-246 P9-10, 235-237 P10. 242
14. Group Bond Group Cohesion (takes time) Group Cohesiveness Solidarity Emotional openness Group cohesion No hierarchy Group bond Vulnerability by disclosure Group Trust	*So you have that sort of solidarity* *you've got the solidarity of the group where everyone knows each other* *comes into the group and opens up and says this why I feel angry all the time or this is why… it's encouraging, it forms that bond.* *In the group someone who's say, a hard case on the outside, they come in the group and they open their*	P10, 254-256 P10, 245 P10, 238-239 P11, 284-286

Helping other group members Group empathy Alpha's are equal	*hearts and say this this and this and they show their cards really. That is the close bond.* *that bond forms again*	P10, 263-266 P10, 260
15. No pressure No pressure to talk	*You've got that freedom of maybe one week you might feel shitty and you'll not want to talk, you've got that freedom to sit back and just listen* *A little bit better because it's as I said, you have the option, if you're having a crap day. Everyone has a crap day, and if you are, you have the option just to sit back and listen.*	P12, 312-314 P 15, 375-378
16. Honesty in the group Honesty in the group	*But it's mostly open ended where people just come into the group and use the time to talk about frankly, openly and honestly.*	P 14 – 365-367
17. Commitment to the group Attendance demonstrates commitment Just being there shows commitment to others Unwritten group rules	*Just by turning up shows the rest of the group that, that's it's not their fault you're having a bad day. And you're still coming to the group.* *It's, it's unwritten. It's a rule that no ones mentioned yet,because we're going to come, and we're going to come to support you, we're*	P15 - 385 -387 P15-16, 396-399

Silent presence demonstrates support Attendance for other group members not just self Attendance is good People only miss sessions for very good reasons, otherwise this breaks the silent code Everyone committed Would unsettle group dynamic if people didn't attend Would shake their faith in the group to question why others are avoiding it	*going to be here for you. So by coming every week, it's showing the other patients that.* *Er…no. Um when somebody misses the group it's for a very good reason. Either they have their CPA or a …I think that's it really. I think that's the only reason anybody's ever missed a group.* *Yeah the commitment to the group is excellent. I think if someone was missing the groups all the time it would have an affect on the group. Err, so human nature would automatically assume that the paranoia would come in or – "why is that person missing the group all the time?"*	P16, 410-413 P16, 417-421
<u>18. Slow disclosures</u> Would be concerning to disclose too quickly Slow disclosure so as not to shock others	*It's never straight away. I think it would be concerning if someone came in on their first day and just said this is what happened.* *So over the months a lot of them are brought together, so when somebody does finally reveal the details of their Index Offence, then most of the people in the room already know what the Index Offence was. So whenever people talk about*	P17, 464-466 P18 , 463-480

	the most painful things then people are ready. They're not in awe of what they say. They're not err… they're not feeling too strong of a emotion about that Index Offence.	
29. Shared offence aides empathy between group members Support others Opening up leaves people raw Help by empathising Participants model disclosure Search for commonalities across offences Empathy	*Erm, that one person has basically just opened up completely about his Index Offence, and I know how they're feeling, they're feeling like they're a raw nerve at the minute. They've just put their cards onto the table , and like, being supportive during that time, I'm there for ya or, I understand what you're going through, it helps that person* *Ermm… what we do really is we, as I said we usually put an example, or mention something about our Index Offence.* *So if someone was saying this is how I feel, and this is how I feel about my Index Offence, then someone else would say during my Index Offence I was doing this or I done that.*	P17, 433-439 P17, 450 – 452 P18, 456-459
20. Homicide is traumatising		

Repressed memory of offence Too much violence Flashbacks Therapy to recall memory	*Erm… Most certainly. With my Index Offence there was so much violence that my brain sort of didn't acknowledge or remember it. I'd get flashbacks or I'd get visions of things, but my brain was thinking that didn't happen, and it's taken years to recall all of the Index Offence and that was done through one to one therapy*	P19-20, 501-506 P20, 507-510
Memory led to distress Felt like scum Traumatised by own offence	*I thought I was the scum of the earth, and I was a murderer. I done this, and I took somebody's son away from them and their parents. I done that and I done this. I was very plain with myself.*	P22, 557-590
Group helped process trauma	*The individual work was over a couple of years and it was just designed to recall the index offence in it's entirety.*	P22, 587-589
Traumatised by offence Had to recall offence Traumatised by memory of the offence Brain switched off the memories of violence	*Realising that_this group is going to be here and you have somewhere to vent your views.*	P19-20, 503-506
Believed detention to be a conspiracy Slow recovery of memory	*I'd get flashbacks or I'd get visions of things, but my brain was thinking that didn't happen, and it's taken years to recall all of the Index*	P23-24, 607-613

Flashbacks Trauma Shock Flashbacks Visions of victim Visions of victim Traumatised by offence Haunted by victim Felt pain and disgust Couldn't handle the memory of the offence Group helped him to learn to cope with the memory of the offence Went back in time, and forward in time and eventually he remembered	*Offence and that was done through one to one therapy.* *Erm.. when I finished the one to one therapy, when I had time by myself, all that was going through my mind was all that I did, and what happened, and it was eating me up inside. And when I came to this group, I learned how to deal with that by other people said about how they had dealt with it and I'm a much better person.*	
21. Reparation Reparation Still planning reparation	*As I say, when I get out I want to do this and I want to do that, I want to put something back into society.* *I feel that I have taken something from society. I feel that society, I feel that I need to pay society back, I need to do what I need to do whenever I'm out.*	P25, 647-649 P27, 701-704 P27, 708-711

Want to be part of something that is intrinsically good Wants to be part of something important	*I'm still thinking about how I'm going to do that. I've had ideas, of going into research and doing something, discovering something or, that's why I've gone ¾ of the way to a BSc at the open university.* *I would like to go into cancer research* *So that's sort of what I'm heading towards, but even to be a lab technician, I'd be happy to just be part of a team that just discovers something.*	P 28, 724 P28, 730-732
22. Improving (becoming a changed person) Rebuilt self Rebuilt ready for society Become greater than used to be Qualifications and new skills make it better	*They rebuild a person who can go into society, who has got the aspirations of becoming greater than they used to be* *But as the years go by and the qualifications build up, It's hopefully going to be a little bit better.*	P 29, 751-753 P 34-35, 903-905
23. Risk Reduction Learned new skills Learn from each other	*the group helps toward making sure that never happens again*	P5, 123-124

Recovery means absolutely no future risk Learned from past mistakes Stable Stable for a long time Fears punishment Moving toward reduced risk	*My idea of recovery is my team knowing 100% that my Index Offence will never happen again, that I will never get unwell again* *I've went through the mistakes of because I'm better thinking that I don't need to take medication anymore, stopping taking medication and then getting unwell again.* *Um.. completely stable since about 2008/2009…* *I'll think oh no they're going to put me in seclusion because I've done this and I've done that.* *One of the things from the group is that though what we did is very very bad, I think the group helps toward making sure that never happens again*	P26, 667-670 P30, 778-782 P30, 793 P 38, 1002-1003 P5, 122-124
24. Challenges to recovery Motivation is difficult Challenge to stay positive when been in hospital for 12 years	*Then maybe another week I'll come in and I'll be like what's the point, I've been here 12 years, I haven't even raised my voice and I'm going nowhere.*	P25, 649-652

The future will be difficult Hard to stay positive Plans for the future Limited Plans adjusted to make them more realistic	*The future for me is going to be very very difficult when I am eventually released. I know that I'm not going to walk straight into a job. I know that it's going to be very very difficult for me to get a job* *Because I have so many plans, and so many goals and ideas, that I can fall back on, I'd love to go to university and get a PHD, do research properly… but… realistically I'll probably go to college and become a lab technician*	P26, 686-689 P43-44, 1141-1148
25. Negative impact of mental illness No quality of life when mentally unwell Fear of leaving hospital and going to prison Stigma Insight into illness	*I do realise that because of my illness, I've slept in fields, I've run away a lot, I've just been paranoid and my quality of life is non- existent really.* *Yeah… one of my biggest fears is having to go back to prison and having to line up at the med hatch with people saying "he's such a fraggle he's taking anti psychotics"* *Erm… I'd prefer to keep it a secret. Sadly, when people think about mental illness*	P30, 772-775 P32, 846-859 P 33, 859-863

Was delusional Beliefs that put him in danger Felt unsafe and paranoid	*they think about what the press says about mental illness and you'll always have a load of people now who think that because you're unwell you're completely bonkers.* *As I became more ill and I started to hear voices, when I was running away, it wasn't for a month or a couple of months it started to become years. And er... I found it safer to be sleeping in a bush in a field somewhere rather than being at home.*	P 32, 827-831
26. Wants to prove himself to others Wants to show people Everyone thinks you are nothing Feels like a moron Wants to prove himself to others	*It's that drive to show the world that I'm not a screw up* *Prove all these newspapers wrong, that I'm not the dregs of the earth* *Even though being stable, and all the qualifications and awards I've got over the years it's … I'm not a complete moron* *and to show the world that someone who's done something that I have done, can make something of their life*	P27, 711-712 P27, 715-716 P33, 863-865 P27, 713-715

27. Learning how to ask for help Not instinctual for him to seek help Fended for self as a child Difficult to ask for help Always pleasantly surprised by the help he receives Flashbacks normalised Fears the worst Learned to ask for help Learned to accept support	*So as I grew up I learned that if I needed to do something I had to do it myself* *Most recently, the thing I've been doing is asking for help when I'm down or which is still extremely hard for me.* *but.. when I, I approach a member of staff and I say this and that and that's happened, they go, "ok and it's perfectly normal" and they get hold of the doctor* *I've learned that, not to build everything up inside, to Ask for help when I need it, I have the support network In here, of course when I get out I'll have a support network as well.*	P38, 986-987 P 38, 990-992 P 38, 1005-1008 P44, 1163-1167
28. Regained Mental Wellness Return to self before mental illness No longer afraid Return to self	*I started to feel like I did before I was unwell* *I know that when I get out, I'll be me before I was unwell, I'll be me when I was 15.*	P42, 1106 P44-45, 1172-1174

No more paranoia Feels close to recovery	*Yeah, and not what the illness made me, all paranoid and not trusting anybody and being so afraid that I'd rather sleep in a field than home.* *This group has opened my eyes, it's given me belief that there is a future. It gives belief that I am on that road to recovery and there's only a couple of stops left.*	P44, 1180-1182 P40, 1052-1054
29. Homicide group is the key to recovery Homicide group unlocks recovery Built back up Without the group he would have far to go Made more progress in the group in fifteen months than in twelve years since committing the offence	**interrupts* This group is the key to all that, before this group I had some understanding of the Index Offence but it's how I understood it, with this group, I have other people's understanding of it.* *As I said before, I've been down to the bare essentials and I've been built right back up again.* *Um… just that as I said without this group I'd still have a long way to go.*	P 45, 1197-1200 P46, 1202-1204 P45, 1210-1211

	I've done fifteen months, and in that fifteen months I've got more understanding of myself and other people than I had in twelve years.	P46, 1220-1222
Interview 2 **1. Developing understanding of the offence** Understands the offence Questioning by other group members helped him to question own understanding of offence Before the group could not understand the offence Changed understanding of the offence Previous belief that the homicide was an accident Group members opinions and advice are helpful	*It's made me reach that level of understanding of it as well.* *You know, and it felt like an accident because everything happened so quickly. But erm… when I went into detail about my Index Offence, and others, said "look, you know what was your thoughts at the time, what were you thinking?" you can't just… I dunno… the feedback they were giving me was that maybe it wasn't an accident.* *And at the time it was a difficult decision but it happened so quickly as well, that's why I wasn't able to understand it, to comprehend the whole thing and put it into words you know* *They made me think about it you know, and after a while, I realised that you know what? I have done what I done*	P48, 27-28 P48, 36-41 P 48, 51-54 P49, 64-65 P49, 71-73

Retold story with new understanding Understanding of offence brings peace Wants to help others understand their offences Learning about offence Learning how to live after taking a life	*it's very difficult for me to word that you know, and for me to come to terms with that. But when I did I felt better about myself you know.*	
2. Acceptance of responsibility for homicide offence Admits offence Understands the homicide was not an accident Realised the homicide was deliberate Realised he had been in denial and avoiding self-blame Accepts responsibility now Previously felt as if something was missing in his understanding of the offence Always knew he was to blame but had not accepted it and this	*I admit to it, and I have done that you know?* *I have committed my Index Offence* *I'm taking responsibility innit?* *And I always said to myself it was an accident and it was a way of hiding away from it I think. And when I faced up to it I realised that that was missing, but at the time I didn't feel like it you know.*	P 47-48, 22-23 P49, 66 P 50, 88 P 50, 98-101

led to an internal struggle Faced up to the truth Denial left him feeling uncomfortable Made a decision to choose his life over the victim's Revisited his understanding of the offence Used to feel victimised Realises impact of offence on victim and victim's family Puts sentence into perspective – feels less victimised Taking responsibility Takes responsibility No hiding from responsibility Used to blame others Realises he is wrong	*Cuz at the time I was thinking it's either my life, or his life, so that was it. I did some thinking you know what I mean? I might as well… I chose my life you know.*	P 48-49, 48-51
3. Identity as a dangerous killer Accepts his identity as someone who is capable of killing		

Believes anyone could kill if cornered Perceived negatively Viewed as dangerous	Just um… I dunno… I just think that people think I'm incarcerated, like ooh I've committed a homicide, just that, someone who's committed homicide and that …you know what I mean [you think that people think that you're…?] *"Dangerous."*	P69, 595-597 P69, 600-602
<u>4. Recovery from difficult emotions through sharing</u> Talking in the group is helpful Complex feelings about the victim Learning not to let the past predict the future Talking about difficult emotions is helpful Homicide support group Regret Doesn't want to feel down thinking about offence all the time Trying to find ways to move forward Can't forget homicide	*The only thing that the group did for me that week was that when I came back I was able to talk about it you know.* *Also it helps when you've done other groups and they've helped you and you've reached a level of like, thinking that the groups are helpful.* *and some people gave me advice like don't let your past determine what you do for the future, and stuff like that you know. It's like a learning curve for me anyway you know*	P56, 242-244 P51, 113-121 226-229 P78, 842-843

Learning to live after taking a life	*It's not something I can forget about you know, it's something I gotta live with, something I think about…* *Yes. It helps me think about that yeah.*	P78, 848
5. Prior experience of therapy groups Prior belief that therapy groups are helpful No prior expectations Felt positive about the group due to previous experiences in group therapy Fast disclosure Fast disclosure because thought it was expected Prior one to one work Belief that therapies work	"Also it helps when you've done other groups" *"I was looking forward to it really because I've done other groups and I thought you know what they said I'm going to a homicide group and I'm going to talk about my Index Offence"* *"Um…someone must have really thought about it because they work"*	P51, 113 P59, 336-339 P77, 796-797
6. Group bond		

Everyone has committed the same offence, no judgement	*"Everyone in the group has done the same offence that I've done, but not in the same way. Our Index Offence is the same so that gave me a bit of a like, like not being able to be judged."*	P51, 116-121
Felt part of the group Familiarity of other group members	*"Because I'm the odd one out or something like that you know. So I didn't feel like that."* *"I knew mostly everybody in the group."*	P51, 125-127 P51, 128
7. Homicide Group is challenging Wouldn't feel comfortable attending the group without prior involvement in treatment groups	*I personally don't, I don't think I would have been able to [attend the group without prior group experience].*	P52, 151-152
Homicide is full scale	*"I would say it's better to ease someone into a group that's full scale like that."*	P53, 157-159
Homicide treatment is like jumping in the deep end of a pool Difficult to talk about homicide	*Instead of jumping into the deep end you know, like of the swimming pool.* *"It's very difficult you know, I was saying to the group a couple of weeks ago I think*	P53, 163-164 P54, 197-199

	yeah… because I spoke about my Index Offence in depth"	
8. Conflicted about own right to recover Feelings of guilt regarding own recovery Feelings of guilt Feels selfish for wanting a future	*So I was like… it brought me back down to earth. Like why do I deserve a future? And I started asking myself all these things cuz I thought, know what I mean, um… I've taken someone's life away from them you know.* *…even though I hated, I hated the people that's what they've done to me, it still didn't give me the right to go and hurt somebody that way you know. My family… his family… him… society* *Now, I'm thinking… I was thinking that erm after that, thinking about my future is selfish*	P54, 207-210 P55, 216-219 P55, 224-225
9. Would like more support Wants out-reach Wants more support for difficult emotions raised in group Difficult hearing about others' offences Wants more support Left alone with difficult emotions between groups	*…it might be something the group could do in the future, if they think that, maybe some time, they could come and check up on how you're feeling, once …. Not even a one to one session…. Just check up on how they're feeling if they wanna talk about something further you know* *The group makes me think a lot about my Index offence, and others' Index Offence, so*	P56, 251-256 P63, 430-432

Left alone with difficult emotions between group sessions Concurrent one to one work	*sometimes I think I think <u>too</u> much you know.* *it might be best if someone was to come and check up on you, you know. Cuz no one comes to check on you, and we're not allowed to talk about our Index Offences and what happened in the group to each other on the ward or on any other places.* *I needed some support and someone to talk to you know, that's why it started.*	P64, 452-457 P76, 791-792
<u>10. Reparation</u> Reparation is important Wants to do something positive Wants to help those with mental illness through sports Wants to make other people happy to repay offence Unpaid work to repay offence Wants to be viewed positively Wants to be seen as doing the right thing Reparation	*And erm… there's no way I can repay that you know. I can try. But there's no way I can physically repay that and say look I want to erase what I've done and give them their son back. You know, I can't do that. So what I thought I could do, is erm… I can't erase my past, but I can do something to er… something to err overshadow it.* *You know, so I could try and do something positive from here on until …* *A lot of positive things I wanna do, I wanna help, I wanted to err.. what I wanted to do is like start, cuz I'm interested in football, I wanted to make a team from*	P57-58, 287-293 P58, 297 P58, 301-308

	the hospital, where people with mental illness outside of Broadmoor and and that wanna play football and everything, it could be young people or teenagers, it could be anyone, it could even be old people you know what I mean? *And I have other goal like getting involved in charities when I get out, and working for charities*	P66, 513-516
<u>11. Recovery</u> Recovery is getting over something Recovery is on-going Recovery is understanding you are unwell and asking for help Recovery is about being guided by others Goals Goal to find mum Goal to move on from high security Wants to stay well Recovery from mental illness	it*'s erm recovery basically you know, like getting over something you know. Like getting better than I am. Like for example I've been recovering since I've been in the hospital, and I'm still recovering you know. So I know that I had a mental illness, you know. That I developed when I was in prison. And um… when I came here and I understood a bit about it, since then I was recovering and becoming better, and getting well. And and and asking for help, and asking to be guided along toward that recovery.*	P65, 484-493 P77, 636-639

Takes time to recover from mental illness Recovery is a learning curve Religion Medication Hope for the future Mental illness historically caused false beliefs No longer affected by mental illness In control of mental illness	*It was a long process, and a learning curve, learning about myself, my mental illness, my Index Offence, everything, all put together makes for a better understanding of the whole situation you know.*	
<u>12. Future risk</u> Won't reoffend Not a violent person Has learned about consequences Does not want to be incarcerated again Uncertainty about reoffending Hopes not to reoffend	*I won't be offending again* *I've learned a lot about my Index Offence, I've learned that, that erm, violence doesn't solve anything you know, in any way, in anyway at all. It doesn't help you, it's got consequences. So offending has consequences you know, and I don't want to be incarcerated ever again you know. I want to be out there, helping people and doing things that are positive.*	P66, 530 P67, 542-547 P67, 553-554

Understanding offence helps prevent reoffending	*I can't be too certain, because you never know what will happen, but I like to think that I'm, what I'm hoping for is going to happen.*	
13. Unstructured Group Others' opinions Unstructured group Everyone talks about different things No Structure No Manual, No structure Stays on topic Participant led Facilitators support Facilitators try to understand Questioning of group members useful Timing of entry to group important Needs are met	*So people with an opinion, or what they think about what I've done, and they say something about what I've done, I think about it and I think is that true you know? And I question myself, and I look back at the situation and I think about whether they're right, and I think that was a good point.* *We talk about all different things and erm…like, there's all them things happen in the group you know. And there's no structure to say like this is how it should be done you know.* *We're not following a book or anything. And mostly I would say the Index Offence, all these things are relevant things you know,*	P73, 689-694 P74, 718-721 P74, 725-727

Everyone is different in terms of when they disclose their offence in the group	*Mmm, I dunno, everyone is different you know, some people could take months, some people could take a year, some people could talk about it straight away like me. Some people take a long time. We're all different you know.*	P78, 833-837
14. Patients challenge other patients Asked questions about crime that help develop understanding of it Patients challenge other patients	*One to one work would just be like, you talk about your Index Offence, and um… that's it really. But this one's a bit more, someone might ask you a question, or someone might say something about it… someone might give an opinion.* *like I might have been thinking a certain way about my Index Offence or a little… or someone gives me an opinion and it makes me think… so erm… more times*	P75, 762-766 P47-48, 18-23

	*it's helped me be *pause* be brave enough to say that I admit to… you know what I mean? I admit to it, and I have done that you know?* *But erm… when I went into detail about my Index Offence, and others, said "look, you know, what was your thoughts at the time, what were you thinking?" you can't just… I dunno… the feedback they were giving me was that maybe it wasn't an accident.*	P48, 37-41
Interview 3 **1. Recent changes in group dynamics** Group size has decreased Different phases of the group: silent Vs lots of discussion Recent quiet phase in group Recently changes of group members and facilitators	*…there have been up to seven or eight of us but at the moment there are only five or six of us.* *And there will be other times, like quite recently, where there will be lots of silences* *And there have been a lot of changes in the group as well from patients moving on, and changing of facilitators as well.*	P 79, 8-9 P80, 16-17 P80, 20-22

New facilitator is quieter and this has impacted on the group Group now more reflective The silences are discussed a lot	*so and that was an interesting shift, because suddenly we'd gone from having GA who would always ask lots of questions, and try to develop the conversation, to G who's quieter and the group seemed to change as a result and become a lot quieter and become a lot more reflective, but that's not necessarily a bad thing*	P80, 31-36
2. Drawing comparisons with the media Discuss films Discuss CJS Could bond over films Discussion of violent films Frightened by an experience Expectations of real life based on films	*when I first joined the group we were spending a lot of time talking about films and the justice system, and portrayal of the justice system in films and how it's completely different to how the justice system operates in real life* *So we talked about the sort of torture porn films like saw and hostel, and erm what it's like to watch those, and what the experience is like. I haven't actually seen them, I've seen a bit of one of the saw films so I thought I got the idea.* *…then like we talked a lot about the Shawshank redemption and experiences of going to prison compared to what it's portrayed as in the media, and what you expect prison to be like and what it's actually like, you know.*	P 81, 49-52 P87, 202-206 P87, 217-221

3. justifying offence Query of free will. Are people free agents? CJS is unfair Not the only one Justifying offence	*…and my memory of it is me sort of sitting there and talking and talking about sort of moral philosophy and like the sort of situations you find yourself in in your life, and whether you have free will to act at any point, in accordance with how you desire or whether you're subject to other forces acting upon you* *Then we got onto how we thought about the justice system and one member of the group was saying "well I think the system sucks" and generally we all agree because we think it was pretty unfair.* *I had reasons… and… erm, I felt a little bit better about myself hearing about what other people had done.* I don't like to compare myself to other people but, it did make me feel like you know, some of the reasons that I had for doing my offence valid.	P81, 61-66 P81, 52-56 P147, 532-534 P148, 540-543
4. Substance misuse	And then there was kind of a hiatus where we talked about	P81-82, 67-71

Drug use Talk of drugs Drugs should be legalised Disagreements over drug use Common experiences i.e. drug use	drugs for quite a while, which actually caused one member of the group to drop out because he's never taken drugs and all he was getting was different people comparing drugging experiences *But anyway we spent ages talking about drug experiences, then we got onto the ethics of whether drugs should be legal or not, and my position was all drugs should be completely legal and people should be educated in how to use them properly, and some people agreed and some people said "well I took some speed and it was bloody horrible"*	P82, 82-87
5. Slow Disclosures, participants take their time. Offence stories disclosed Slow disclosure Learn about how others came to high security Learn about others' hopes for the future No initial expectations	*We have of course talked about like…people's offences, quite individually as well, and people have shared sort of stories and past stories and the general idea of the group is that peoples stories are allowed to emerge over time* *Errr you'll get a bit one week, you'll get a bit the next week, you'll get a bit three weeks later and it will sort of piece together into this whole story of how someone has*	P82, 91-95 P83, 96-101

Expected to have to disclose offence details Slow to disclose When he did, he released a stream of consciousness Filling the silences Gave a part of himself to the group over time Unhelpful to be pushed by facilitators Unhelpful to push new members Slow disclosure, people join discussion in their own time	*experienced coming to high security really, and having committed an offence and erm what they hope in the future.* *I can certainly remember that for the first two or three sessions that I attended the homicide group I didn't really say very much at all, I was just kind of scoping the place out* *but then after that I got more into actually opening up and just talking really. And it was almost like a stream of consciousness thing. It was very interesting; I would just talk about whatever was on my mind.*	P85, 171-174 P85-86, 174-178
6. Unstructured Group No structure Facilitators keep group on topic Facilitators stop the group going off on a tangent Facilitators use open questioning No set agenda Psychodynamic	*And there's no structure to say like this is how it should be done you know.* *It's completely free, there's no structure to it at all. Um…it's completely up to what people want to bring into the room each week. But it's guided by the facilitators who will occasionally bring things back to the focus of either*	P74, 721-720 P83, 109-116

Free to talk about whatever Debates arise Different from other more structured groups Open ended No agenda Anyone can talk whenever Conversation may seem irrelevant at first but develops understanding of the wider issues and factors that contribute to offending Open format group takes discussion to relevant but unexpected places Unclear expectations of the group Nothing expected of participants Stays on topic Mostly relevant A Balance of people who want to help and people who want to find understand their place in the world Facilitator – patient balance	*focussing on, either focussing on what people think about their offence, or focussing on whatever we were focussing on before we went off on a tangent, and started talking about something else.* *I understand it's a psychodynamic group and as far as I can tell, that means that basically people are free to talk about whatever they want.* *So… people are free to chip in whatever they want at any time. I found that immensely helpful for myself personally. I know we'll get onto this in a bit, but I found it very helpful because I felt like I could talk about things which might not immediately seem to be related to homicide but actually in my own mind they form part of the larger issues which were going on for me, at the time and also now in relation to who I am and where I fit in the world and what the point of my life is now that I've killed someone.*	P84, 128-130 P85, 151-160

7. Facilitators take on different roles Facilitators differing strengths Judy pushing agenda onwards Sarah sensed emotions Sophie had a different quality Facilitator personalities are important Facilitators have different roles Good quality therapists	*I can remember that she was very good at asking questions and sort of pushing the agenda onwards. With a kind of focus, but also leaving it open ended. So she'd ask about what people thought with relation to people's offences. Um… and ummm errr the different facilitators brought different things to the group, so we had SB (name anonymised) and a lot of the time she would say sort of like, she'd be like, counsellor Deanna Troi in star trek, in that she'd say that "I feel there's a lot of erm sort of, resentment in the room at the moment, or I feel there's a lot of frustration in the room at the moment". And she'd be very good at picking up on that.* *And then we had Sophie and she brought a different quality as well. So it's as much about the personalities in the group as it is about the personalities in the facilitators and what they bring to the mix really.* *Well the quality of the facilitators has been very high; they've been very good and very helpful.*	P88, 239-251 P88, 255-258 P127, 1283-1284

8. Recovery and feeling at peace Feels at peace Less alone in the offence Group makes him feel better Doesn't blame self for parents' divorce Feels stable now Feels more at ease Not alone in his suffering	*I mean as I say, for myself, as a result of being in the group I feel more at peace with myself and what I've done …as a result of the work I have done in the group. That's not a result of X, Y and Z… that's down to much more just the experience of being in the group really.* *Um… well in a very basic sense, Um… I'm less alone now in my offence that I was at the time. Mmm in that um…I'm not the only person who has committed a homicide* *and ummm my parents have recently got a divorce in the past two years, and that's about their relationship breaking down and I initially blamed myself, and all my friends were saying, "well no don't blame yourself"* *Um… just knowing that…erm I wasn't the only one to have a difficult upbringing, and having that in common with people makes the burden a little less difficult to bare, because you don't feel like you're the only sort of tortured soul in the universe. Um. And… I think that*	P90, 284-288 P94, 403-405 P96, 449-443 P100, 556-553

	emotionally I feel emmm more relaxed in myself and more able to give an account of myself, that I did before I joined the group.	
9. Group bond Offence in common Participant bond Friendship Special bond unique to homicide group Special bond – can talk about many things not just homicide. Shared experience of killing someone you know Common experiences	*And it's partly about, I mean very obviously having what I've done in common with other people. But that's only really like the tip of the iceberg.* *So there's a bond, a bond you have with other members of the group and that can be quite strong…* *Well it's very different in that I've done groups with other people where I haven't really bonded with them or I've bonded with some of them but not others, and erm… but the discussions I have with people I've met on other groups seems to be limited to what we cover in the group.* And then we had someone join the group who actually, their victim was their own father and when they started talking about that, I sort of started to kind of understand my god I've really got this in common with this person	P90, 289-281 P92, 351-353 P91-92, 357-362 P96, 461-565

10. Acceptance and being human Self as a human Greater sense of being human	*it's about being accepted in my views and my position. Not just because of what I've done, but because of myself as a human being.*	P90, 292-294
11. patients challenge other patients Patients challenge other patients Patients invaluable in reflecting ideas Bounce ideas	*Being able to talk to other people and being able to sense that they may agree or disagree with what I'm saying.* *Ok, um… I think that um… what's most helpful is being able to reflect off other people, ideas I might have or whatever* *and that mix is quite useful because you're sort of exposing yourself to quite a broad audience and you can get quite a few sort of qualities and reflection on what you're saying, from what other people react to it and how they sort of, what they say afterwards*	P90, 294-296 P94, 342-344 P110-111, 841-845

12. New Understanding of Offence Unexpected commonalities	*But um… there are things I have in common with other people who have killed someone close to them, which I wouldn't have thought I would have in common with them*	P94, 406-409
New understanding of offence; learned that his relationship with victim was fantasy	*Well my offence is slightly different to most people in the group in that I didn't know my victim that well personally but I had quite a strong kind of imaginary relationship with her. In that I knew who she was and I knew kind of her position and what she did a lot of the time. And… erm… in my mind I kind of had this kind of fantasy relationship with her*	P95, 422-428
Changed understanding of offence Understands complexities of offence i.e. didn't just 'go crazy on drugs'		P95, 435-440
Understanding of offence changed Offence was about him as a whole person and his life and lived experiences	*Well it certainly has, um… in that when I first started the group I believed, well I've just done lots of drugs and gone crazy and killed someone and that was it. And actually as a result of exploring what I have in common with other people in the group, I've come to realise that there's a lot more to it than that.*	P96, 444-449
Can process more than the offence in the group *important for recovery	*In that erm… I mean, it's partly about growing up, it's partly about going through sort of rites of passage that*	P96, 456-461

Understands familial relationships Real understanding Telling own story out loud Getting story straight Getting story straight brings new understanding Learning about relationships via relationships in the group Deeper understanding of offence Understanding of the role of external factors.	*can go wrong, it's partly about just how you cope with things like rejection and personal difficulty when you're growing up, and it relates to all sorts of other stuff, it relates to things like school and parents* *But it got me thinking a lot more about how I relate to my parents and erm… that affected quite strongly my understanding of my index offence in that I felt it was a lot more about my father and the way he had influenced me when I was growing up* *Umm because once, I mean, you can tell your story to yourself however many times you want, and it will change each time, but once you've told your story to someone else, someone else has an understanding of it, and that doesn't change until you give them new information, so what you've got is a situation where by telling your story to other people you're making it real and more concrete, instead of something that is just something in your own internal dialogue.* *and in getting your story straight, you draw upon all these elements in your life that have led up to your offence, and you start to recognise how things that*	P98, 501-509 P99, 522-528

	have happened to you in childhood or things that were going on for you at the time of your Index Offence contribute directly to things that you did.	
13. Making sense of culpability Trying to understand own culpability Ashamed about sexual element of offence Does not identify as someone who poses a sexual risk	*But it's very hard to sort of identify where personal culpability ends and just being a victim of circumstance begins. And I still haven't fully managed to do that.* *Yes and no. In that, I still feel guilty for what I've done, and erm… but I've had members of the group say to me that they don't think I've done anything wrong. But I don't necessarily agree with that, I think I have done something wrong…* *And I find that quite uncomfortable and quite difficult. Umm because actually there is a sort of sexual component to my offence, in terms of I undressed my victim and was going to have sex with her and didn't but, could have done, and I still find that quite difficult because that sometimes sends out messages about myself that I don't feel completely at ease with, because I don't feel that I'm actually that sort of*	P99, 539-542 P99, 535-539 P126, 1253-1262

	person, and I feel that one of the reasons I did that because I was very disturbed	
14. Preparing for hospital discharge Preparing to leave hospital which is difficult	*Yeah I would say so. I mean It's been a bit difficult for me recently because I'm kinda in the process of leaving Broadmoor now. And that can be stressful in its own way, and that makes all sorts of things more difficult rather than less difficult, for me personally anyway. Um, so I've actually been sort of hiding, and spending more time in bed, and sort of waiting for things to end really, umm but certainly like feeling more relaxed makes day to day living more easy really.*	P100, 569-577
15. Developed relationship skills Developing relationships within the homicide group has helped teach him how to build relationships outside of the group Warned not to trust other patients Homicide group has helped him to learn how to trust others	*And.. ermm once you start to feel more relaxed and at peace with yourself you can start to talk to other people more, and not just people in the group but friends you may have outside of the group or just on the ward or across the hospital* *It's quite difficult because my primary nurse said to me, well you're in High Security, don't trust anyone. And like… I think he's right, but in the same time I think there's a case for trusting some people*	P101, 577-581 P103, 640-644 P103, 640-645

	to be closer to you than others. *I came to Broadmoor and everything was very new and very alien and I didn't trust anyone. And I felt it quite difficult still. But umm that has shifted and … I think it's… partly it's just familiarity of being in the same place with the same people all the time. But I think the group has affected that as well* *Certainly how I relate to other people in terms of trusting them.*	P103, 635-636
16. Changed self His experiences have changed who he is New person Still the same but feels different Personality has changed Self is changing changed use of humour More at ease with others as he becomes more at ease with himself	*Um… and like, I am myself with other people but myself has changed as a result of my experiences.* *And what's interesting about that is that I can still recognise myself in myself but what I can't recognise is some of the things I say because they're new.* *I mean things that have happened in the last 6-9 months that have demonstrated how my*	P101, 586-588 P101, 592-594 P101, 683-688

Identity changed	*identity has changed, and they've been experiences that I've learned from, umm as a result of what's happened in light of my offence. So…erm… (someone's gonna come through the door)* *but actually like, erm… in light of what I've done it's actually quite a frightening thing for someone to receive, and umm I didn't really understand that before, but I understand that more clearly now that it's happened.*	P106, 702-706
17. Negative impact of Mental Illness Psychotic when committed the offence Mental illness started his pathway to the offence Couldn't live a normal life	*Cuz everything was sort of very surreal on the lead up to my offence and I was suffering from psychotic illness as well.* *Ok so in the past I started to get depressed when I was 17 aaand I was definitely suffering from full on depression at University. Erm… coupled with a kind of prodromal psychosis that made it quite difficult for me to concentrate on anything really*	103-104, 656-658 P121, 1120-1124 P121, 1134-1138

	So those are the most kind of obvious effects of mental illness, on my life really, and it's kind of made it very difficult to kind of live in the way that most people would expect	
18. Viewed as dangerous and becoming dangerous Become a riskier person as a result of being hospitalised in high security If you're characterised as dangerous then you become dangerous Treated with caution Doesn't feel that he is dangerous enough to warrant high security	*he was another member of the homicide group way back when he said 'well, um when you come to High Security your risk goes up automatically, just by merit of you being in a notorious hospital* *No I believe your actual risk suddenly goes up because suddenly you're classed as a high security patient.* *Um.. so… I don't know because you're deemed to be worthy of high security so people will treat you very carefully in the future. I mean it's partly down to perception but it's also partly down to the categorisation* *For me personally I don't think I should have come to high security I think that my needs could have been met in medium security and I would have been alright.*	P108, 768-772 P108, 780-781 P108, 785-788 794-797

19. Learning to live as someone who has killed Understanding more about the ramifications of his homicide. Cant behave in the same way he would have done prior to the offence Getting used to living life as someone who has killed someone and what this means in terms of how he can behave now A marked man Understands repercussions Coming to terms with a changed future because of homicide Highly scrutinised with huge repercussions if he was to do anything wrong again Depressed either because of current restrictions or the possibility of future restrictions	*So an example is where I've written sort of very aggressive ganster rap lyrics and sent them to one of my friends, and he rang up the hospital and said he was very worried that I was going to get out and sort of kill someone else. And I haven't actually written back to him yet to sort of explain and apologise, um.. but I realise that if I hadn't have committed an offence I would have been able to do that and it would have been like 'oh he's just written something strange'* *But all these things, that sort of came up in my tribunal reports and people were saying 'well we're a bit worried about Wayne moving on because of how he's been acting lately' and the consultant just said 'no this is just Wayne just getting used to who he is and what he's done'* *So I mean… when I first came to this hospital the doctors said to me, 'well, your life will be different now, to the life that you might have led'*	P105, 694-702 P106, 716-721 P114, 942-944 P107, 756-758

	and I think that he's absolutely right in that I'm gonna be scrutinised for quite a long time after I leave here, and if anything goes wrong I'm gonna be brought back	
20. Feelings of injustice Feels his position in high security is unfair, but believes it is better than prison A space to complain Minimises offence Unlucky to be in high security	*it's either here or prison, you can't really … there's no middle ground you know' and I mean um… I'd rather be here than prison, for a lot of reasons but umm it still seems kind of unfair *laughs*.* *And I certainly had this period in the group where I was saying, 'well this isn't right and why have I been brought here'* *What's the rationale behind it when there are people who do things similar to what I've done but they go straight to medium security'? And they're sort of back out within two or three years. And there wasn't really an answer to it* *I think it's just the way things go, and I think it's the luck of the dice in some scenarios.*	P110, 809-812 P110, 822-824 P110, 824-828 P110, 829-831
21. Group Challenged beliefs		

Group can change perspective and challenge beliefs Difficult to make friends Changes his perspective and beliefs Intellectually and emotionally testing to witness a friend's beliefs being challenged	*And that was a different perspective on it that I kind of took on board* *but then to bring him into the group and actually have some of the facilitators challenge his point of view was very interesting because it made me challenge his point of view in some regards.*	P112, 886-887 P112, 880-884
22. Recovery as improving Recovery does not conceptualise his change appropriately Wouldn't have had the opportunity to do the homicide group in medium security Going somewhere new not returning to what he was like before Recovery is too simplistic as a term Recovery insinuates his journey has been a linear process of which he should aim to return to the start Recovery is improving from where he was originally	*I think recovery is the wrong word… Because I think recovery is going back to something… and for me that's not what it's about, for me it's about going forward to something else.* *And um.. this idea sort of implies that well you were doing alright, and then you got ill, and you had a breakdown and now you're recovering from a breakdown to a point where you can function and be handed back as much responsibility as you can deal with. And that's fine, I don't really have problem with that, I just don't think it's the whole story.*	P114, 931-938 P115, 955-961 P115, 962-969

	erm… it's about doing very well, and kind of thriving in the future despite what's happened in the past. And… for me recovery is about actually kind of advancing myself and not going back to where I used to be, because I wasn't too happy with where I used to be. It's actually about going forward into a new place which is much more kind of fulfilling and kind of good for me really	
23. Hopes for the future Future should be good	*I think that what's realistic is more me to live in the community and to have an alright life. A pretty good one actually.*	P117, 1013-1015
Tempted by drugs	*there are certain complicating factors such as the temptations posed by drugs*	P117, 1015-1016
Unsure whether he could manage drugs		
Education important to his future Considering being a teacher	*and it's quite easy for me to go into teaching, I mean I have a degree I have a masters, and I can get*	P117, 1027-1030

Considering future employment possibilities Unsure about what is possible for him Wants a job, a partner and somewhere to live Thinking about the future Would like close relationships Not happy about having to start again Questioning what sorts of friendships would be desirable What he does is the future is important because historically having to do things he doesn't like has caused trouble The group talks about what is realistic for a homicide offenders future	*funding to do a PGCE and I can go into teaching, but I don't know* *I'd like to have an independent income, independent of sort of state benefits. Umm I'd like to have somewhere to live that's kind of okay* *a group of people who I really liked, would be really important to me, and I've started to develop that here but I'd like to continue that in the future* *…but um just talking in the group to the facilitators I've realised that it was possible [to go to the USA], as long as you don't have a drugs conviction then they tend to be ok about letting people in. So that's something I'd like to do in the future and that's something we talked about I the group, and seems quite feasible so…*	P118, 1045-1948 P118, 1061-1063 P125, 1227-1232
24. Risk Reduction Learned how to form relationships which has specific implications for his risk	*And I mean one of the things that's come out of the work I've been doing in the SOG is that relationships are very important to me, and sort of having lots of relationships, or slightly fewer relationships but more satisfying ones, is very kind of central to my*	P116, 994-1002

Understanding gained from other groups combines with that developed within the homicide group No intention of reoffending Doesn't mind that repercussions of future offences would be serious because does not intend on reoffending Understands repercussions	*life. And it's quite interesting that at the point that I kind of suffered a break down and became very depressed and then acutely psychotic I had very few relationships in my life, in fact practically none.* *Um… yeah… er…. Certainly in terms of offending I mean, different people have said different things to me, but the one thing that seems to be absolutely clear is that any kind of trouble with the police, for any kind of offence, a violent offence or a sexual offence would lead to me being recalled, probably immediately, to conditions of security. Umm… er… which is fine, because I don't intend to commit any sort of offence of a violent nature or of a sexual nature in the future. So that's alright. Um what is more difficult is things like drugs offences, in that I have sort of quite liberal views about drugs and wouldn't mind experimenting with whether I could get away with taking them again or not*	P124, 1195-1207
25. Positive impact of medication Continues to need medication for depression	*Umm and in terms of depression, I was depressed when I came to hospital, they put me on some anti-depressants, they took me off them and I got depressed*	P122, 1151-1155

Better when on anti-depressants Doesn't mind relying on medication to stay well Medication works for him and with few side-effects	*again, they put me back on them for four years* *so I started taking them again just a few weeks ago…And I've perked up kind of considerably* *Um… errr and I would say that I'm happy to comply with the anti-psychotic medication. I'm on a very low dose, I don't get any of the side effects, I'm very fortunate and it works very well for me.*	P122, 1161-1157 P122, 1169-1173
26. Group helps to think about explaining the offence Knows how he will explain his offence Uneasy about the idea of getting his story straight	*Um… I mean… for my offence there are different sort of ways you can talk about it. Um… and the way I choose to talk about it at the moment is that I was 22, and I had a breakdown, and I went and killed one of my neighbours. Um.. and er… and that's all I really have to say. And then I went to prison, and then I went to hospital for ten years, or however long I've been away for…* *but then there are other people who that I dunno I'm thinking more in terms of intimate partners or maybe social workers in the future who aren't so clued up about me, who I'll have to go into more detail with*	P125, 1240- P125, 1240-1247 P126, 1249-1253

Interview 4: Benjamin		
1. Difficult to talk about homicide in a group setting Participants drop out early Can be difficult to talk about homicide	*Um. When we started the group off there was about 6 or 8 of us, some people dropped out early doors* *For some people it's harder than others, because some people are a lot more ashamed for what they've done.*	P128, 7-8 P129, 40-41
2. Group unstructured Facilitators prompt Free discussion Expected facilitators to take a more directive role Staff taking a step back entails that conversations are lead to unpredictable places Patients lead the group to unforeseen places	*Um… we were encouraged to talk pretty much amongst ourselves. Every now and then one of the facilitators would question something or give a theory or idea and the group would talk around it. It wasn't as structured as a group like CBT or UMI or anything like that, it's a lot more free.* *You're encouraged more to talk among yourselves rather than theories and ideas from facilitators.* *I expected it to be a bit more input from staff…* *I dunno, I think… it's good in some ways and it's not good in some ways. In some ways it's good cuz the conversations might lead to*	P128, 10-15 P128, 15-17 P130, 65-66 105-107

	places that they might not of been able to predict	
3. Gain understanding of the offence Gain insight into offence by getting others' opinions Realises there are reasons people act the way they do New understanding of his offence Understands why he did what he did	*It's about understanding the offence, by other people asking, and telling their opinions, so it's about getting insight into your offence.* *And when I went to the group, and people said certain things to me, I guess it made me realise that sometimes people do things because of reasons, they don't randomly do it.* *It's made me realise the reasons I did what I did. And it made me understand and homicide a little bit more.*	P129, 29-31 P133, 151-155 P145, 482-484
4. Others have committed worse offences Some offences more depraved Some struggle with what they've done Some people's offences are depraved There is judgement to a degree	*Some people's offences are different to others, some peoples are a lot more straight forward, and other peoples have a lot more serious elements to it*. *I dunno, some people, the things that they've done, they find it hard to cope with the things that they've done*	P129, 42-44 P129, 45-47 P132, 130-134

Comparing his offence to depraved offences makes him feel better Other people have done worse Compares himself to others who don't take responsibility A better person than some	*I mean, I don't like to compare myself to other people, but I did feel like some of the things that people have done were quite depraved so, you know… kinda…kinda… it set my mind at ease a little bit.* *I think in the back of my mind I knew there were much worse things that could have happened to me, and other people have done much worse things* *and also there are people who don't really take any responsibility for what they've done, and people who don't face up the fact that they did what they did*	P148, 548-551 P148, 554-557
5. Judgement in the group To a certain degree there is judgement Mental health professionals judge	People to a certain degree judge them, and because they're aware of that, it makes them hard to talk about it. *cuz you've got three mental health professionals in the room, and anyone who has been in the mental health system will kind of be aware of the fact that what we're saying can affect the way you live in hospital.*	P129, 48-50 P130, 56-60

6. Unequal engagement of participants Some people unexpectedly quiet Same people starting the conversation	*Some people didn't really talk. It was about 50-60% of the group that actually spoke about things, and usually it's the same one or two that instigate the first kinda dialogue.*	P130, 72-75
People sleep in the group Some discussion circular	*but then some of them left the group and some of them left the hospital. But there were guys that were snoozing, it was a morning group and they were like, falling asleep and snoring and that. *laughs**	P130-131, 80-83 131-132, 108-114
People sleeping is an elephant in the room Hard to stay awake when you're on medication	*in other ways, sometimes you're just going round in circles: talking to someone, talking about their offence, talking about them now, then talking about their offence and it just goes round in circles, the same people as well so… maybe if they can draw people into talking a little bit*	

7. Recovery from difficult emotions by sharing them Feels more at ease Is better able to deal with historic life events Better able to cope with the things he has done because of the group	I dunno, it made me feel… a little bit more at ease with the things that I've done *When I first started the group, you know I found it hard to deal with things that had happened in my life. And I dunno… I look back at that time now and see it scarred me a bit mentally, it scarred the way that I … I can't really explain it but in a certain way, the things that I've done they really effected, in the past it really effected the way I thought about my future and that* *so it's about getting insight into your offence…Or ways to cope.*	P132, 128-130 P133, 143-151 P129, 30-35
8. Becoming normal Used to feel like a freak Used to feel strange Feels more normal now	*When you come into high security, you feel strange, you feel like a freak or whatever* *it kind of made me feel a bit more normal.* *listening to his account of his Index Offence definitely made me feel like, on some level, what I did was normal.*	P133-134, 163-164 P133, 162-163 P133, 166-168

9. Group needed more structure/direction If he had to attend the group as part of his treatment then the staff owed it to him to tell him what they wanted from him Group needed more structure Positives and negatives about lack of structure Would like an educational component	*so I thought that if I'm being asked to go to this group then I should kind of, they should be able to tell me what they want to know, rather than me just talking about things.* *You know, I do kind of feel that it needed more structure* *in some ways it was good and some ways it was bad. Maybe a bit more structure, but like balance it out. Like half way through the session kind of let it flow, and the first part of the session structure it. Talk about ideas, like I dunno, theories, medical theories and things like that. And then for the other half let people talk amongst themselves.*	P134, 181-184 P134, 188 P135, 191-199
10. Recovery by improving himself and becoming strong Recovery is not getting better but improving	*It could mean getting back to a place where you can function… on the level of a normal person. I mean don't ask me what a normal person is! Um… you know… being able to look after yourself after being dependent on*	P136, 220-227

Developing from beyond where they started Making unexpected progress Always improving Recognised as improving Meaningful life is being the best he can be every day Recovery Achieving and improving Always been someone who wants to improve Recovery is being strong Using music to recover Recovery was a journey Took control	*other people, or getting yourself to a point where you can say to yourself that you're no longer getting better, you're improving.* *And um… at the moment I feel like I'm at a point where I'm making progress. That I never did think I could make* *And if I'm the best I can be every day, then I'm always making progress, I'm always improving* I think I've done well…Um, I have the motivation to you know achieve and improve. *Recovery to me means, being strong enough to tackle or you know, approach things again after a period of recuperation or rest.* *writing lyrics or *inaudible* it put me in a place where you know I could visualise and understand the person that I wanted to be* *Um, my medication got changed, and after that it was a journey, you know, a process of doing everything that I needed to do to be the person that I wanted to be.* *changed over time… Not as much as it could have… if I*	P136, 240-242 P138, 275-277 P142, 397-402 P135, 214-216 P143, 407-412 P144, 435-438 P150, 597-600

	wouldn't have taken control of my situation as far as RSU's, and doctors and medication and things like that	
11. Feels fortunate Feels he has been given rare opportunities Much help received Gratitude He could be in a worse position	*I feel like I've been given a lot of um… quite rare opportunities in my life. And erm… I think um a lot of people have helped me to get to a point where I can understand society in a way that is quite rare.* *I think in the back of my mind I knew there were much worse things that could have happened to me*	P135, 231-235 P148, 548-550
12. Sobriety important to progress Absolute sobriety Sobriety and no medication	I feel like medication is something that is going to hinder my progress and feel like sobriety is something that you know, not a lot of people have fully. *And because I spent a lot of my time smoking, drinking, things like that, I've got an opportunity now to approach life from an angle that doesn't really usually …*long pause* you know.*	P136, 243-246 P136, 248-252

13. Hope for the future Wants to travel Hopes to experience without addiction Be around people and culture Hope is important to recovery Used to be hopeless	*I mean… people… I wanna travel and I wanna meet people, I wanna experience life without the constraints of addiction and you know, lack of, you know, understanding.* *you know just experience culture and you know… become …. A people person.* *In a place like this, if you lose hope, it's really not conducive with recovery* *you know, I didn't have hope*	P137, 270-273 P138, 285-286 P138, 290-291 P145, 464-465
14. Negative impact of mental illness Mentally unwell age 19 Mental illness hinders insight Mental illness hinders understanding of people Mental illness & dependency Mental illness changed him Suicide	*When I was 19, I was admitted to my local psychiatric unit, erm, I was on medication for a while. I wasn't I mean. I was sober and in the hospital, but I was still smoking tobacco… it got to a point where erm… I didn't feel I was being treated right and I tried to leave. Then I got put on medication* *I think it's hindered my insight, and it's hindered my understanding of people* *erm, I feel like mental illness has definitely changed me…*	P138-139, 297-303 P139, 309-310 P139, 313-314 P145, 465-466 P145, 469-471

Contemplated suicide Suicide attempt was a wake up call	*And a couple of times, you know, I did um try suicide* *if I didn't change something then I wasn't gonna make it out of the situation that I was in*	
15. Positive impact of MI Mental illness motivates Mental illness makes you work harder Have to work double hard	*Um… it changed me for the better in that it's given me the motivation to everyday do things that I want to improve on, like learning Japanese, things like that…that I never thought I'd be able to do.* *it's given me that push cuz you have to work double harder, work double hard to …make that progress*	P140, 322-326 P140, 331-333
16. Homicide is life changing Homicide gives you a different world view Life is valuable Assess own life when facing life sentence New understanding of the world	*It does give you a different insight into the world* *It makes you think about how valuable life is.* *it makes you assess your life, when looking at a life sentence or an indeterminate sentence … it does make you face up to factors in your life that you wouldn't necessarily have thought about.*	P140, 339-330 P140, 338 P140, 346-350 P141, 357-359

High security has helped him Priorities Would have been in a worse situation if hadn't committed homicide On a hopeless trajectory Being hospitalised helped People are vulnerable Homicide changed who he is Opportunity to strip himself bare and rebuild A lot different now The offence stopped his self-destruction	*if I was out there I don't think I would be functioning on the level that I am now* *When I look at the alternative to what I did, I know it might sound you know, careless or whatever, but if I didn't do my Index Offence then I wouldn't be in the position where I'd be able to think even about my Index Offence or about the things that I've done. I wouldn't be in the position to … I wouldn't be in the position to change.*	P147, 520-527
17. Acceptance of responsibility Never going to get away with it Accepts responsibility Takes responsibility Acceptance	*but I'm glad that I, you know, held my hands up in the beginning* *and also there are people who don't really take any responsibility for what they've done, and people who don't face up the fact that they did what they did, so erm….*	P140, 344-345 P148, 554-564

	(Is that something you've done?) *Faced up to what I did? Yeah.*	
18. A changed person Made life changes Becoming who he wants to be High security whittles you down Stripped bare for rebuilding Now a new person Cares The group has changed him	*you know you're going to have to make a difference for yourself. You know, people aren't going to make that difference for you.* *And it made me realise that you know, if I didn't change something then I wasn't gonna make it out of the situation that I was in. And as far as I'm concerned, that situation I made it out of cuz now I'm at a point where you know, I'm not that person anymore.* *The group…I think it has* (changed him).	P143, 426-429 P145, 468-474 P146, 488-492
20. Reduced risk No longer a risk Not a risk even to those who are a risk to him	*That's not a big question though for me, cuz I don't think I'm a risk to anybody*	P150, 617-618

Wants to end cycle of violence Avoids fact that he may have started the cycle of violence Previously used violence as a means to take control of his life Learned new ways to take control of life Past acts of violence shapes the way he now manages violence Reduced risk is accounted for by numerous factors Has rejected all old friends and family Lots of factors reduce risk Group will impact on risk depending on the individual Learned from the group Wasn't making progress before the group	*I don't even think I'm a risk to people who are a risk to me. You know, I think it's different. I'm not gonna get involved in any of this tit for tat knife crime, gang culture, or anything like that, I mean, that's where I come from, but at the same time it's … I did what I did you know, and I don't want it to be a crazy cycle of you know, you hurt me, I hurt you again and again and again you know* *Yeah I mean, I'm not about to use violence as a means of you know, taking control of my life again* *It's lots of things, it's no one thing, I had a change in my medication, I stopped drinking coffee, ahh I changed my diet, I went to the gym more, you know, I've taken up past times and skills and it's a lot of things. I don't talk to my family and friends. Which has made a lot of difference.*	P151, 623-631 P151, 640-642 P152-153, 671-677

Interview 5: Alex **1. Acceptance of offence** Came to terms with the offence Come to terms with offending Came to terms with offence Homicide group helps with acceptance Has come to terms with the offence Come to terms with offence To accept and deal with something that's difficult and unpleasant	*How to open up and talk about your crimes, how to come to terms with it…* *I just come to terms with what I did.* *Helps me come to terms with things.*	P154, 12-13 P168, 375 P164, 252
2. Learning to talk about the offence was helpful Opening up was helpful Easy to talk in the group Everyone in the same situation	*Just opening up.* *Everybody else was in the same boat.*	P155, 18 P155, 30 P156, 44

Can talk about offence but also general topics Open talking is beneficial Learning to open up Made progress Being able to talk about offence indicates a huge shift Initially apprehensive Past difficulty in talking about offence Discuss offences Talk about lots of topics Get things off his chest Everyone is in the same boat Always understood the offence but was too scared to talk about it Homicide group reduces fears of talking about it	Err … it [talking] helps me a lot. It actually does help me. *Learning to open up*	
3. Unstructured group Lack of structure unexpected Preferred open format	*Erm.. homework, structured group, but it was nothing like that.*	P155, 34

	I actually preferred it to structured groups cuz you can talk about what's going on, talk about your crimes, how your weeks been things like that.	P155-156, 38-40
4. Learning about the offence Changed thinking about offence Able to process offence in the group Learning the reasons not to offend Understands why he offended	*and explaining to everybody the whys and how's and things like that.* *Learning to open up, learning to come to terms erm… whys and why nots of reoffending.*	P156, 56-57 P157, 87
5. Recovery of difficult emotions through sharing them Less stressed since sharing feelings More relaxed since doing the group Surprised by extent of the positive impact the group had	*Well, if you're stressed you want to talk to someone about it be it your doctor or your primary nurse or whoever, and the more you talk about it, the less stressed you get* *It's helped me a lot. I'm quite surprised by how good I am from doing this.*	P157, 74-78 P164, 269-270

6. Positive impact of group Group beneficial; no negatives Wouldn't change the group	*There's lots of positives, there's no negatives.* *Nope.*	P157, 83 P168, 363
7. Reduced risk of re-offending More self-control Scared to offend again Confidence in doctor Patients don't come back when discharged Doesn't want to reoffend Doesn't want to reoffend but won't know until out in the community Helps reduce likelihood of re-offending Reinforces message not to reoffend Provides insight into what it might be like if they reoffended	*Err… it's made me more in control of meself.* *It scares me.* *But… my doctor, the turnover of her getting her patients out, the turnovers very minimum… Well I mean she gets a lot of people out but I don't think none of them's come back.* I hope I won't reoffend. But I can't tell until I get there. I could say to myself now, I'm not going to reoffend when I get out, in the same way I can say I'm not gonna drink when I get out, but I got to be there, I can't say yes or no. *Yeah, um… I think it enables you not to commit a crime or it gives you a boost not to commit another crime.*	P156, 63 P158, 95 P158, 95-108 P158, 110-114 P159, 119-121 P159, 126-129

	Um… I dunno, it's just drummed into your head not to commit another crime, and it tells you, well if you do you come back and go through it all again, so no, it's not for me.	
8. Recovery and leaving hospital Recovery is about leaving hospital and having support Want to leave hospital Needs community support Wants to maintain wellness in the community	*Um… to get out. To have a nursing team for me when I do get out.* *It's about having support when you do get there.* *For now, just keep with the programme, and just carrying it off outside.*	P160, 142-143 P160, 155 P161, 169-170
9. Hope for the future Wants a job and hobbies, somewhere independent to live Hope for the future Return to past hobbies Use new skills in the community	*a job, me own flat, be able to go fishing again.* *(Is that something you enjoyed before?) Yeah.*	P160, 159-160 P160, 162-164 P161, 175

Wants to settle down and have a decent life Wants simple pleasures Job, House and Hobbies in the future	*Yeah and using it (new skills) for outside.* *Er just to settle down and have a decent life.* *Nothing too special*. *Fishing. Working as a gardener. That's the ideal life for me really.*	P169, 398 P169, 400 P169, 405-406
10. Learning to live with guilt Homicide has huge effect on the perpetrator Coming to terms with it Guilt Suicide Starting to have less of an effect Can talk about it Extreme guilt historically Suicidal guilt No longer self-harms Homicide group helped to reduce self-harm	*It affected me quite a lot. At certain stages of coming to terms with it, with this group and other therapies I've done over the years.* *Um, I felt guilty for what I done, I got reasons for why I did it, but it doesn't give me the right to go and do what I did. I felt guilty about it; I tried committing suicide a few time* (when asked about how the guilt affects him now) *Yeah not too bad, sometimes I can talk freely about it to patients or staff members or the doctor.* *Yeah. For a couple of years I felt a bit guilty for what I done. As I said, I tried committing suicide a couple of times. I come to terms*	P161, 181-183 P161, 187-190 P162, 195-197 331-334 P167, 339

	with it now so I don't usually self-harm no more. *Yeah, and the other groups that I do as well.*	
11. Effect of Mental Illness Mental illness affects life Long period of stability (10 years) Attributes stability to medication Being mentally unwell feels horrible Mental illness doesn't affect behaviour	It does… as long as I keep on taking my medication, because I've been level headed now for about *pause* 10/11 years *It [MI] would [affect him], if I didn't keep taking my meds*. *Cuz when I was not taking my meds I know I'm unwell, cuz there's that horrible feeling.* *No not really, I can just tell I'm not right.*	P162, 204-206 P162, 215 P163, 220-222 P163, 226
12. Ownership of recovery Helped myself	*Oh I help myself as well...*	P163, 231 P163, 235-236

	Cuz I go to work, I do my therapy, I see a doctor every now and then, that's about it.	
13. Homicide Group has helped him to progress Homicide group draws everything together Doctor supports his discharge from hospital Homicide group has helped prepare him for transfer Acceptance Everyone has successes	*Completes in all things really. Um… *long silence* It's just that bit of help I need.* *She doesn't want to keep me in here but the RSU want me to do another 5 months. She's only keeping me here because of that.* *Um… bit scared, cuz I never really talked about my Index Offence, but as soon hearing other people, and then me talking about mine, I felt I suppose, that they all accepted me in the group, and yeah we all do well.*	P163, 242-243 P165, 284-286
14. How the group operates Facilitators help Different sort of group Unstructured group Discussion of a variety of topics	*Um… it's different cuz it's not a structured group, the other groups are structured groups. But instead of staying on the same topics all the time like in a structured group, the homicide group*	P167, 344-349

Don't just focus on one problem	*you can chat about different things all the time…* *You know, not centralising on one complete problem.* *No, not all the time, just about general life as well, we think about things that went on in our lives, why we committed our crimes.*	P176-168 353-354 P162, 320-322

Appendix Twelve: List of Super-Ordinate Themes

REVISED SUPER-ORDINATE THEMES

Interview 1

1. Developing understanding of the offence (5)
2. Apprehension starting the group
3. Recovery from difficult emotions through sharing them (4)
4. Guilt is punishment
5. Conflicted about own right to recover (2) –*linked to difficult emotions?*
6. Homicide group is a support group
7. Recovery of identity as more than a homicide offender (3)
8. Re-humanising (4)
9. Loss of self-worth through homicide
10. Recovery of hope for the future (5)
11. Attendance to get out of hospital
12. Unstructured group (5)
13. New group members changes the group dynamic (2)
14. Group Bond (3)
15. No pressure
16. Honesty in the group
17. Commitment to the group
18. Slow disclosures
19. Shared offence aides empathy between group members
20. Homicide is traumatising
21. Reparation (2)
22. Improving as a person (3)
23. Risk Reduction (5)
24. Challenges to recovery
25. Negative impact of mental illness
26. Wants to prove himself to others
27. Learning how to ask for help
28. Regained Mental Wellness
29. Homicide group is the key to recovery

Interview 2

1. Developing understanding of the offence
2. Acceptance of responsibility for homicide offence (2)
3. Identity as a dangerous killer
4. Recovery from difficult emotions through sharing
5. Prior experience of therapy groups
6. Group bond
7. Homicide Group is challenging
8. Conflicted about own right to recover
9. Would like more support
10. Reparation
11. Recovery
12. Future risk
13. Unstructured group
14. Patients challenge other patients

Interview 3

1. Recent changes in group dynamics
2. Drawing comparisons with the media
3. justifying offence
4. Substance misuse
5. Slow Disclosures, participants take their time.
6. Unstructured Group
7. Facilitators take on different roles
8. Recovery and feeling at peace
9. Group bond
10. Acceptance and being human
11. Patients challenge other patients
12. Developing Understanding of Offence
13. Making sense of culpability
14. Preparing for hospital discharge
15. Developed relationship skills
16. Changed self
17. Negative impact of Mental Illness
18. Viewed as dangerous and becoming dangerous (identity)
19. Learning to live as someone who has killed
20. Feelings of injustice
21. Group challenges beliefs
22. Recovery as improving
23. Hopes for the future
24. Risk Reduction
25. Positive impact of medication
26. Group helps to think about explaining the offence

Interview 4

1. Difficult to talk about homicide in a group setting
2. Group unstructured
3. Gain understanding of the offence
4. Others have committed worse offences
5. Judgement in the group
6. Unequal engagement of participants
7. Recovery of difficult emotions through sharing them
8. Becoming normal
9. Group needed more structure/direction
10. Recovery by improving himself
11. Feels fortunate
12. Sobriety important to progress
13. Hope for the future
14. Negative impact of mental illness
15. Positive impact of MI
16. Homicide is life changing
17. Acceptance of responsibility
18. A changed person(2)
19. Reduced risk

Interview 5

1. Acceptance of offence
2. Learning to talk about the offence was helpful
3. Unstructured group
4. Learning about the offence
5. Recovery of difficult emotions through sharing them
6. Positive impact of group
7. Reduced risk of re-offending
8. Recovery and leaving hospital
9. Hope for the future
10. Learning to live with guilt
11. Effect of Mental Illness
12. Ownership of recovery
13. Homicide has helped him to progress
14. How the group operates – unstructured group