Making Sense of Offense-Related Trauma: Exploring Two Patients' Lived Experience

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Offense-related trauma refers to a trauma reaction following the perpetration of a violent offense. This research explores the lived experience of offense-related trauma, in two forensic patients. The meaning and understanding these individuals make of their own coping strategies, triggers, and treatment, and how this contributes to their behavior, was explored using a semi-structured interview and analyzed using Interpretative Phenomenological Analysis. Two super-ordinate themes emerged from the data: "Journey to Forgiveness" and "Living with the Whole Me." These themes and their subthemes highlight the nuances of offense-related trauma and raise the question of how processes such as complicated grief and associated shame can impact on recovery and rehabilitation. The implications of the findings for professionals providing treatment in forensic settings are considered.

Keywords: offense-related trauma; forensic mental health; trauma; PTSD

Psychological trauma is a response to a stressful, distressing, or frightening event, for example, a car crash (Fear et al., 2014; National Institute for Health and Clinical Excellence [NICE], 2018), and is deemed clinically significant when it meets the classification of posttraumatic stress disorder (PTSD), as set out in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5). PTSD may develop following exposure to these events, with symptoms that can include: re-experiencing, feelings of isolation and irritability, insomnia, and difficulties concentrating. Complex PTSD may be diagnosed in adults or children who have repeatedly experienced traumatic events, such as violence, neglect, or abuse (NICE, 2018). Symptoms are similar to those of PTSD, but may also include feelings of shame or guilt, emotional dysregulation, dissociation, suicidal thoughts, destructive or risky behavior, for example, substance misuse and self-isolation (NICE, 2018).

Around a third of the adult population in England have reported having experienced a traumatic event in their lifetime (Fear et al., 2014; NICE, 2018). However, this figure is considered much higher amongst people within the criminal justice system (CJS; Facer-Irwin et al., 2021; Tyler et al., 2019), who are more likely to be exposed to traumatic events and therefore at increased risk of developing PTSD (Baranyi et al., 2018; Howard et al., 2017).

Experiences of trauma are known to adversely impact executive functioning and cognitive resources

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(De Bellis & Zisk, 2014), which can activate and exacerbate maladaptive behaviors and coping strategies (Clark et al., 2014), which, for some, can lead to increased risk of offending (Every-Palmer et al., 2019) through post-traumatic reactions (Ardino, 2012).

Offense-Related Trauma

Trauma is a concept usually associated with victims of offenses. However, there is evidence it can be as a result of an individuals' own actions. Such responses have been reported amongst police officers and military personal (MacNair, 2002; Manolias & Hyatt-Williams, 1993). A growing body of research has shown evidence of this amongst offenders, coining the phrase "offense-related trauma," which describes a phenomenon whereby individuals who have committed violent or impulsive offenses develop a trauma reaction (e.g., Gray et al., 2003; Kruppa et al., 1995; Pollock, 2000). While the majority of research into offense-related trauma has focused on homicide (Harry & Resnick, 1986; Papanastassiou et al., 2004; Pollock, 1999; Rogers et al., 2000), some have argued that violent offenses of any kind can lead to psychological trauma for the perpetrator (Payne et al., 2008).

Prevalence of Offense-Related Trauma

The majority of research into offense-related trauma has focused on determining the prevalence of this condition in different offender populations. Prevalence rates have been found to range from 15% (Collins & Bailey, 1990) to 32% (Steiner et al., 1997) in prison populations. However, in samples of forensic patients in secure hospital settings, the prevalence is reported to be much higher, with rates between 33% and 64% (Crisford et al., 2008; Gray et al., 2003; Papanastassiou et al., 2004; Spitzer et al., 2010).

Symptoms of Offense-Related Trauma

Symptoms of offense-related trauma have been reported to present as similar to other psychological trauma and include recurrent and intrusive memories of the offense, nightmares, flashbacks, guilt, intrusive thoughts, hyper-arousal, and avoidance of offense-related stimuli (Harry & Resnick, 1986; Pollock, 2000). Further, higher levels of trauma symptoms have been found to correlate with increased occurrences of shame cognitions (Buchman-Wildbaum et al., 2021) and it has been hypothesized that shame and guilt may impede emotional processing and therefore exacerbate and perpetuate symptoms of PTSD (Crisford et al., 2008). Trauma symptomatology, if left untreated, can have adverse life-long consequences (Gray et al., 2003; Kruppa et al., 1995).

Individual Characteristics of Offense-Related Trauma

Meichenbaum's (1996) Narrative Theory of Traumatic Events hypothesizes that trauma occurs after an event that is unforeseeable, unpredictable, and uncontrollable. In line with this, Pollock (1999) suggests that offense-related trauma is more likely to affect those with no prior history of violence and whose offense is reactive and not premeditated in nature. Further, Pollock maintains that individuals who view themselves as having high moral standards and who hold prosocial views experience an intrapersonal challenge of the self when they commit homicide, showing a loss of control, self blame, and culpability, all of which are natural consequences, but can lead to a complicated bereavement reaction. Pollock suggests that these individuals may therefore be more likely to suffer from emotional disorders following the offense.

Intervention for Offense-Related Trauma

Research suggests that PTSD symptoms within forensic patients may act as a stressor, exacerbating co-morbid psychiatric illness and contribute to poor treatment response and relapse (Gray et al., 2003). Unfortunately, trauma symptoms are not always identified and consequently remain untreated. Untreated offense-related trauma symptoms may prevent an individual from fully engaging or benefitting from offense-related treatments until they have received an intervention focused on resolving their trauma symptoms. Consequently, an individual's future risk of violence towards themselves or others, and therefore risk of re-offending, may remain until trauma resolution has been achieved (Clark et al., 2014; Pollock, 2000), therefore making any offense related treatments offered before trauma resolution redundant.

Gray et al. (2003) highlights how intervention for forensic patients focuses on offending behavior, targeting victim empathy, the perpetrator taking responsibility for their actions, and in-depth discussions about factors leading up to and surrounding the offense. This focus potentially increases an offender's likelihood of developing offense-related trauma, either by developing an understanding that the offense was unjustified, acknowledging feelings of shame and guilt (Gray et al., 2003), or re-traumatizing offenders through talking about their offending (Rogers et al., 2000), which in turn may act as a trigger and

potentially heighten the immediate risk of reoffending (Clark et al., 2014; Pollock, 2000).

Pollock (2000) maintains that trauma-focused intervention should be available to perpetrators. Researchers have argued that all offenders should be screened for offense-related trauma prior to engaging in offending behavior programs, and if present, offense-based interventions should be suspended until trauma resolution has been reached (Clark et al., 2014).

Experiences of Offense-Related Trauma

To date, offense-related trauma has not been investigated through a qualitative methodological lens. This research proposes to further examine offense-related trauma and how forensic patients cope with this in a hospital setting before, during, and after receiving an offense-related trauma intervention.

Method

This study used qualitative research methods to explore forensic patients' experience of offense-related trauma, and was therefore exploratory in nature. Qualitative research is used to understand how people experience the world and can produce rich meaning in the interpretation of data. A phenomenological approach was chosen for this research as it can provide a nuance insight into the participants' lived experiences (Tuffour, 2017), which is what the authors set out to achieve.

Ethics

This study received ethical approval from the National Research Ethics Service Committee London - Dulwich (REC ref 12/LO/0223).

Participants

Participants were recruited from one medium secure forensic hospital in the United Kingdom where patients are detained under the Mental Health Act (1983). For inclusion in this study, participants were required to have had experience of offense-related trauma, an established diagnosis of PTSD as per the DSM 5, and to have received a trauma-focused intervention related to their offending. Only two patients were identified as suitable for participation in this study. These potential participants were discussed with treating clinicians before being approached to take part. Both agreed and consented to take part in the study, one male (Richard, aged 52) and one female (Tina, aged 41)—names have been changed to maintain anonymity. Both participants had a diagnosis of borderline personality disorder and were detained for the offense of manslaughter. As per the inclusion criteria, both participants had completed a trauma intervention for offense-related trauma (eye movement desensitization reprocessing or EMDR), had reached an adaptive resolution and no longer reached the criteria for PTSD as measured by the Impact of Events Scale-Revised (IES-R; Weiss & Marmar, 1997).

Procedure

The participants' clinical teams were consulted in regards to capacity and suitability to take part in the research, prior to recruitment. A member of the research team approached participants to discuss the research and provide an information sheet. Once agreeing to take part in the study, participants gave written consent; their understanding was verified by the researcher prior to commencing interviews.

Face to face semi-structured interviews were conducted by a member of the research team. Interviews were audio recorded. The interview schedule was developed from questions raised by literature review and is presented in Table 1. Interviews lasted between 1–2 hours.

Analysis

Interviews were transcribed and analysed using Smith et al. (2009) version of Interpretative Phenomenological Analysis (IPA). IPA has a primary aim of understanding an individual's lived experience by exploring how they make sense of it (Smith & Osborn, 2003) and so is useful for research examining the lived experience of offense-related trauma. The analysis was broken down into three stages. First, listening to the audio–recordings and reading through the transcripts numerous times to become familiar with the data and ensure accurate interpretation of the context. Second, establishing initial exploratory comments and highlighting quotations of interest. Comments focused specifically on the descriptions, linguistics, and concepts presented within the data. Finally, emergent themes from the initial interpretations were identified and developed using psychological concepts, phrases, and patterns across the two transcripts were identified, examined, and developed further. Underlying connections across the emergent themes were then established and super-ordinate themes identified alongside the subthemes.

TABLE 1. Interview Schedule

1.	Can you describe your experience of offense-related trauma?
2.	In your opinion, how do you think others see your experience? How does this impact on you?
3.	Can you tell me about any situations when you felt that you were being re-traumatized?
4.	Were there any situations that led to you experiencing trauma symptomatology? How do you make sense of this?
5.	How did you experience others asking you to talk about your offense?
6.	What was your experience of offense specific treatment like?
7.	Can you describe how offense-related trauma affected everyday life for you?
8.	Can you describe your experience when you first discussed your offense within the context of trauma?
9.	Since you completed your trauma treatment, what is different for you?
10.	How do you understand offense-related trauma now?

The researcher interacted with the data by making exploratory comments and interpretations in each of the analytical stages to ensure that the original context and content of what each participant said was preserved.

Validity of the research was ensured by: (1) Transcripts were read by another author to check the analysis and ensure subthemes and super-ordinate themes reflected the data extracts. Discussion, further exploration, and reflection between authors included consideration of further themes, overlapping of themes, and an agreement of themes. (2) Following data analysis, the research results were presented to participants to ensure that the themes developed reflected the participant's experience. Participants agreed with themes presented.

A member of the research team, familiar with the chosen methodology but independent from this specific research, was also utilized as a second rater, to ensure reliability and check the analysis was accurate in order to reduce subjectivity. Themes presented were considered reflective of the data collected.

Findings

The data analysis aimed to make sense of and identify themes associated with the experience of offense-related trauma within forensic patients. Two super-ordinate themes emerged: (1) Journey to Forgiveness; and (2) Living with the Whole Me. These overarching themes consisted of several inter-related sub-themes (Table 2).

TABLE 2. Themes and Sub-Themes

Superordinate Themes	Sub-themes
1. Journey to Forgiveness	The Right
	Punishment
	Never-Ending
2. Living with the Whole Me	Victim vs. Perpetrator
	Living in the Minds of Others
	Feeling the Shame
	The Role of Trauma Intervention on the Self

Theme 1 – Journey to Forgiveness

Narratives within this theme described a process taking place, experienced by participants as an ongoing journey with barriers to overcome. The narratives gave a sense of participants taking steps towards self-forgiveness which entailed facing uncomfortable truths. Their experiences appeared to deviate from the so-called 'normal' bereavement process in a manner that limited movement forward in their own recovery. Whilst relief from acute symptomatology was recognized after treatment, there appeared a realistic and adaptive acceptance of the changes that had taken place along the way.

The Right

For Tina, there was a sense that she had broken her own moral code by committing the offense and was experiencing maladaptive shame. She described a feeling of unworthiness to grieve because of her role in the death, which in turn, as she saw it, prevented the "prescribed" response to losing a loved one:

> *I had no right to grieve because, how can you be sad, how can you, you did it… All the normal things that you would feel after your partner dies or is killed becomes very complicated. Personally, I didn't feel that I had that right.*

This shame and sense of anger towards herself that she described appeared to impact on her willingness to be helped, and the sense that she deserved to

remain stagnant in her care pathway was evident at an intrapersonal level:

> *It makes you feel that you don't deserve help. You don't deserve to have a life… to move on… At the time I didn't feel I deserved to be any better.*

For Richard the right to move forward revealed itself as an external facet, whereby he described a sense that his right to be heard was no longer permitted, and he should remain submissive to those he perceived as potentially judgemental:

> *They could have just said I'm not speaking to you because of what you did, meaning your offense.*

Punishment

There was a sense from the narratives that the role of punishment was crucial in the participant's journeys with regards to the self-punitive guilt experienced by participants. There appeared a great deal of weight given to the concept of suffering for their actions, and a sense that the level of perceived punishment must be dictated from within – not from interpersonal agents. There was a sense that punishment was experienced by participants as one aspect in the journey they had control over. Tina spoke of seeking the hardest route to redemption by prolonging her sentence and thereby avoiding the "easy option." For Richard, this revealed itself by forcing himself to feel uncomfortable by attending the most challenging groups:

> *My theory is, if I sit in a group and it's easy. There's no point in doing it. If I sit in a group and it's difficult and it's challenging, I'll get gains from it.*

Providing that they had appeased their own sense of shame within person-centered individual therapy, in the process of suffering, participant's narratives gave the sense that this type of punishment had a finite quality. Tina described a conscious decision whereby punishment transformed from her captor to her releaser:

> *Punishment is the only thing that has actually made me able to think, right OK, I've suffered enough.*

Never-Ending

Participants described trauma resolution as a discrete process following trauma-focused treatment, EMDR. For Tina, there was a sense that the acute reminder of her actions came to an abrupt and surprising end, as she described the first time she found herself holding an instrument that she had avoided for so long:

> *And then there it was, one day I was washing cutlery, and somebody had left a knife out, and I just washed it up and put it away… I just thought "I've done it."*

Richard described learning how to adapt, by placing it safely in the past in order to move forward. Richard is not repressing or dissociating from the memories, he is processing them within treatment. He uses a metaphor of a cabinet; he can recall these memories at any time by opening it, however he is not reliving it everyday anymore like other unprocessed traumas:

> *It's locked in the cabinet now and it's not current now… that's where it stays.*

However, participants also described chronic feelings of remorse, remaining as background noise and integral to their new sense of self. Narratives gave the impression that participants had reached a state of acceptance, acknowledging that things could not be changed. Tina acknowledged that whilst her EMDR treatment may be completed, her life going forward would forever be shaped by her actions:

> *Everything about my life changed from that day. And it's never going to go away, it's always going to be there, and, no amount of treatment is going to change what's happened.*

Theme 2 – Living With the Whole Me

Narratives within this theme described participant's experience of living with a fragmented sense of self as a result of their actions. Accounts described a division that was generated and experienced by intrapersonal emotions of shame and grief; and externally, with feelings of blame and rejection; the latter highlighting the role of others being key in shaping their own sense of self. The theme describes participants needing to find acceptance of each part in order to reach reconciliation and feel whole again.

Victim vs. Perpetrator

Participants described conflicting emotions when trying to understand their offense; this suggested there was a sense of cognitive dissonance experienced, with participants feeling torn and uncertain of their identity. Tina described living with two incompatible views of herself – perpetrator and victim. These two identities appeared to present themselves interchangeably throughout the narrative. She indicated needing to acknowledge and accept these two roles in order to reach reintegration of the whole self; however, as the following account described, this was only possible if

she separated herself from her actions, akin to a dissociated state:

> *If I had watched somebody stab my partner, I would be traumatized and nobody would be surprised by that… I suppose to make sense and to accept that I can be traumatized by it now, I have to view it like that because otherwise the guilt kicks back in and the how dare you feel bad about it.*

Participants' accounts gave the impression that previous victimisation continued to impact on their current sense of self. For Tina, she alluded to a sense of feeling trapped, knowing that her offense had occurred within the context of an abusive relationship, but internally fearful that sharing this would be interpreted as her minimization which in turn may invite negativity from others:

> *That catch 22… if I'm in a group and I bring up the context, the responses were you are not taking responsibility for your actions. You are trying to blame him for what you did.*

Living in the Minds of Others

Throughout both accounts, participants described experiencing opinion and judgement from others. These perceived interpersonal views appeared to have impacted on participants' own intrapersonal sense of self, serving to strengthen, mirror, and reinforce their own self-criticism and negativity. Tina described transference of encompassing others' views as her own, believing that this was proof that the fears she had about herself were true:

> *It just compounds everything that was already there.*

As Tina progressed in her recovery, she described an intrapersonal shift that appeared akin to reconciliation, evidenced by her developing compassion for herself. This was accompanied by a reduction in feelings of destruction towards herself. This gave the impression that there was a point of realisation that she could in fact separate herself from her actions. However, and despite this, as the following quote highlights, her ability to separate remained fragile and was easily threatened by interpersonal agents:

> *You, worry constantly, well I did, about what, what other people think… I started to feel better, but there was still this sort of disbelief when others were around.*

Richard described experiencing a varied response from others, which he appeared to internalize, ultimately leaving him feeling confused and uncertain about how he lived in the minds of others, " I thought I was a bad person." Richard described a sense of projective identification in how he perceived, others viewed him:

> *Just made me feel that the person hated me and just reinforced my feelings of rejection.*

Feeling the Shame

Narratives within this subtheme described the role of shame on the participants' views of themselves. There was a sense that maladaptive shame was not only present subsequent to the offense, but seeped into other areas of their recovery. For Tina, she described feeling shame with regards to her role in her daughter's schemas and how she may now interpret the world and others:

> *I've got to accept that my daughter is going to grow up knowing that her dad was killed by her mum.*

Evident in both accounts was the impression that shame was experienced within offense-focused treatment (EMDR). Tina described disclosing to others an offense which she considered the most severe and therefore opening herself up to further judgement from others. Tina described a sense of feeling coerced to do this to demonstrate remorse and take responsibility in order to appear rehabilitated; however, she described that this process "un-did" any internal reconciliation she had already achieved:

> *If you are in a group like that, the only way to do it and to be seen to be, to take responsibility, is to say yeah this was all my fault. So again it's back to its confounding to me, you're a bad person, you did this.*

Throughout Richard's narrative, he described how his progress in treatment was strongly influenced by the shame he felt:

> *My behavior was all over the place and rather than me sit down and tell somebody what it was linked to, I'd display it on to somebody else or something else rather than actually what the core issue, core thing was.*

There was a sense that he survived by blocking his shame, keeping his true feelings buried and hidden from others. He denied the need for support and gave the impression of wanting to show the world that he was coping. There was a sense that shame would be interpreted as a weakness by others and he appeared to believe that showing power, "a bravado thing" and strength in other ways, would compensate for this:

Very angry on a regular basis, I gave the opinion that I didn't care what I said to anybody or do to anybody or anything or myself.

The Role of Trauma Intervention on the Self

Participants described talking about the offense as difficult and at times re-traumatizing: "it's a distressing thing to talk about" (Tina). There was a sense of generic offense treatments being negative and unhelpful: "brought up a lot of anxiety" (Richard). Throughout both narratives, participants described powerlessness towards the prescribed care pathway, experiencing this as punishing: "it was a case of 'you have to do this'" (Tina)

Trauma-focused intervention (EMDR) on the other hand was associated with feelings of safety and containment:

> *I felt I had more control and that was the thing that I didn't have before.* (Tina).

Tina's sense of control appeared to develop with treatment she perceived as less judgemental and more collaborative. She felt as though she was listened to and as a result was more hopeful: "I felt like we were working together, all of us." There was a sense it allowed her to consider how her own recovery may look: "it can help you live with it," and that it allowed and supported her to reintegrate those different parts of herself that she struggled with. She described that EMDR would "not just talk about what I had done. To actually think of it as a whole treatment", helping her to feel less fragmented.

For Richard, his perceived safety within EMDR intervention allowed him to open up and trust others with what he had feared to share for so long. He trusted that his psychologist would be able to contain what he shared and not reject him as he had feared in other treatments:

> *It brought me back into a safe place and I think that really helped me to feel comfortable to keep carrying on doing EMDR, which has helped me with my trauma-related offense.*

The narratives appear to conclude that recovery for participants came when they were supported and allowed to see themselves as different from their actions. There was a sense that EMDR encouraged participants to become more mindful of their situation and as a result were able to notice distinct and welcome changes in their own sense of self:

> *Now I don't think I'm a bad person, I feel that I made mistakes.* (Richard).

Discussion

The aim of this study was to widen existing understanding on the lived experience of offense-related trauma in forensic patients, from which two key themes emerged; "Journey to Forgiveness" and "Living with the Whole Me."

Within the first theme, "Journey to Forgiveness", three subthemes emerged; "The Right," "Punishment" and "Never-Ending." Within "The Right", participants described experiencing maladaptive shame, complicated grief acting as a barrier towards their recovery, and a sense of feeling stuck. Nathanson (1992) describes maladaptive shame as a mechanism of attacking the self; within the current study, this is observed as self-directed anger and feelings of unworthiness towards the self. Individuals who suffer a complicated grief reaction, hold the view that they have no right to be content (Shear, 2010). Our participants reported that they did not believe they had the right to grieve or recover. Research tells us that both guilt and shame predict more intense grief reactions (Duncan & Cacciatore, 2015). Grief can relate not only to the offending behavior, but also to the loss of a more fulfilling life. In this study, grief appeared to differ as result of the relationship the participants had with their victim. It suggests that the variability of this closeness related to the intensity of the complicated grief and the following experience of offense-related trauma, and should be considered in psychological treatment. At present, coping with and managing grief is a concept missing from generic offending behavior interventions. Psychological treatment for individuals with offense-related trauma may also benefit from a focus on processing the feeling of being "stuck" described by participants.

"Punishment" describes how, as a result of their offense, participants' own moral codes were broken, resulting in a belief that they should suffer. Previous research has highlighted that individuals with offense-related trauma see themselves as *the* threat, rather than as themselves being *at* threat (Clark et al., 2014); our participants experienced what Howell (2020) refers to as self-punitive guilt for their wrong-doing, which was independent of their punishment from an external source, i.e., prison, and held beliefs that they needed to protect others from their actions.

Whilst shame is related to an appraisal of the whole self (Dorahy, 2010), guilt activates efforts to repair damage by either reparative action or punishment (Tangney, 1996). Participants in the current study appear to experience both self-punitive guilt and maladaptive shame as a result of their offense, and at times these appear blended (e.g., breaking a moral code).

Within the second theme, "Living with the Whole Me", four subthemes were identified; "Victim vs. Perpetrator," "Living in the Minds of Others," "Feeling the Shame", and "The Role of Trauma Intervention on the Self." "Feeling the Shame" highlights how participants found many aspects of their treatment and care pathway shameful. Shame is a painful emotion that affects how individuals view themselves (Gilbert, 2000) and is recognized as a major component of a range of mental health problems and proneness to aggression. Shame also affects expression of symptoms, abilities to reveal painful information, various forms of avoidance (e.g., dissociation and denial) and problems in help-seeking (Gilbert & Procter, 2006) – all symptoms identified by participants' in the current study.

"Living in the Minds of Others" explored how shame was exacerbated by perceived views of others, in turn impacting on participants' own internal sense of self and supporting existing literature that shame can impact on people's sense of self, well-being and vulnerability in mental health (Matos et al., 2015). As Gilbert and Procter (2006) explain, "to experience 'self' as 'living in the minds of others' as a rejectable person can make the social world unsafe and activates a range of defences" (p. 354). This subtheme also supports existing findings from Øktedalen et al. (2014) that patients in clinical settings are sometimes reluctant to disclose feelings of shame out of fear of being exposed and rejected (Macdonald & Morley, 2001), our participants describing fear of judgement and criticism. Failure to identify shame in patients can be disruptive to "treatment, e.g., lead to treatment stagnation, prolonged treatment, or reduced treatment outcome". (Arntz et al., 2007; Brewin et al., 1996; Resick & Schnicke 1993). Øktedalen et al. (2014) also report that shame can maintain PTSD symptoms (Harman & Lee, 2010) and that both trauma-related shame and guilt can function as reminders of trauma memories by reinforcing the sense of ongoing threat (Ehlers & Clark, 2000).

"The Role of Trauma Intervention on the Self" described how trauma-focused intervention (EMDR) supported participants to feel more in control in comparison to offense-focused treatment which was experienced with a feeling of punishment, lack of choice/control, and fear, leading to a lack of engagement with the treatment and the risk of recidivism. Welfare and Hollin (2015) suggest that there is a specific association between offense-related trauma and further violence towards others, raising consideration to assessment and specialist treatment as crucial, a view that is supported by others in the field, for example Karatzias et al. (2018) who wrote that PTSD may interfere with the ability to benefit from rehabilitative programmes, may have an impact on impulse control (Cauffman et al., 1998) and may be associated with higher rates of recidivism (Kubiak, 2004).

The current research raises the following implications and considerations for clinical practice. First, for participants in this research, trauma resolution for offense-related trauma is akin to other traumas. Participants reported a fragmented sense of self, which was reinforced by the interpersonal world. Beneficial treatment for participants suggests supporting reintegration of these parts, considering the role of shame and complicated grief. The complex relationship between shame and dissociative parts is beyond the scope of this article, but is discussed elsewhere (Dorahy, 2010; Dorahy et al., 2015; Dorahy, Gorgas et al., 2017; Dorahy, McKendry, et al., 2017). A trauma-informed care environment, as explained by Sweeney et al. (2016), is put forward as a systemic intervention that could support individuals suffering from trauma to feel safe and empowered within mental health systems, in addition to providing them with access to a clear trauma specific care pathway.

Second, although no conclusive evidence, the current research indicates that facilitating offense-focused treatment without trauma resolution could be re-traumatizing, may not address the real risk, and therefore it is possible that the risk of violence to themselves and others could remain, however more research into this is required. It is hypothesized by the authors that facilitating trauma-focused interventions, ideally alongside a trauma-informed care environment, would be person-centered and help to reduce the likelihood of further violence due to processing the trauma and therefore the presenting risk, which is considered in the current study as essential in the rehabilitation process.

Finally, the current research highlights the issue of why offense-related trauma is not routinely screened for and treated in mental health settings. Kayrouz and Vrklevski (2014) suggest that often, patients' psychotic symptoms can mask trauma history and become the focus of the treatment, resulting in neglect of trauma symptoms. They also suggest that it could be due to the clinician's reluctance to open up old wounds, or maybe the patients' reluctance to revisit trauma, with the "later" described by current participants.

Limitations and Suggestions for Future Research

The main limitation of this study is the small sample size ($N = 2$) and its subjective IPA analysis. Despite being rich in data, this research was conducted in one

medium-secure forensic hospital in a specific area of the United Kingdom, therefore the sample pool was limited and cannot be generalized, as the findings may only be representative of these individuals, not the experience of offense-related trauma in general. Future research should focus on replicating the current study with a larger more representative sample. It is also possible that the experiences described are not the only ones experienced with offense-related trauma. In addition, more studies evaluating trauma-informed care and interventions on offense-related trauma would be beneficial for understanding the best treatment and recovery pathways for these individuals.

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