I'M NOT THAT PERSON: A QUALITATIVE STUDY OF MORAL INJURY IN FORENSIC PSYCHIATRIC PATIENTS

SARAH K. ATKEY

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Abstract

Few studies have examined the psychological impacts of committing criminal acts of violence on the lives of perpetrators who were mentally ill at the time of offence and in which the act itself may reflect behaviour that is uncharacteristic of the individual. Theoretical and clinical reports describe a phenomenon termed moral injury which profiles the deleterious emotional effects that can arise from actions that transgress moral beliefs and expectations (Litz et al., 2009). Shame, guilt, spiritual/existential conflict, and loss of trust are considered to be core symptoms of moral injury (Jinkerson, 2016) with growing empirical studies which examine moral injury in military and public safety worker samples. The extent to which these kinds of moral injury phenomena might be evident among mentally ill perpetrators was explored using a qualitative-methods approach in a sample of 19 adult participants hospitalized in a forensic program inpatient service in Ontario, Canada. A qualitative interview was conducted where participants were asked to describe feelings about the index offence, the effect it has had on their well-being, and how they have coped with having committed the offence. We also collected quantitative measures of shame, guilt, psychopathology, and traumatic stress; findings indicated that the sample was demonstrating mean moderate levels of traumatic stress. Qualitatively, using a reflexive thematic analysis process, five themes and 23 subthemes were generated. Each theme relates to the various impacts, emotions, and cognitions experienced by the participants as a result of the index offence. The five themes which emerged were: (1) Living with the Emotional Aftermath; (2) Trying to Make Sense and Coming to Terms; (3) My Eyes Have Opened; (4) Facing the Music; and (5) Moving On. The findings are discussed in terms of their implications for understanding forensic inpatients who may be attempting to come to terms with offences they committed and

for informing moral injury intervention strategies which might be adapted for the forensic mental health hospital service and recidivism prevention programs.

Dedication

This work is dedicated to the participants who courageously and generously allowed me into their worlds. I am deeply grateful for your willingness to share your experiences and perspectives with me.

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Chapter 1: Introduction

Few studies have examined the psychological impact of the criminal act on the lives of the perpetrator who has subsequently been admitted into a forensic psychiatric hospital. For individuals in the Canadian forensic system, the index offences are typically committed when the individuals are acutely mentally ill and as a direct result of illness symptoms (Crocker et al., 2015b); therefore, the acts themselves may reflect behaviour that is uncharacteristic of the individuals. Moral injury is the psychological suffering that results from the violation of deeply held moral beliefs and is characterized by shame, guilt, inner turmoil, and a loss of trust (Litz et al., 2009). Understanding that forensic inpatients may be attempting to come to terms with offences they committed and experiencing a moral injury is important to inform psychological intervention strategies which may need to be adapted for the forensic mental health hospital service and recidivism prevention programs.

Canada's Forensic System

The forensic mental health system in Canada is designed to manage the care of individuals with mental illness who come into contact with the law. When individuals are found to be Not Criminally Responsible on Account of Mental Disorder (NCR), they fall under the supervision of the provincial or territorial review boards (Chaimowitz et al., 2022). Individuals are deemed NCR by the courts under the following conditions: they were suffering from a mental disorder at the time of the offence that rendered the person either (a) incapable of appreciating the nature and consequences of their offence or (b) incapable of knowing that the offence was morally wrong (Criminal Code, 1985). Individuals receive care and supervision from forensic psychiatric hospitals as either inpatients or outpatients. The provincial or territorial review boards provide dispositions after yearly reviews of the individuals' progress and risk,

with the ultimate goal being rehabilitation and community living. The review boards' three possible dispositions are: (1) a detention order, (2) a conditional discharge, and (3) an absolute discharge. The population of forensic psychiatric patients who have committed an offence is one which appears to be particularly misunderstood by the general public, who seem to have difficulty seeing the person behind the label (Crocker et al., 2015a). Understanding their lived experience of possible distress associated with the criminal behaviour is a key focus of this study.

Posttraumatic Stress Disorder (PTSD) and Criminal Behaviour

The fundamental feature of PTSD is the development of characteristic symptoms subsequent to exposure to one or more traumatic events (American Psychiatric Association, 2013). Symptoms include avoidance, negative affect and cognitions, hyperarousal, reactive-externalizing, dissociation, and re-experiencing the traumatic event. PTSD has been widely studied in victims and perpetrators of legally sanctioned violence, including in military and law enforcement contexts. There is increasing literature examining PTSD as a result of non-legally sanctioned violence and homicide in correctional and forensic populations.

While many studies have indicated a high prevalence (between 8% and 75%) of PTSD in correctional populations (Baranyi et al., 2018; Ben-David, 1992; Facer-Irwin et al., 2022; Friel et al., 2008; Kruppa et al., 1995; Payne et al., 2008; Pollock, 1999; Soh et al., 2023), fewer studies have determined the prevalence of offence-related PTSD. Existing literature suggests that the prevalence rate of offence-related PTSD in correctional populations is between 15% and 43% (Badenes-Ribera et al., 2021; Chung et al., 2016; Kruppa et al., 1995; Payne et al., 2008; Pollock, 1999). PTSD has been associated with future risk of aggressive behaviour and criminal recidivism in correctional populations (Ardino et al., 2013; Sadeh & McNiel, 2015).

Forensic patients' offending has an immeasurable impact on their lives and many find committing the index offence to be extremely distressing. The index offences, including homicide, severe assaultive violence, and sexual abuse, have been reported by forensic patients as a trauma, leading to PTSD or post-traumatic stress symptoms (Crisford et al., 2008; Evans, 2010; Fleurkens et al., 2018; N. S. Gray et al., 2003; Kayrouz & Vrklevski, 2015; Soh et al., 2023; Spitzer et al., 2001). N. S. Gray et al. (2003) found that a third of their sample of forensic patients met DSM III-R criteria for PTSD and over half had significant PTSD symptomology. They found that patients with index offences consisting of murder or manslaughter experience more PTSD symptomatology than patients with index offences consisting of other violent offences. Crisford et al. (2008) discovered that offence severity predicted PTSD in forensic inpatients. The prevalence of PTSD in a Dutch sample of forensic psychiatric patients was 75% (Henrichs & Bogaerts, 2012). Forensic patients have prevalence rates of PTSD resulting from their offences ranging between 33% to 58% (Crisford et al., 2008; Friel et al., 2008; N. S. Gray et al., 2003; Papanastassiou et al., 2004; Soh et al., 2023). There is a dearth of information about patients' experiences of offending and the emotional effects and psychological impacts of the perpetration of their index offences.

Moral Injury

The experiencing of moral emotions, such as shame, guilt, anger, contempt, and disgust, referred to as moral pain, is viewed as adaptive for social bonds (Farnsworth et al., 2014, 2017; Haidt, 2002) as it guides moral decision making and behaviour (Tangney et al., 2007). There is a growing literature describing moral injury, a term that, according to Farnsworth et al. (2017), describes "expanded social, psychological, and spiritual suffering stemming from costly or unworkable attempts to manage, control, or cope with the experience of moral pain" (p. 392).

There is not currently a consensus within the literature on a definition or measure of moral injury (Currier et al., 2020; Griffin et al., 2019). A definition that is commonly used in the literature is that moral injury describes the long-term deleterious emotional, psychological, behavioural, spiritual, and social effects that perpetrating, failing to prevent, or bearing witness to acts that transgress deeply held moral beliefs and expectations may have on an individual (Drescher et al., 2011; Litz et al., 2009). Moral injury was initially defined by Shay (1994) as "a betrayal of what's right by someone who holds legitimate authority … in a high stakes situation" when psychological challenges he was seeing in his practice with Vietnam veterans differed from the fear-based roots of PTSD (Shay, 2014, p. 183). The term was later expanded to include acts committed by the individuals themselves in addition to those in authority (Jinkerson, 2016; Litz et al., 2009).

A theory proposed by Litz et al. (2009) postulates that moral injury involves an "act of transgression that creates dissonance and conflict because it violates assumptions and beliefs about right and wrong and personal goodness" (pg. 698). Whether this dissonance is reconciled by the individual is a key determinant of moral injury. When individuals are incapable of assimilating or accommodating (integrating) the act with their existing self and relational schemas, they experience shame, guilt, and anxiety about possible personal consequences such as ostracization. A failure to integrate or poor integration leads to psychological distress (Litz et al., 2009).

Litz et al. (2009) theorize that the outcome of the moral transgression is impacted by the type of attributions the individual makes about the transgression. They state that if the attribution regarding the cause of a violation is "*global* (i.e., not context dependent), *internal* (i.e., seen as a disposition or character flaw), and *stable* (i.e., enduring; the experience of being tainted)," (Litz

et al., 2009, p. 700) it will lead to persistent moral emotions such as shame and anxiety caused by uncertainty and an expectation of judgement. According to this theory, should these emotions and experiences cause the individual to withdraw, the individual is prevented from experiences that could be beneficial in terms of promoting self-forgiveness, eventually resulting in self-condemnation and a failure to forgive themselves (Litz et al., 2009).

Moral transgressions committed by oneself are more likely to cause adverse self-directed cognitions and emotions such as guilt, shame, and lack of self-forgiveness, while moral transgressions committed by others are more likely to cause negative outwardly-directed cognitions and emotions such as anger, loss of trust, and lack of forgiveness for others (Barnes et al., 2019). The moral transgression necessary for moral injury is most commonly referred to in the literature as a potentially morally injurious event (PMIE; Litz & Kerig, 2019).

In his syndromal definition, Jinkerson (2016) describes the core symptoms of moral injury to be shame, guilt, spiritual/existential conflict, and loss of trust, while depression, anxiety, anger, re-experiencing, self-harm, and social problems are considered to be secondary symptoms. As demonstrated by systematic reviews, there is a significant relationship between the presence of moral injury and subsequent psychiatric disorders in military populations (Hall et al., 2022; McEwen et al., 2021; Williamson et al., 2018). Research has connected moral injury to anxiety, anger, depression, PTSD, substance use, suicidality, and self-harm in various populations (Ashwal-Malka et al., 2022; A. B. O. Bryan et al., 2014; C. J. Bryan et al., 2018; Currier, Holland, & Malott, 2015; Frankfurt & Frazier, 2016; Kelley et al., 2019; Nash et al., 2013; Nazarov et al., 2018; Nickerson et al., 2015; Papazoglou et al., 2020). Self-compassion has been found to moderate the relations between PMIEs and PTSD and depression (Forkus et al., 2019).

While there are similarities between moral injury and PTSD, the criteria for the traumatic event of PTSD includes a threat to physical safety of the individual or someone else (exposure to actual or threatened death, serious injury, or sexual violence; American Psychiatric Association, 2013), whereas the PMIE transgresses moral beliefs and expectations, but does not require a physical threat. PTSD stems from fear-inducing threats to physical safety that result in an anxiety response, while moral injury stems from threats to one's moral beliefs that result in shame, guilt, and inner turmoil. Various studies, mainly in military populations, have found evidence that moral injury is often (but not necessarily) present in individuals with PTSD (Barnes et al., 2019; C. J. Bryan et al., 2016; Nash et al., 2013; Smigelsky et al., 2019).

While initially developed with military populations, the concept of moral injury has been explored more recently in other populations, including healthcare workers (Chary & Flood, 2021; Dean et al., 2019; Denham et al., 2023; DiCiro et al., 2023; French et al., 2022; Kothari et al., 2020; Mantri et al., 2020; Mewborn et al., 2023; Morris, Webb, & Devlin, 2022; Morris, Webb, Trundle, et al., 2022; Nelson et al., 2022; Webb et al., 2024; Williamson et al., 2020), first responders (Burke, 2023; Kleinig, 2023; Lentz et al., 2021; Papazoglou et al., 2020; Papazoglou & Chopko, 2017; Roth et al., 2022; Smith-Macdonald et al., 2021), correctional staff (Gangemi, 2021), veterinarians (Williamson et al., 2022), teachers (Currier, Holland, Rojas-Flores, et al., 2015; Levinson, 2015), refugees (Hoffman et al., 2018), child protection professionals (Haight et al., 2017), human rights advocates (Pfeffer et al., 2022), journalists (Feinstein et al., 2018), and photojournalists (Walsh, 2023).

Moral Injury and Criminal Behaviour

Given that PTSD is present in military and public safety personnel, that is, legally sanctioned perpetrators of violence, it is reasonable to expect that moral injury may also be

present among offenders and forensic patients, although there is a dearth of research investigating this. An unpublished dissertation examined moral injury in the context of justice-involved veterans in California (Gauthier, 2015). Gauthier's study demonstrated that moral injury contributed to prediction of depressive and posttraumatic stress disorder symptoms and substance use, controlling for pre- and post-deployment trauma and combat exposure. The most frequently reported types of PMIE were perceived personal and systemic betrayals rather than combat violence.

Given that forensic patients' index offences are committed while they are acutely mentally ill and occur as a result of their illness (as determined by the courts), it is hypothesized that the offending may be very uncharacteristic behaviour for the patient. In this context and following moral injury theoretical conceptualizations, it is considered that forensic patients' index offences may serve as PMIEs. It is possible that forensic patients experience a dissonance they are unable to resolve between their actions while acutely ill and their moral beliefs.

At the proposal stage of this dissertation, no literature existed on the subject of moral injury with non-legally sanctioned acts of violence as the transgressing event. This gap in the literature was subsequently identified by teams in both the UK and Canada, who approached the topic in various ways, and subsequent to the time of initial study proposal, literature examining this now has been published.

In his 2021 dissertation, Maddocks conducted two qualitative studies, the first with practitioners working within a therapeutic context in forensic settings in the UK which examined the utility of the concept of moral injury in assessing and treating violent perpetrators, and the second with individuals who had been convicted of violent offences which examined how they may have comprehended any PMIEs they may have experienced.

In the first study, Maddocks did not differentiate between practitioners working within correctional settings and those working in secure psychiatric hospitals. While some practitioners struggled with the idea that violent offenders had morality and therefore the capacity to become morally injured, they indicated that individuals who committed the violent offences when mentally unwell may experience moral injury upon their recovery (Maddocks, 2021). The practitioners also indicated that the context in which the offence occurred was important in determining whether it was a PMIE. They further suggested that the offenders that attempted to justify their actions may have been trying to avoid the adverse consequences of moral injury. Generally, the practitioners accepted the relevance of moral injury for individuals convicted of violent offences (Maddocks, 2021).

The participants in Maddocks' second study were individuals who had received mental health treatment and were convicted of violent offences. The participants' offences were not necessarily committed while the individuals were mentally unwell. The results demonstrated that the participants experienced moral injury as a result of their offending in addition to other PMIEs including adverse childhood experiences and their treatment in the criminal justice system.

There was also a Canadian study, conducted by Roth et al. (2021), that employed qualitative methods to study forensic psychiatric patients who were determined to be NCR, as well as examining staff members on their hospital units. The results suggested that patients experienced symptoms of moral injury such as guilt, shame, and a loss of trust in their own morality.

Lastly, a study exploring moral injury in individuals in forensic secure care settings in the United Kingdom discovered that 89.5% of participants endorsed experiencing moral injury (Steen et al., 2023). The participants' PMIEs were unknown to the researchers and may or may

not have been the participants' offences; however, on the Moral Injury Events Scale (MIES; Nash et al., 2013), the ratings for other-transgressions and betrayal subscales were higher than those for the self-transgressions subscale (Steen et al., 2023), suggesting that the participants were victims of the majority of PMIE's they experienced. The moral injury scores were correlated with ratings of trauma, guilt, and poorer quality of life, but not shame or self-compassion (Steen et al., 2023), though, as noted above, both guilt and shame were evident in the Roth et al. (2021) investigation using qualitative methods.

Guilt and Shame

Guilt and shame, considered to be moral emotions, are important for encouraging altruistic conduct and deterring antisocial conduct (Tangney et al., 2011). The terms guilt and shame are frequently used interchangeably, both in casual and academic discourse (Tangney & Dearing, 2002) yet there are both theoretical and empirical suggestions of the need for their differentiation. The most empirically supported and dominant distinction, developed by Lewis (1971), indicates that while guilt and shame are both self-focused emotions that occur after a transgression or failure, shame involves a focus on the self (I am a bad person) and guilt involves a focus on the behaviour (I did a bad thing; Tangney et al., 2007, 2014; Tangney & Dearing, 2002). Shame is understood to be more painful and damaging than guilt as it is focusing on and denigrating the core self, rather than merely a behaviour (Tangney et al., 2007). Feelings of guilt elicit remorse, regret, and tension and tend to provide motivation to engage in reparative behaviour such as apologizing or confessing; whereas shame elicits feelings of worthlessness, being diminished, and being exposed which tend to provide motivation for defensive behaviours, such as externalizing blame, hiding, denying responsibility, and escaping (Tangney et al., 2011, 2014).

Guilt has been associated with other-oriented empathy, while shame has been demonstrated to negatively affect individuals' capacity to relate empathically with others (Joireman, 2004; Leith & Baumeister, 1998; Silfver et al., 2008; Stuewig et al., 2010; Tangney et al., 2011; Tangney & Dearing, 2002). Guilt is considered to be more adaptive and less damaging than shame (Tangney et al., 2007, 2011). Guilt and shame have been determined to be distinct emotional reactions to offences in forensic populations (Wright & Gudjonsson, 2007). While guilt has been found to be a protective factor in terms of criminality, the same effect was not found for shame (Hosser et al., 2008; Stuewig & McCloskey, 2005; Tangney et al., 2011, 2014; Tangney & Dearing, 2002; Tibbetts, 2003).

In sexual offenders, shame after offending has been theorized to increase the risk of recidivism by decreasing self-efficacy, victim empathy, and the ability to use adaptive coping skills, and increasing distress, cognitive distortions, and externalizing of blame. Guilt, however, has been theorized to decrease the risk of recidivism in this population by increasing victim empathy, reparative behaviours, self-efficacy, and adaptive coping (Bumby et al., 1999, as cited in Proeve & Howells, 2002).

In forensic patients, offence-related shame and guilt proneness have been found to be positively correlated with treatment readiness, while proneness to shame was not associated with motivation for change or treatment readiness. Offence-related guilt, however, was associated with both motivation for change and treatment readiness (Fuller et al., 2019). Offence-related shame has been found to be associated with anger issues, while offence-related guilt is associated with anger management ability in forensic patients (Wright et al., 2008). Offence-related shame and guilt have been found to be associated with intrusive memories in justice-involved adult males, although the relationship between guilt and intrusive memories no longer existed when

controlling for shame, indicating that it is shame that contributes to intrusive memories (Mossière & Marche, 2021).

Experience of Forensic Patients

There is a paucity of qualitative research examining the subjective experiences of forensic psychiatric patients, and in particular, those who committed violent offences (Luigi et al., 2024). The research that does exist demonstrates the richness of forensic patients' narratives and experiences. It is imperative to gain an understanding of this population's experiences given the involuntary nature of much of their treatment and restrictions on their freedom. As a group, their voices have often not been heard due to stigmatization (Crocker et al., 2015b).

Many of the qualitative studies conducted with forensic psychiatric patients to date have examined their accounts of recovery (Adshead et al., 2015; Barnao et al., 2015; Ferrito et al., 2012; Laithwaite & Gumley, 2007; Mezey et al., 2010; Møllerhøj, 2021; Olsson et al., 2014; O'Sullivan et al., 2013). A meta-synthesis of qualitative recovery research revealed three overarching themes: safety and security as a necessary base for the recovery process, the dynamics of hope and social networks in supporting the recovery process, and work on identity as a changing feature in the recovery process (A. Shepherd et al., 2016). Recovery in this population is unique as they are not only recovering from severe mental illness, but also from their offences while living under the auspices of the review boards in the forensic psychiatry system.

Closely related to those examining recovery, several studies investigated forensic patients' experiences of their offences (Adshead et al., 2015; Askola et al., 2015, 2020; Ferrito et al., 2012; Stanton et al., 2000). Adshead et al. (2015) posit that the processes of the patients providing a narrative of their offences and their self-reflection in terms of their identity are

important to the understanding of recovery in forensic treatment. A study investigating forensic patients' experiences of their offences and the meaning they have given them concluded that the narratives fell into one of three groups: criminal stories, victimization stories, and recovery stories (Askola et al., 2015). Askola et al. (2020) concluded that the processing of the offence and the factors leading up to and relating to the offence is an integral part of forensic treatment. The analysis of forensic patients' narratives of their offences during a UK study produced themes that emphasize the importance of their offence narratives in their search for meaning (Ferrito et al., 2012).

Work by O'Donahoo and Simmonds (2021) exploring remorse in forensic patients demonstrated that while the majority of individuals experienced remorse, expressing their remorse was extremely challenging due to painful memories of the offence, its consequences, and its irreversibility. The participants indicated that poor insight, active symptoms, and a hesitancy to be unguarded with mental health professionals prevent them from communicating their remorse.

Several qualitative studies have examined the experience of trauma caused by committing the offence in forensic patients (Maddocks, 2021; Rew et al., 2022; Roth et al., 2021). As previously discussed, the studies by Maddocks (2021) and Roth et al. (2021) investigated and found moral injury in forensic patients by conducting interviews with both patients and staff. An interpretive phenomenological analysis of interviews with two forensic patients with diagnoses of PTSD who had completed treatment for offence-related trauma produced two superordinate themes related to their experiences of trauma (Rew et al., 2022). The first theme, journey to forgiveness, described an ongoing journey toward self-forgiveness with obstacles to overcome along the way. The second theme, living with the whole me, depicts the

participants' experience of a "fragmented sense of self" (Rew et al., 2022, p. 232) resulting from committing the offence. They felt the internal emotions of shame and grief in addition to the more external emotions of rejection and blame, creating a division in their sense of self. Participants described the need to accept and reconcile both parts of themselves to "feel whole again" (Rew et al., 2022, p. 232).

Females are a minority in the forensic psychiatric system (Revelj et al., 2023) and few studies have considered that their experiences and needs may be different than those of males. A qualitative study investigating female psychiatric patients' use of self-injury and aggression to deal with negative cognitions and emotions concluded that self-injury and aggression should not be assessed separately but instead should be viewed in a more holistic manner (Selenius & Strand, 2017). A study examining females' experiences of forensic psychiatric care resulted in five themes: (1) being yourself and being confirmed about who you are; (2) a need to understand, be understood and taken seriously; (3) being involved in a meaningful and comprehendible everyday life; (4) feeling (un)safe in an (un)predictable and (un)known environment; (5) the desire to help despite being vulnerable (Revelj et al., 2023).

Given their unique position of being mandated for treatment in the forensic system, it is essential to develop an understanding of forensic patients' views of the care received in order to provide the best possible care for this population. In line with this concern, a study of Swedish forensic patients' perceptions and experiences of the inpatient care received determined that they largely felt the care had been monotonous, unindividualized, and predetermined. The participants indicated that they were required to adapt in order to prevent losing themselves in the system (Marklund et al., 2020). A study examining Swedish patients' experiences of their participation in forensic inpatient treatment concluded that participation in treatment occurs in moments that

are elicited by interpersonal encounters, a humanizing culture on the unit, and the ways in which people treat others (Söderberg et al., 2022).

In another study exploring forensic psychiatric patients' experiences of care, this time with a Finnish population, the participants described stages of their narratives in care. Initially, upon their involuntary admissions, they "seem to be a protagonist fighting against the antagonistic, forensic psychiatric institution, yet very vulnerable" (R. Askola et al., 2018, p. 69). After adapting to their new situation, the participants indicated that they began processing their mental illness and offence before finally experiencing hope and becoming "clearly oriented toward the future" (Askola et al., 2018). In addition, studies have been conducted investigating patients' experiences of the more coercive aspects of psychiatric care in the forensic system (seclusion, chemical restraint, and mechanical/physical restraint; Haw et al., 2011; Holmes et al., 2015; Knowles et al., 2015; Tingleff et al., 2019). These studies found the use of restraint had a negative impact on the therapeutic relationships with staff (Haw et al., 2011; Knowles et al., 2015; Tingleff et al., 2019), and highlights the power imbalance (Haw et al., 2011; Knowles et al., 2015). Further, some participants experienced these practices as positive and or necessary (Haw et al., 2011; Holmes et al., 2015; Knowles et al., 2015; Tingleff et al., 2019).

Finally, a study was conducted investigating patients' experiences of participating in the Swedish equivalent of the provincial review board hearings in Canada. The researchers elucidated three themes: a significant, correct, but also meaningless formality; an imbalance of power within the hearings; and existential and practical disorientation (Söderberg et al., 2023). In a qualitative study exploring forensic patients' experiences of familial support, four superordinate themes were produced: connection, growth, power, and ambivalence (Gillespie et al., 2021).

The studies described above provide insight into the subjective experiences of forensic psychiatric patients in terms of recovery, how they experienced their offences and resultant trauma, the care they have received, as well as the unique experiences of female patients. A broad examination of the impacts of the offence on the ways in which forensic patients think and feel about themselves and the world around them and the ways in which they cope with these impacts is lacking in the existing literature. Given the lack of power patients in the forensic system possess, engaging in research to determine their experiences of their offences and the treatment received is imperative to providing the best care and treatment for this vulnerable population.

The Current Study

The index offences of many forensic patients are committed while they are acutely mentally ill, and their offences may transgress their deeply held moral beliefs. It is possible that these patients may suffer from moral injury as a result of their index offences. This qualitative study will explore the potential for the presence of moral injury among forensic patients by examining their cognitions and affect regarding their index offence and their coping strategies. It will also collect information about their psychopathy levels, levels of psychopathology, risk for future violence, PTSD symptoms, and mental health recovery. The results of this study will expand on our knowledge of the emotional impact committing the index offence has on patients and will assist in the development of further approaches to recovery for forensic patients. Given that intervention strategies for moral injury have been developed in the context of working with veterans, these strategies could be modified for a forensic patient population to assist with a full recovery that takes into account moral injury and trauma symptoms arising from the index offences.

Objectives

The primary objective of this study is:

- To explore moral injury among a forensic patient population.

Secondary objectives include:

- To explore the ways in which the index offence has impacted forensic patients.
- To explore the ways in which forensic patients cope with their offences.
- To explore whether participating in the interview has an effect on participants' mood states of shame and guilt.

Chapter 2: Methods

Participants

Participants consisted of 19 adult patients receiving inpatient services from the forensic program at Ontario Shores Centre for Mental Health Sciences. Ontario Shores is a 346-bed public teaching hospital providing assessment and treatment services to individuals living with serious and complex mental illness. Six medium and minimum secure units provide treatment for individuals found to be Not Criminally Responsible on Account of Mental Disorder (NCRMD) in Ontario and Nunavut, Canada. Inclusion criteria included having an oral proficiency in the English language and having committed a violent offence with identifiable victims who likely would have experienced physical or psychological harm (murder, attempted murder, manslaughter, assault, etc.) in the past ten years. Only those patients who are deemed to be capable to consent by the researcher were included in the study.

Procedure

This study was reviewed and approved by the research ethics boards at Ontario Shores Centre for Mental Health Sciences (19-007-B) and York University (STU 2019-106). The reporting of this study conforms with the consolidated criteria for reporting qualitative research (COREQ; Tong et al., 2007).

A combination purposeful sampling strategy was used, comprised of snowball and convenience methods (Patton, 2002). Participants were recruited via advertisements on the inpatient forensic units and by a member of the research team at community meetings. Please see Appendix A for the advertisement posted in the units. A member of the research team attended community meetings on the units to describe the study and answer any questions. Patients indicated their interest in the study and were advised that a member of the research team would

return to the unit at a later date to facilitate their participation. Patients were also able to contact the researchers should they wish to participate. Other recruitment strategies included asking unit staff to suggest patients who may be interested in participating in the study and approaching these patients on the units. The first 25 interested patients were able to participate in the study; the data from six participants was removed from the data set for not meeting inclusion criteria or not answering the interview questions.

The writer (S.A.) met with interested potential participants individually on the units to explain the study in more detail, answer any questions, conduct the informed consent process, and study protocols. All interviews were conducted by the writer (S.A.). The writer (S.A.) had previous clinical contact with three of the participants (two in a group format, one in individual therapy) several years prior to the data collection during a placement at the site. Participants were informed that the interview would take approximately 60 minutes and the questionnaires would take approximately 30 minutes. While some participants in the study may be considered marginally incompetent to consent to medical treatment, they may still be competent to consent to participate in research. Therefore, once patients met with the researcher and the consent form was explained and shared, capacity was assessed by the researcher. Patients were asked the following questions to determine their level of comprehension: 1) In your own words, please describe what the study is about; 2) What are some benefits of participating? 3) What are some risks of participating? Patients were required to answer all three questions correctly to be deemed capable to provide consent. Patients were permitted to refer to the consent form when answering these questions. All participants were found to be competent to consent to participate in the study. Please see Appendix B for the consent form. Participants were compensated $10 for their time. Participants were not pre-screened prior to the interview for ineligibility based on the

recency or the level of violence of their offence criteria. All otherwise eligible and interested participants participated in the interview and their eligibility was determined post hoc. Interviews were conducted with 25 participants. Two participants were deemed ineligible based on low levels of physical violence or seriousness of their offences and/or not having an identifiable victim (uttering threats and threaten to burn property; flight from police, theft over $5000, breach probation, and driving while disqualified) and four participants were not included for not answering the interview questions. The data provided by the aforementioned six participants were removed from the dataset.

Once informed consent was obtained, participants rated their current levels of shame and guilt on a visual analogue scale (VAS). They then participated in a semi-structured interview with the writer (S.A.). Interviews were semi-structured and comprised of follow-up questions and prompts in addition to the prepared questions in order to obtain detail, depth, and nuance in the answers (Rubin & Rubin, 2012) and any clarification needed. Participants were asked to describe the index offence's meaning in their lives. Questions probed the participants' feelings about the index offence, the effect it has had on their well-being, and how they have coped with having committed the offence. Participants were not asked explicitly about moral injury or moral injury symptoms but were instead asked about emotions produced by their offences to ascertain whether moral injury symptoms would arise spontaneously. Please see Appendix C for questions that guided the semi-structured interviews. The interviews lasted between six and 126 minutes (M = 25.4, SD = 25.8). The interviews were audiotaped and subsequently transcribed verbatim.

After the interviews were completed, the participants were asked to complete the PTSD Checklist for DSM-5 (PCL-5; Weathers et al., 2013), the Symptom Checklist 90 Revised (SCL-90-R; Derogatis, 1975), and asked to rate their current levels of shame and guilt on visual

analogue scales. Participants were instructed to consider their index offences to be the "stressful experience" during the administration of the PCL-5. The researcher was available to assist the participants with reading the questionnaires if necessary. The questionnaires took the participants less than 30 minutes to complete. The following information was collected with consent from the electronic health record and most recent Ontario or Nunavut Review Board report by a research assistant: year of birth, gender, diagnoses, index offence, the first and the most recent Recovery Assessment Scale – Revised (RAS-R; Giffort, et al., 1995) scores, Psychopathy Checklist Revised (PCL-R; Hare, 2003) score, and the Historical, Clinical, Risk Management-20: Version 3 (HCR-20V3; Douglas et al., 2013) score. Electronic data was stored in password protected files. Completed paper questionnaires were kept in a locked filing cabinet located in a locked office. Only members of the research team had access to the data. Interview recordings were deleted immediately once the transcriptions were checked for accuracy.

It was not anticipated that the interview questions or the questionnaires would cause significant distress for participants, however, we recognized that some participants may become upset. To assist the participants, the researcher mentioned that should they need support, they may notify a research team member or seek support from their attending nurse. Should they have advised a research team member that they were experiencing distress, the researchers would have assisted them with seeking support from their attending nurse. Patients had a clinician that they were able to access easily at any time.

Measures

Two visual analogue scales (VAS) were created to measure the participants' mood states of shame and guilt before and after the interview. The PCL-5 and the SCL-90-R were administered after the interview to measure the participants' PTSD symptoms and levels of

psychopathology respectively. Participants' results from the HCR-20V3 and scores on the PCL-R and the RAS-R were retrieved from their electronic health records to assess their risk for future violence, psychopathy levels, and mental health recovery respectively. Please see Appendix D for the measures utilized.

Demographics

Demographic information collected from the electronic health records included gender, year of birth, mental health diagnoses, index offences, year of index offences.

PTSD

Participants' symptoms of PTSD were measured using the PCL-5 (Weathers et al., 2013). The PCL-5 is a self-report scale that assesses the presence and severity of PTSD symptoms based on DSM-5 criteria. It is a 20-item measure utilizing a 5-point Likert scale anchored by 0 = *not at all* and 4 = *extremely*. Higher scores on the PCL-5 indicate the increased experiencing of PTSD symptomatology, with total scores ranging from zero to 80. Items on the PCL-5 are based on DSM-5 (APA, 2013) PTSD criteria and enquire about respondents' experiences of various problems in response to a "very stressful experience" in the past month. For the current study, participants were instructed to consider their index offences to be the "stressful experience." Items on the measure fall into DSM-5 (APA, 2013) diagnostic symptom clusters B, C, D, and E, allowing cluster severity scores to be obtained by adding the scores for each item in the cluster (Weathers et al., 2013). Sample items on the PCL-5 include "Repeated, disturbing, and unwanted memories of the stressful experience," "Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)," and "Being 'super alert' or watchful or on guard." The PCL-5 has been found to be valid and reliable in both military (Weathers et al. 2013) and civilian populations (Blevins et al.,

2015; Weathers et al., 2013). According to the developer, a cutoff score of 33 on the measure is a reasonable indicator of a provisional PTSD diagnosis (Weathers et al., 2013). In the current sample, the internal consistency was excellent, with a Cronbach's α of .96.

State Shame and Guilt

Two visual analogue scales (VAS) were created to measure mood states of shame and guilt immediately before and immediately after the interview. Each scale consists of a 100 mm horizontal line with the anchors of *none* and *extremely*. Participants were asked to place a mark on the line indicating how they are currently feeling with regard to shame and guilt. The distance was measured between the *none* anchors and the participants' marks, resulting in a score ranging between zero and 100, with higher scores indicating higher levels of state shame and guilt. VAS are frequently used to reliably measure fluctuations in pain intensity (Funke, 2016; Hjermstad et al., 2011) and other outcome measures (Flynn et al., 2004). The advantage of VAS is that participants are less able to remember their previous response as they are not selecting a numerical or categorical answer. This allows for more sensitivity to change in state.

Psychopathology Symptoms

The Symptom Checklist-90-Revised (SCL-90-R; Derogatis, 1975) was administered to evaluate participants' current symptoms of psychopathology. The SCL-90-R is a 90-item measure utilizing a 5-point Likert scale anchored by 0 = *not at all* and 4 = *extremely*. The measure asks respondents to rate how much they have been distressed or bothered by symptoms in the past week. The SCL-90-R includes both physical symptoms (e.g., "Headaches," "Pains in heart or chest") and psychological symptoms (e.g., "Feeling lonely," "Other people being aware of your private thoughts"). It was created to measure current psychological symptoms and psychological distress in a wide range of individuals. The SCL-90-R has been deemed to be valid

when used with community nonpatients, medical patients, and the majority of patients with psychiatric disorders (Derogatis, 2017). It provides scores in nine domains: Somatization, Obsessive-Compulsive, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic Anxiety, Paranoid Ideation, and Psychoticism. Three global scales were designed to summarize overall distress: Global Severity Index (GSI), Positive Symptom Distress Index (PSDI), and the Positive Symptom Total (PST). The GSI is indicative of both the number of symptoms and their intensity, while the PSDI reflects the intensity of distress and is adjusted for the number of symptoms (Derogatis, 2017). The PST simply indicates the number of symptoms endorsed regardless of intensity (receiving a rating of one to four). Norms exist for the SCL-90-R for adult psychiatric inpatients which allowed raw scores to be converted into T-scores. Reliabilities ranging from 0.84 to 0.90 have been reported for the subscales (Derogatis, 2017). In the current sample, the subscales had acceptable internal consistency (Somatization scale's Cronbach's α = .82; Obsessive-Compulsive scale's Cronbach's α = .90; Interpersonal Sensitivity scale's Cronbach's α = .89; Depression scale's Cronbach's α = .79; Anxiety scale's Cronbach's α = .86; Phobic Anxiety scale's Cronbach's α = .72; Paranoid Ideation scale's Cronbach's α = .77; and Psychoticism scale's Cronbach's α = .87), except for the Hostility scale (Cronbach's α of .58).

Psychopathy Levels

The participants' scores on the Psychopathy Checklist Revised (PCL-R; Hare, 2003) were used to determine their psychopathy levels. The PCL-R is a 20-item standardized clinician-rated measure of lifetime psychopathic symptoms in adults. The PCL-R has served clinicians and researchers as "an anchor and touchstone for conceptualizing psychopathy and as the gold standard for its measurement" (Richards et al., 2015, pp. 137-139). Each item on the scale reflects a different symptom or characteristic of psychopathy and is rated on a three-point scale

ranging from zero to two. Total scores on the measure range from zero to 40, with scores of 30 or greater indicating the presence of psychopathy. The PCL-R provides scores for two factors of psychopathy: Factor 1 reflects the interpersonal/affective domain and Factor 2 reflects the lifestyle and antisocial domain. Each factor is comprised of two lower-level facets; Factor 1 is comprised of the Interpersonal and Affective facets and Factor 2 is comprised of the Lifestyle and Antisocial facets. The "promiscuous sexual behaviour" and "many short-term marital relationships" items did not saturate either of the two factors on the PCL-R. The PCL-R is commonly used with criminal offenders and forensic psychiatric patients and norms exist for male offenders, female offenders, and male psychiatric patients. Scores are obtained through interview and review of collateral information. As the PCL-R is scored for each patient's yearly Ontario Review Board or Nunavut Review Board report, participants did not need to partake in an interview to determine their score. Participants' scores were extracted with their permission, from their most recent Ontario Review Board or Nunavut Review Board report which is conducted annually.

Risk for Future Violence

The Historical, Clinical, Risk Management-20: Version 3 (HCR-20V3; Douglas et al., 2013) was used to evaluate the participants' risk for future violence. The HCR-20V3 is a widely used 20-item structured professional judgment tool that guides the assessor to consider the historical (ten items), clinical (five items), and risk management factors (five items) linked to re-offending behaviour. It aids assessors to evaluate an individual's likelihood of future violence and determine the most suitable approaches to risk management and treatment (Judges et al., 2016). The items are divided into three domains: historical risk factors, clinical risk factors, and risk management factors. Each item is rated for its presence (*yes*, *partial/possible*, and *no*) and

relevance (*high*, *moderate*, and *low*). The HCR-20V3 has demonstrated excellent internal and interrater reliability and good concurrent and predictive validity in addition to good clinical utility (Judges et al., 2016). As the HCR-20V3 is completed for each patient's yearly Ontario Review Board or Nunavut Review Board report, participants did not need to partake in a clinical interview and their results were extracted with their permission from their Ontario Review Board or Nunavut Review Board reports.

Mental Health Recovery

The participants' scores on the Recovery Assessment Scale - Revised (RAS-R; Giffort et al., 1995) were used to measure their mental health recovery. The RAS-R was derived from the Recovery Assessment Scale (RAS; Giffort et al., 1995), a 41-item self-report scale intended to measure patients' levels of recovery. It was determined that 24 of the 41 items loaded onto five factors, indicating that a 24-item version of the scale would be sufficient to assess personal recovery (Corrigan et al., 2004). The RAS-R is scored on a 5-point Likert scale anchored by 1 = *strongly disagree* and 5 = *strongly agree*. Higher scores indicate higher levels of recovery, with total scores ranging from 24 to 120. The RAS-R measures recovery in five domains: personal confidence and hope, willingness to ask for help, goal and success orientation, reliance on others, and not dominated by symptoms. Items include "I have a purpose in life," "I can handle what happens in my life," "My symptoms interfere less and less with my life," and "I am willing to ask for help." It is one of the most commonly used measures of mental health recovery (Biringer & Tjoflåt, 2018; Law et al., 2012) The RAS has demonstrated good internal consistency, test-retest reliability, and interrater reliability in addition to consistent factor structures (Salzer & Brusilovskiy, 2014). As the RAS-R is completed regularly as part of the standard treatment at Ontario Shores, participants were not required to complete the measure for this study. Their

earliest and most recent scores were obtained with their permission through the electronic health record.

Analysis

Quantitative Data Analysis

Means and standard deviations of all variables with sufficient data were calculated. Scores were calculated for the HCR-20V3 as is common practice for research purposes, where *not present* was scored as 0, *partially or possibly present* was scored as 1, and *present* was scored as 2 for possible scores of 20 for historical, 10 for clinical, and 10 for risk management factors. To assess the study objective of exploring whether participating in the interview had an effect on participants' state shame and guilt, Wilcoxon signed-rank tests were conducted on the pre- versus post- analogue mood ratings. The quantitative data were analyzed using IBM SPSS Statistics and Microsoft Excel.

Qualitative Data Analysis

The qualitative analysis was conducted utilizing Braun and Clarke's (2006, 2022) reflexive thematic analysis method, selected due to its flexibility and accessibility (Braun & Clarke, 2012, 2023). Reflexive thematic analysis highlights patterns of meaning across the data set, enabling the researcher to "see and make sense of collective or shared meanings and experiences" (Braun & Clarke, 2012, p. 57). Researcher subjectivity and reflexivity are crucial to conducting quality reflexive thematic analysis (Braun & Clarke, 2006, 2022, 2023). According to Braun and Clarke (2021, 2022), it is essential to discuss the theoretical assumptions of the application of reflexive thematic analysis in terms of ontology (the nature of reality or being) and epistemology (the nature of knowledge and knowledge production) in addition to the researchers' personal and social positionings. An interpretative paradigm and

experiential orientation were utilized, and analysis was conducted from a critical realist perspective. Critical realism posits that while “a material reality exists independent of our ideas about it, … our experiences and representations of reality are mediated by language and culture” (Braun & Clarke, 2022, p. 286). Using this framework, the writer operated under the assumption that what the participants relayed to her during the interviews reflected their realities, in that their accounts are an accurate representation of their perceptions and experiences. The writer also assumed, however, that the participants’ accounts would be affected by the interactions between the participants and the writer during the interview. In addition, through the analysis, interpretation of, and empathic engagement with the text, the writer acted as a mediator of the meaning in the data, and as a result, the writer’s subjectivity is inherently involved in the process. The writer entered the interactions with the assumption that some of the participants may have experienced moral injury as a consequence of their offences. The writer, a cisgender white woman in her mid-40s, recognizes her position as an outsider researcher (not a member of the population studied; Braun & Clarke, 2022), having never been involved in the criminal justice system or diagnosed with a major mental illness. The writer has experience working clinically with forensic inpatients.

Braun and Clarke’s method involves six recursive phases of analysis: 1) familiarizing yourself with your data, 2) coding, 3) generating initial themes, 4) reviewing and developing themes, 5) refining, defining, and naming themes, and 6) producing the report (2006, 2022). As per Braun and Clarke (2022), the writer (S.A.) maintained a reflexive journal throughout the data analysis process. The interview recordings were initially imprecisely transcribed by a research assistant. The writer (S.A.) then corrected the original transcriptions to produce orthographic

transcripts and to refamiliarize herself with the interviews. The writer read through each transcript prior to generating any initial codes.

According to Braun and Clarke (2022), codes are the "building blocks of analysis" that "capture specific and particular meanings within the dataset" (p.52) relevant to the research question. Initial codes were generated from the complete dataset by the writer (S.A.), whereby a code was applied to all excerpts of the dataset potentially relevant to the research questions using NVivo R1 software to assist with the collating process. It is considered to be good practice in reflexive thematic analysis to have a single individual generating codes (Braun & Clarke, 2022, 2023). The writer (S.A.) frequently debriefed the research team throughout the code generation process. Codes evolved throughout the coding process, either expanding to include additional segments of data, becoming more defined, or separating into multiple codes to better differentiate various meanings in the data. A primarily inductive, or bottom-up, approach to data coding was utilized, meaning that the coding was driven by the content of the data rather than existing theoretical constructs (Braun & Clarke, 2006, 2022). Both semantic and latent coding were conducted, depending on the writer's judgement of the most suitable coding method to capture meaning in each particular data segment. As per Braun and Clarke (2022, 2023), semantic and latent codes are not a dichotomy and it is typical for both semantic and latent coding to be used in reflexive thematic analysis. Semantic or descriptive codes normally "stay close to content of the data and to the participants' meanings and use of language" while latent or conceptual codes "develop meanings that lie beneath the semantic surface of the data" (Braun & Clarke, 2023, p. 71).

During the third phase of data analysis, generating initial themes, codes were grouped together by meaning and candidate themes were formed and named. During this phase, some

codes were discarded, others were placed into a 'miscellaneous' theme to be revisited at a later stage of analysis, and some codes formed candidate themes. Candidate subthemes were created to delineate salient elements of the candidate themes. The coded data extracts were collated within the identified candidate themes and subthemes. A preliminary thematic map was created to assist with visualization. The theme development phase was iterative, with themes and subthemes consistently being refined and renamed. The fourth phase of data analysis, reviewing and developing themes, involved the refinement of the candidate themes and subthemes. During the first portion of this phase, the candidate themes and subthemes were evaluated in relation to the coded data, with some codes being discarded and others being placed under different themes. Candidate themes were also altered during this review in relation to the coded data. The second portion of this phase involved evaluating the candidate themes and subthemes in relation to the data set as a whole. Significant redevelopment of the themes and subthemes occurred during this stage, with some themes discarded, others amalgamated, and new ones created to ensure that the candidate themes effectively captured the meaning present in the data set. The thematic map was modified to represent the revised themes. During the refining, defining, and naming themes phase of data analysis, the collated data extracts for each theme and subtheme were revisited and arranged in a way in which the essence of the theme or subtheme was identified. A definition for each theme and subtheme was developed by selecting extracts from the data that illustrated the researchers' interpretation of the data. An analytic narrative was written for each theme and subtheme explaining the meaning of the data extracts, how they related to the experience of moral injury in the forensic population, and their relation to the other themes. Each theme and subtheme were given an informative and pithy title. Producing the report, the final phase of the reflexive thematic analysis process, involved creating a "compelling story about [the] data based

on [the] analysis" (Braun & Clarke, 2023, p. 78) that addressed the research question. The qualitative data were managed using NVivo R1 software and Microsoft Excel and Word.

Chapter 3: Descriptive Characteristics and the Effect of Interview Participation on State Shame and Guilt

Demographic, Clinical, and Legal Variables

The final sample consisted of 19 participants, of which 13 were male (68%) and six were female (32%). The mean age of participants was 36.2 years (*SD* = 10.8, ranging from 22 to 60 years). In terms of diagnoses, 11 participants had schizophrenia as their primary diagnosis, five participants had schizoaffective disorder (four with bipolar subtype), one participant had intellectual developmental disorder, and one participant had unspecified schizophrenia spectrum and other psychotic disorder as a primary diagnosis. There were high rates of comorbidity within the sample, with 17 participants diagnosed with at least one comorbid disorder, 11 participants diagnosed with at least two comorbid disorders, eight participants with at least three comorbid disorders, six participants with at least four comorbid disorders, and one participant with five comorbid disorders. The participants had a mean number of diagnoses of 3.4 (*SD* = 1.5). Substance use disorders were prevalent, with 15 participants diagnosed with at least one substance use disorder (alcohol use disorder, cannabis use disorder, cocaine use disorder, amphetamine use disorder, opioid use disorder, stimulant use disorder, substance disorder not otherwise specified). Seven participants had been diagnosed with a personality disorder (antisocial personality disorder, personality disorder not otherwise specified). Other comorbid disorders included autism spectrum disorder, attention-deficit/hyperactivity disorder, conduct disorder, and intellectual disability. Interestingly, only one participant had a formal diagnosis of PTSD. Violent index offences ranged in severity from threaten death to first degree murder. Participants had committed between one and 10 index offences with a mean number of offences of 4.6 (*SD* = 2.5). Not all index offences were violent, with non-violent offences including

breach of recognizance, failure to comply with probation, flight from peace officer, mischief, and possession of a dangerous weapon. However, as a study requirement, each participant had at least one violent index offence. Age, diagnostic, and offence data were unavailable for one participant. A summary of sample characteristics is displayed in Table 1. A summary of sample diagnoses is displayed in Table 2.

Table 1

Sample Characteristics

Variable	*M* (Range)	*SD*
Age	36.2 (22-60)	10.8
Number of Psychiatric Diagnoses	3.4 (1-6)	1.5
Number of Index Offences	4.6 (1-10)	2.5
Variable	*N*	%
Gender		
Female	6	31.6
Male	13	68.4

Note. $N = 19$

Table 2

Diagnostic Characteristics

Diagnosis	*N*	%
Schizophrenia	11	57.9
Schizoaffective disorder	7	36.8
Bipolar type	3	15.8
Unspecified schizophrenia spectrum and other psychotic disorder	2	10.5
Intellectual disability	2	10.5
Substance use disorder	15	78.9
Cannabis use disorder	9	47.4
Alcohol use disorder	7	36.8
Amphetamine use disorder	3	15.8
Cocaine use disorder	3	15.8
Opioid use disorder	1	5.2
Stimulant use disorder	1	5.2
Substance use disorder NOS	3	15.8
Antisocial personality disorder	4	21.0
Personality disorder NOS	2	10.5
Conduct disorder	1	5.2
Attention-deficit/hyperactivity disorder	1	5.2
Posttraumatic stress disorder	1	5.2
Autism spectrum disorder	1	5.2

Note. N = 19

PTSD Symptomology, Psychological Distress, Psychopathy Levels, Risk for Further Violence, and Mental Health Recovery

PCL-R scores were unavailable for nine participants, and HCR-20V3 scores were unavailable for three participants. As the RAS-R scores of 12 participants were missing, the RAS-R data were not included in the analyses. Scores for the PCL-5, SCL-90-R, and the VAS were available for each participant as the data was collected at the time of the interview.

According to the developer of the PCL-5, a cutoff score of 33 on the measure is a reasonable indicator of a provisional PTSD diagnosis (Weathers et al., 2013). Using a cutoff score of 33, five of the participants met criteria for a provisional PTSD diagnosis. The only participant with an official PTSD diagnosis in their electronic health record had a score of 40 on the PCL-5. The mean score of 21.2 reflects on average moderate levels of trauma stress symptoms.

Participants displayed lower levels of self-reported psychopathology on the SCL-90-R than expected, with the majority obtaining T-scores lower compared with those of the male and female inpatient psychiatric normative samples, and suggestive mainly of current symptom remission, though as noted below, there was a 'peak' score on the Paranoid subscale. The mean T-scores and standard deviations are presented in Table 3.

Table 3

T-scores of SCL-90-R Scales

Variable	*M* (Range)	*SD*
Somatization	43.6 (31-57)	8.8
Obsessive-Compulsive	41.9 (30-58)	7.7
Interpersonal Sensitivity	42.7 (31-64)	8.6
Depression	42.2 (30-54)	5.8
Anxiety	38.9 (30-58)	8.7
Hostility	41.6 (36-54)	5.5
Phobic Anxiety	41.6 (34-56)	6.0
Paranoid Ideation	46.4 (34-68)	8.9
Psychoticism	42.0 (31-63)	9.8
Global Severity Index (GSI)	42.1 (30-78)	10.9
Positive Symptom Total (PST)	42.2 (30-60)	9.4
Positive Symptom Distress Index (PSDI)	43.1 (31-69)	9.9

Note. $N = 19$

Of the participants who had PCL-R scores available (*n* = 10), three (30%) had scores above the mean typical of forensic psychiatric populations (*M* = 20; Hare, 1996). The participants' PCL-R scores ranged from 8 to 27, with a mean of 15 (*SD* = 6.8).

The HCR-20V3 data was available for 16 participants. There is no recommended cutoff score for violent recidivism for the HCR-20V3, however, total scores of 29 (Strand et al., 1999) or 30 (S. M. Shepherd et al., 2018) have been commonly used for research purposes. Five (31.3%) participants in the sample had total scores meeting the cutoff score of 30. The mean scores and standard deviations of the HCR-20V3, PCL-R, PCL-5, and the VAS variables are displayed in Table 4.

Table 4

Descriptive Characteristics of HCR-20V3, PCL-R, PCL-5, VAS Variables

Variable	*M* (Range)	*SD*
HCR-20 Historical	15.6 (10-20)	3.1
HCR-20 Clinical	4.4 (0-9)	2.6
HCR-20 Risk	5.5 (1-10)	3.1
HCR-20 Total	25.6 (17-39)	6.6
PCL-R	15 (8-27)	6.8
PCL-5	21.2 (1-65)	20.4
Pre-Shame	38.3 (2-100)	31.4
Post-Shame	34.2 (1-100)	31.8
Pre-Guilt	41.3 (4-100)	31.8
Post-Guilt	35.3 (1-100)	30.0

Note. HCR-20 Historical = Historical, Clinical, Risk Management-20: Version 3 Historical score; HCR-20 Clinical = Historical, Clinical, Risk Management-20: Version 3 Clinical score; HCR-20 Risk = Historical, Clinical, Risk Management-20: Version 3 Risk score; HCR-20 Total = Historical, Clinical, Risk Management-20: Version 3 Total score; PCL-R; PCL-R = Psychopathy Checklist Revised score; PCL-5 = PTSD Checklist for DSM-5 score.

Interview Effect on Shame and Guilt

The VAS variables were non-normally distributed except for the post-guilt variable. Of the four VAS variables, only the pre-shame variable met the homogeneity of variance assumption. While the ranked scores for both shame and guilt were lower overall post-interview, the differences were not statistically significant, with considerable variability evident. The difference between the post-shame scores, *Mdn* = 20.0, and the pre-shame scores, *Mdn* = 29.0, was not statistically significant, $z = -1.00$, $p = .318$, nor was the difference between the post-guilt scores, *Mdn* = 27.0, and pre-guilt scores, *Mdn* = 34.0, $z = -1.59$, $p = .113$. The results of the Wilcoxon signed-rank tests may be problematic due to the small sample size. Two participants

rated their post-interview shame as greater than their pre-interview shame, while three participants rated their post-interview guilt higher than their pre-interview guilt (using a 10mm difference).

Participants' Experience of the Interview

The participants were asked at the end of the interview, "what has been your experience of this interview?" The responses were largely positive (n = 15), with many of the participants describing the interview as "good." Some participants (n = 4) were more enthusiastic in their responses, using terms such as "very excellent," "great," and "absolutely beautiful" to describe their experiences. Three participants were more neutral in their responses, describing the interview as "alright," "fine," and "okay." No participants provided a negative description of their experience during the interview, although one participant was apprehensive prior to the interview that it would cause her to experience unpleasant emotions: "I was a bit worried about talking about the offence, that maybe it might bring up feelings of shame for what I did" and another stating that he does not "like talking about these things." Three participants noted that they felt comfortable during the interview and one participant asked the writer (S.A.) if she could meet with her again.

Several of the study participants (n = 8) indicated that they found the interview to be helpful in various ways. Some participants stated that they simply found talking about their feelings and the effect their offences had on their lives helpful. A participant noted that talking about the experience made him feel "less horrible." One participant described the interview as facilitating reflection:

> It helped me look into, every time I talk to someone… it helps me to um, reflect on any kind of like, details that I might have missed in my own life… and actually kind of review um, you know, why, I why I am the person I am today.

Another stated that the interview helped her to appreciate her progress in dealing with her offences: "Yeah, makes me, makes me aware of like, how different things are, you know? Like, and that I'm not so upset about them as I used to be." One participant indicated that being able to discuss his feelings about the offence without discussing the offence itself was valuable:

> It releases the mind from the situation that happened… And um, it's a good feeling just to let it out and just to talk to somebody about it. Because I don't want to keep it in me for so long and just think about it to myself when I could actually talk about it and kind of not say, say the situation that really happened… Like um, explain to somebody but not really, just focus on my feelings and not really say the actual thing to people… What actually happened.

One participant responded that the interview prompted him to think about aspects of his situation that other interviews have not:

> It just got me thinking about the moral aspect of it more. Nobody really asks those questions. Like, no one has ever, ever asked like… the doctor who NCRed me didn't care if I felt bad or, or what my moral standing was, or the shame involved. It was just trying to find all these different things on me to prove her side.

He elaborated saying, "no one's cared to ask, ever." It appeared that the participants were not often given the opportunity to discuss or explore their emotions regarding their offences and appreciated having the chance to do so. Another participant differentiated between speaking with psychiatrists and with individuals in the psychology field, stating that "there's always judgement

involved" with psychiatrists. According to participants, the interview provided an opportunity for participants to explore their experiences in a setting where the content of the conversation will not be summarized in their medical chart and could potentially affect their progress through the forensic system. Three participants indicated that they wanted to be helpful and make a difference by participating in the study.

Chapter 4: Experience of Moral Injury: A Reflexive Thematic Analysis

The purpose of the qualitative portion of this study was to determine forensic patients' potential for moral injury by examining their cognitions and affect regarding their index offence, the impact of the offence on their lives, and their coping strategies. During the reflexive thematic analysis process, five themes and 23 subthemes were generated from 19 participant interviews. Each theme relates to the various impacts, emotions, and cognitions experienced by the participants as a result of the index offence.

The five themes are (1) *Living with the Emotional Aftermath*; (2) *Trying to Make Sense and Coming to Terms*; (3) *My Eyes Have Opened*; (4) *Facing the Music*; and (5) *Moving on*. The three subthemes subsumed under the *Living with the Emotional Aftermath* are *shame*, *guilt*, *and regret*, *anger and frustration*, and *shattered and shaken*. The *Trying to Make Sense and Coming to Terms* theme has five subthemes: *rough lessons*, *could have been prevented*, *finding the positive angle*, *symptoms are to blame*, and *dissonance*. The Eight subthemes subsumed under the *Facing the Music* theme are *injustice*, *loss of trust*, *loss of connection*, *diminished self-concept*, *stigma and judgement*, *loss of freedom*, *sense of loss*, and *life on hold*. Lastly, the *Moving on* theme has seven subthemes: *resilience*, *focusing on the future*, *unaffected*, *learning to cope*, *restorative justice*, *receiving support*, and *better times now*. Following the recommendation of Braun and Clarke (2022), numerical frequencies of the themes and subthemes will not be provided. The themes and subthemes are displayed in Table 5.

Table 5

Themes and Subthemes

Theme	Subtheme
Living With the Emotional Aftermath	Shame, Guilt, and Regret
	Anger and Frustration
	Shattered and Shaken
Trying to Make Sense and Coming to Terms	Rough Lessons
	Could Have Been Prevented
	Finding the Positive Angle
	Symptoms are to Blame
	Dissonance
My Eyes Have Opened	
Facing the Music	Injustice
	Loss of Trust
	Loss of Connection
	Diminished Self-Concept
	Stigma and Judgement
	Loss of Freedom
	Sense of Loss
	Life on Hold
Moving On	Restorative Justice
	Receiving Support
	Unaffected
	Learning to Cope
	Resilience
	Focusing on the Future
	Better Times Now

Living With the Emotional Aftermath

Almost all participants reported that they have felt a plethora of unpleasant emotions that have negatively impacted their lives after their index offences, and that they are now living with the emotional aftermath of their offences. Participants stated that these emotions are challenging to cope with: "It was just like, very difficult for me to deal with all the emotions like, to do with my offence." This sense of an emotional aftermath stays with the participants long after the offences occur and cause further suffering. One participant stated, "Sometimes I have to relive the assault where the police come to arrest me for the assault causing bodily harm" while another one noted, "Like, I never stop thinking about that day, you know?" Some participants found some emotions more salient than other emotions, while other participants were bombarded with multiple unpleasant emotions. Participants disclosed varied coping methods for handling their unpleasant emotions resulting from their offences.

Shame, Guilt, and Regret

Participants frequently endorsed experiencing shame, embarrassment, guilt, and regret after their offences. Initially shame, guilt, and regret were treated as three separate subthemes, however, it became clear that there was too much overlap between the subthemes for them to be treated as separate subthemes.

Many participants indicated they felt shame over various aspects of their offences. One participant noted that he felt shame, but that he felt removed from it:

> It's like, right now, my level of shame is just like, I know the shame is there, like… Trust me. [laughs] You know, when I was in like jail, like I could just hear, you know, it seems

> like I could, it's like I perceived it, you know? … The, the shame is there but I'm not subject to it … You know, it's like, it's like, without a doubt the shame is there.

This participant went on to say that the way in which he "respects" his feelings of shame prevents them from affecting him: "Yeah, I respect it, you know? It's like, it's, it's, so my view of it it's not like, oh my God, like you know, it's like that's going to have a negative impact on me." He stated that by respecting his shame, it is "easier to deal with" and is a way of coping with it. One participant expressed feelings of shame over her illness rather than her offences. As she described:

> So, [pause] I've been having a bit of a rough time because of the voices… And sometimes they say awful things like, I hate to say this [facilitator's name] and I know it's on the recorder, but they say strip down to your bra and underwear, say you are the queen three times, run down to the nursing station, run back to your room and stay there for an hour.

This participant stated at a later point, "you know, I, I hate to say this [facilitator's name], but I know you're doing all the recorder, but I take 12 pills at night." Another participant expressed shame over her lengthy hospitalization: "Um, well, I, I feel ashamed, I feel embarrassed. I feel like not everybody who has mental illness ends up being in the hospital for a year." One participant indicated he felt shame regarding his multiple charges by comparing himself to a serial killer: "I feel like I'm getting worse than Ted Bundy walking around like, walking around with all these charges… Like, assault causing bodily, robbery…" A participant indicated that she felt "embarrassed" about her "erratic" behaviour at the time of her offence. Another participant stated that she felt more ashamed about the offence than upset by it. Other participants indicated that their feelings of shame have dissipated over time: "Well, when I did the offence, I would

have a lot more stress but as of right now, I don't have that stress of guilt or shame or anything about that."

Feelings of guilt were frequently endorsed along with feelings of shame by the participants. For instance, one participant stated: "It's that that bothers me, like living in the, living in the like, shame and guilt" while another one stated he felt "still a bit ashamed, still a little guilty."

Participants expressed feeling guilt and regret over various aspects of their actions, with one individual stating, "I still feel guilty about it… I wish it never happened." Another described her feelings by saying, "there's a lot of guilt and a lot of sadness and grief surrounding it. Like I feel terrible about having done that." When asked about their feelings about their offences, one participant indicated he felt "down" while another stated she felt "bad and sad." Many participants expressed remorse over the offences, with one stating about his offence: "[it's] something I could, like, I wish I could take back" and another stating, "I hate the fact that it happened." A particularly guarded participant stated: " Uh, the best thing I can say it's an unfortunate event that transpired and um, I feel horrible and wish events did not take place, but they did." One participant expressed the wrongness of his actions and his inability to resolve his issues:

> It was, it was dangerous and it was bad, it was wrong… I'm trying to get it sorted out … And I'm really trying to get this sorted out, right? And I'm sorry for what I did. I'm, I don't know how to fix it, it's still there.

While some of the regret expressed by participants was about the damage done to others (i.e., the victims), for others the regret was about the ramifications for their own lives. One participant, who assaulted a peace officer, expressed regret over resisting the police officers who were

engaging with her under the Mental Health Act: “I wish I had just gotten in the police car and, and been handcuffed and gone to [hospital]. If I had gone to [hospital], I probably would have been there two weeks to a month or two months.” One participant conveyed regret over his substance use, lifestyle, offence, and resulting hospitalization:

> When I look back, I wish I could change that. I wish I could fix everything. I wish I could, I could have done something better instead of just smoking and drinking alcohol. I should have quit, I was getting good payment, I was on disability for good payment and now I’m stuck in here… Like if I could go back in the past and stop myself, I’d stop myself.

Some participants noted the seriousness of the harm to the victims when discussing their offences: “You know, so, I did try to kill my mom with a knife… And uh, you know, she was still wounded but it was a very close experience where like, she could’ve died…” One participant described one of his offences, stating, “She didn’t give me any money so I struck her… And she fell on the ground and hit her head, and had some serious problems.” The same participant stated about another offence: “The one… with the bottle, I hit the girl with the bottle. She wouldn’t give me any change… her eye got all fucked up. Like, I, I’m like shit, man. Like her eye got all screwed up.” One participant, while acknowledging it could have been worse, described his offence as: “Worst thing I have ever heard of. Well, I guess there’s been worse stuff I have heard of like murders and stuff... But worst thing I’ve done.” One participant denigrated himself over his offence, “Yeah, I was stupid. Stupid on my part to think it would help” while others were gentler in their appraisals of themselves: “I could’ve been wiser” and “you know, like, there are better ways that you could have handled that situation.” Several participants acknowledged that their offences were wrong: “I feel like I was wrong for using too

much force … by throwing rocks. That's, that's going too far." A few participants described their offences as "horrible." For example, one participant stated, "Miss, honestly, it, it, it's horrible, you know? It's really, really horrible" and another stated, "It was horrible… A horrible thing to do… Disgusting. Unacceptable. I wish, I wish I could take it back, you know?" Lastly, the participant described above expressed regret that the victim of his offence was his mother:

> It would be different if it was just a, even like, it would be easier, if it was a random person that I had done that to, it would have been a completely different experience than that being my mom. You know, it would be a completely different experience than that being my mom.

Other participants, however, noted that when the victim was a stranger, it made the offence more rather than less difficult to deal with.

Anger and Frustration

Many of the participants expressed anger and frustration directed at various targets, including themselves, others, and their involvement in the forensic system. One participant expressed anger toward herself for not avoiding the situation in which the offence occurred and allowing the offence to happen. Several participants expressed anger at being deemed to be NCR for their offences, with one describing feeling "angry and trapped." Some participants indicated they were angry with their families for various reasons. For instance, one participant experienced feeling anger in the past toward his father's actions at the time of his offence:

> And I got mad at my dad, and I was blaming him for calling the police because like, he didn't have to call the police. And then like, you know, the way he dealt with the whole situation, that fact just started to make me mad.

Another participant expressed anger toward his family for their actions: "I still get a little bit worked up or I have a little, like, I have this rise in feelings where, where I get, of anger and frustration about it." One participant stated that he has difficulty managing his anger and frustration caused by the offence while he has been hospitalized:

> Um, there's been some incidences on the unit, two incidences since COVID, and in the past I have attacked people, I've thrown things, I've done things out of anger and frustration instead of thinking and acting. I just act out instead of thinking.

This participant also described his frustration as holding him back from moving through the forensic system.

Shattered and Shaken

Some participants relayed a sense of emotional devastation after their offences, that moved beyond the experiencing of unpleasant emotions. One participant described himself as shaken after the offence when he realized that he had injured his mother: "I was shaken up by, you know, uh, when I had, I had uh, sobered up and was in jail. Like, I was shaken up by it," while another participant described shaking over the enormity of her offence:

> I still talk to my parents every day and my mom tells me not to be anxious about it but like it still happens … Like, it's, it's one of those difficult things to deal with. It's like, I can't believe I did that and then like I'll like shake over it and like stuff like that.

She went on to state that she experience a feeling of "shock" over her offence. One participant described feeling "shattered" over the offence: "I was feeling like remorse, I was just broken, pretty much. Um, my spirit was just broken, um, wounded … I was, I was shattered." These participants had attempted to or succeeded in injuring their loved ones, possibly making the offence more shocking to them. One participant described experiencing anxiety about exposing

himself to others and being misunderstood. Several participants endorsed experiencing anxiety about becoming symptomatic and reoffending in the future.

Trying to Make Sense and Coming to Terms

Many participants described a period after their offence during which they examined the lead-up to their offences in an attempt to discover why they committed their offences. They indicated that they questioned themselves, as one participant who appeared to have no insight into his illness at the time of the interview stated: “there was a part of me that wanted to be like, you know, did I, did I go too far?” This participant, who believed he was instructed by God to kill his mother, began to question his relationship with God:

> I did, you know, based on my relationship with God, I started asking God questions, like, why would God make me do that? Put me through something like that and whatnot? … You know or, you know, um, yeah, it was just like why, why would God like, you know, my mom, and I was like, it just kept going through my mind, like, my mom, like really, my *mom*? … It’s like, I can’t, I can’t see why God would have me do that.

Another participant expressed her experience of questioning why she committed the offence by stating: “And I’m like, why would you do that? … Like why, why would I have that feeling to go and do that? Like, I don’t know.” She also indicated that the offence led her to question her sanity: “I just, like, at one point I was thinking of myself as crazy.” In the process of trying to make sense of their actions, many participants appeared to go through a process of coming to terms with their actions.

Rough Lessons

Many participants appeared to come to terms with their offences by seeing their actions as teaching experiences, or “rough lessons.” Lessons learned ranged from gaining knowledge

about the criminal justice system to how to avoid offending in the future. For instance, one participant described the offence and its ramifications as “a learning experience” wherein he discovered more about his illness:

> I’m just, just understanding more about like my mental health... And like, whatever my disability or difference might be. Like, it’s just I find it, I kind of look at it just more as just like growing pains and like, learning about it, and how to deal with it better. So, maybe it’s like a rough lesson.

He indicated that he has learned about the importance of being compliant with his antipsychotic medication:

> So, like I definitely want to stay on the medication this time… Whereas last time I got a notion that well, I’m better now, so I don’t need the medication no more… But it doesn’t work that way though, because then it just comes back, right? … So now I know now, that now I know that, right? I learned that from this experience, right? So, and these days my priority is to stay on the medication.

This participant stated that he now understands the need to be proactive with his mental health as “you can’t just wait for things to go down or go bad.” He further indicated that his offence was a learning experience not only for him, but also for his family in terms of recognizing symptoms and the need to intervene to provide assistance: “Same thing for my family too, right? Because it’s not like something they know how to deal with or understand themselves, right?” This participant indicated that he is now able to communicate with his family to enable them to assist in the prevention of another offence: “I can have a conversation with them now about how to make sure it doesn’t happen again.” One participant indicated that she is able to feel less guilt and shame about her offence by viewing it as a lesson in prevention:

> I think it's common to say you feel guilt and shame but like I say it's a learning experience for me. It's a learning experience for me to, to show this is not how uh, more than just even having to be consequenced [sic]. But beforehand I want to make sure I'm prepared and have a plan for, for those triggers or those negative, those negative experiences.

Another participant stated that rather than have negative thoughts about herself, she realizes she "ha[s] to just, you know, chalk it up to a learning experience… I've learned all my lessons, that's for sure." One participant described learning through self-reflection:

> I've learned a lot of lessons throughout all this stuff… And like, um, a lot of lessons about like the past and what's happened and how I can like, like learn to be better and avoid circumstances and stuff… Yeah, while in here and just because there's so much time to do all this thinking, so, like exploring all these different ideas and like um, just like finding all these answers by myself and stuff, so…

Several participants indicated that they have gained a deeper understanding of themselves as a result of their offences. As stated by one participant, "Uh, I've kind of learned a lot about myself, insight into my mental illness. Um, I've learned about myself as a person, uh, that has helped me in my growth… and in my journey uh, for recovery." Finally, one participant stated that he now is committed to avoiding violence and further offences through his experiences in the forensic system: "Not willing to give up my freedom so easily, you know? Not willing to do violent acts ever again. Never again. Not gonna fight." He is now committed to living a more prosocial and peaceful life.

Could Have Been Prevented

A common refrain among the participants was disappointment and anger when they realized that their offence could have been prevented. While some participants were upset with *themselves*, others are upset at the inaccessibility of psychiatric care, receiving poor care, or others' failure to intervene and provide assistance. Several participants expressed disillusionment with the medical system owing to their perceived sense that they did not receive or were unable to obtain adequate care, resulting in their mental health deteriorating to the point where they committed the offences. One participant described an "uphill battle just to get treatment." Participants detailed the lengths to which they went while seeking treatment. For instance, one participant stated:

> Like, I thought, I thought I needed help at that time, I didn't know where to go. Like, I was, I was in and out of like, the hospital system, not this one in particular, but the, the voluntary one, I'm not sure what it's called… Um, so like, I was frustrated over that especially… About being stuck in hospital for so long. Not knowing why at the time. Because I, I'm from [city name] actually so uh, there's only like two psychiatrists in the whole city. By the time I, like, actually found help it was a crisis situation.

Another participant described his attempts and subsequent failure to obtain medication for his psychosis:

> Like, I tried going to the ER to get back on the medication. But I couldn't. And um, I tried a few other ways to get medication but I wasn't able to… And then eventually, it just spiraled out of control. I started believing in the same things I was believing when I first had this issue, right? … I'd noticed it going bad this time. I went to the ER about twice… I tried going to doctors. I don't have a family doctor though… That was a big,

> big challenge. Like, in order for me to get the medication, they all just told me get a family doctor, right? But it was really hard for me to find a family doctor. I tried. I tried calling them, they gave me a number to call, and I could never get through to anyone, or I could never, never get the result I wanted, which was a family doctor, right? … So, yeah, I wasn't able to get um, a family doctor… And um, yeah, there should be more like things in place for dealing with mental health before it gets bad like, it's way too hard for me to get back on medication.

This participant went on to state that his medication has a prohibitive cost of $600 per month. Another example of the inaccessibility of mental health care is evidenced by the following quotation from another participant who was unable to obtain his medication prior to his offence: "I went to the hospital in [city]… and I got a prescription for my meds. And I wasn't able to cash it because I didn't have any cash at the time – I was waiting on my welfare cheque to come through." Another participant detailed her attempts to receive treatment prior to her offence but was denied treatment:

> Um, so, I went to [hospital], which is my local hospital in [city]… I tried to get admitted to the hospital but the doctor sort of thought I was a nuisance… Um, some people there in Emergency thought I should have an admittance and they said they knew me, I was a [job] peer with lived mental health experience and they thought I should have an admission. Security kicked me out of the hospital.

One participant expressed not receiving adequate or effective treatment during a previous hospital admission at a different psychiatric facility: "If they had helped me at [hospital], I wouldn't have been in this situation."

Participants expressed disappointment with the way in which their loved ones handled their mental health issues, indicating that the offences could have been prevented had their loved ones sought assistance for them. For instance, one participant stated:

> I was thinking about how different this could have been handled, you know what I mean? Like, he could've came and talked to me directly to my face, you know what I mean? Or sent someone, or like, go to the hospital, or like call the cops then, like then I wouldn't have committed a crime but like, you know? … If you're worried about a loved one with a mental health issue, like call the police before they commit a crime, you know what I mean? So that they could come and take me to the hospital or something like that, or maybe if the police take me to the ER, they'd take it more seriously.

These statements express a sentiment held by the participants that their offences could have been prevented by their loved ones, healthcare professionals, or a better mental health care system with more community supports.

Finding the Positive Angle

While participants realized that committing their offences was generally not a wholly positive act, it was evident during the interviews that many participants were attempting to find the positive aspects of their situations. For some participants, particularly the participants whose offences did not seriously harm the victims, the positive aspects tended to concern the offences themselves. For example, several participants (whose offences did not cause significant physical harm to the victims) expressed relief as evidenced with the following quotations: "I'm happy that I didn't like really hurt anybody seriously or anything like that… Because then like, it's something you can't take back, right?" and "At least I'm getting the help and at least I never killed nobody." Another participant expressed that his original intentions prior to intervention

were far more serious: “So, I had like ten people I was gonna kill. I was trying to get a gun and stuff like that, too.” In contrast to a participant previously mentioned who found it more upsetting that his victim was his mother and not a stranger, one participant expressed relief that his victim (who was not seriously injured) was his father:

> I mean I shouldn’t be happy it was my family but I kind of am happy it’s like a family member, and not like a random person on the street or a stranger, or a completely innocent bystander or something like that, you know what I mean? Like traumatize someone that doesn’t even know me or...

Other participants found the positive in their offences to be the subsequent hospitalization and treatment received. As one person stated in general about being deemed to be NCR rather than being criminally sentenced:

> I think that uh, sometimes when you get out, when you reoffend or offend and you get put in the right situation like I did in a hospital, like where you and get checked out if they think you’re not well in the head… I think that can turn out to be a good thing for a lot of people. Like, some of them just end up going to jail. Jail isn’t always the answer. Sometimes there’s things going on, that they need medication, they need help.

This participant expressed that she had requested to be hospitalized as she knew she needed psychiatric treatment that she would not be able to receive in jail. Several participants indicated that they have found the treatment they have received during their hospitalization to be beneficial. For instance, one participant stated, “All the programs, the working, you know, everything’s been great.” Other participants described successful group treatment:

> I learned in CBT that my thoughts and feelings don’t have an effect on the world. It is something that, that gets jumbled up if you just grow up and just see things. But when

> you break it down, if you think a certain way about something, that doesn't necessarily, or, or that doesn't change at all the truth of that thing, you know? … And that, and that gets jumbled when you just grow up, you know? You know what I mean? I can think that, but that doesn't necessarily change the environment.

And, "in terms of my behavior, um, I'm a lot calmer, I'm getting a lot better with my mom. I took some anger management courses." Another participant indicated that she was hoping that her hospitalization would be a turning point for her recovery: "So, maybe having a big dramatic hospitalization like this is helpful um, with the goal that when I am out of the hospital, I will get so many outpatient supports that maybe I'd eventually stay out of hospital."

Participants expressed an appreciation of the hospital environment over the alternatives (jail, underhoused). One participant described her thoughts while in jail, "I wanted to shower and bathe every day… I wanted to be with doctors, I didn't just want to be in a jail" and juxtaposed this with her environment at the hospital:

> I have a big, spacious, beautiful room, nice view of the lake, um, I didn't have much clothes on me but I had access to laundry. So, I had cleaner clothes… I got to have some familiar items and some winter coats and a comforter um, and bras and underwear.

This participant discussed feeling fortunate to be in the hospital during the COVID-19 pandemic lockdowns by comparing her situation on her unit to that of people in the community:

> Um, because people were isolated, people were talking about depression, people were saying it's horrible that they can't go to the gym. Um, you know, um, I felt the world was beginning to suffer the way I had suffered. Um, and then I also felt that um, in a way I was lucky because we weren't really socially distancing during COVID in the ward… Um, so I felt like I was surrounded by people. They are not friends and family, they are

> more patients and staff. But, um, I felt like I was um, able to do quite a lot during COVID. We didn't always have the gym but we had recreational therapists and peer support workers or peer support facilitators who are um, able to help us with what we need to do um, in order to make ourselves comfortable.

Some participants indicated that their offences provided them with improved living situations than they had prior to their offences. One participant described no longer being underhoused as a positive of being deemed NCR for her offence: "I was no longer on the streets, I was in a home. I kind of consider this place a home because I have a roof over my head, I get my food given to me, I get clothes on my body." She went on to state that she will have housing secured for her in the future as a result of her offence: "Now, I'm actually going somewhere. I'm going to, like, get my own apartment. It might, I might not have gotten my own apartment being on the streets, but I'm getting my own apartment through the … NCR system." Another participant communicated the many positives her hospitalization had on her and credited it with the health of her daughter and saving her life:

> I'm glad I ended up in a hospital when I did, finding out I had a baby in my stomach, when I did. That she's with my [family member] and I know she's safe and she's getting all the things that she needs… I'm pretty, I'm pretty positive about that. I don't like being here but it did, it does help you when you're down and out… And if I wouldn't've, if I wouldn't've ended up in here, or whatever, then I could've went out and kept smoking crack or whatever… You know, so I'm just glad that I ended up where I am at to save my, my life.

Symptoms are to Blame

Another aspect of trying to make sense of and coming to terms with the index offence for the participants is examining what was happening in their lives and minds at the time of the offence. During this process, most participants were able to recognize their mental illnesses and determine that their psychotic symptoms were largely to blame for their offences. Symptoms contributing to the perpetration of the offences included auditory hallucinations and delusions. Some of the participants believed they were protecting themselves from harm by their actions. As explained by one participant who was attempting to protect herself from her parents:

> I felt like my parents were going to do it again because they were involved with the, with the human trafficking, trafficking me to my ex-boyfriend. Um, so, that, that like really overcome all my thoughts and everything and I ended up, I, I grabbed a knife and I went and I tried to go stab them.

Another participant stated that prior to his offence, “I felt like people were following me, that people were trying to kill me. It felt like my mama was trying to poison me.” He went on to state:

> I’ll meet people and they tell me they’re going to kill me; they’re whispering to me they’re going to kill me… My mom’s boyfriend is telling me to kill him. Stab him up and kill him. And say he’ll try to kill me. Stuff like that would happen, right?

Another participant described feeling that his “life was at risk” and “in jeopardy” prior to his fatal offence, while another reported thinking that “people were out to get [him] for some reason.” Another participant described a delusion leading to his offence wherein he believed he was being watched: “I thought everyone could follow me around, and like, know what’s going on and like... You know *The Truman Show*? … It’s like that, like, I felt like I was living through an episode of like *The Truman Show* every day.” Similarly, a different participant explained:

> I was suffering from a delusion that made me feel like I was living in the, in a virtual reality simulation instead of living in the real world. And the person I attacked, I attacked him because I figured he was sort of pulling strings and giving orders for things to happen. So, I decided to hit him with a hammer.

Another participant stated: "I came to know too much, uh, and that was alarming. It was alarming to uh, the powers that be. You know, literally, I'm learning too much and it's becoming problematic and there's eyes on me." One participant explained his offence by stating: "The reason why I lit the fire was because I was paranoid that someone was stealing all my shit, I was hearing voices and all this and um, that's pretty much it" while another described assaulting a correctional officer in the jail as a result of her delusions: "I was delusional. I thought I was in the ocean, there was big boats around me, it scared me. I started throwing things around in the tub room. I came out and attacked the guards."

While themes of persecution prior to the offences were common among the participants, others were attempting to *prevent* harm to others with the perpetration of their offences. For example, for one participant, the offence was an attempt to save someone's life: "I thought, oh my God, this is terrible I've got to save his life, you know? … Because I thought if he doesn't come back to [city], someone might kill him."

Two participants believed at the time they were obeying the voice of God by committing their offences. As described by one participant who believed God instructed him to kill his mother:

> God had spoken to me and, you know, testing my character at that particular time. So, I uh, I took the initiative to, to do that. You know, um, I got up, took a knife, um, uh, went upstairs, and you know… Proceeded to do exactly what God told me to do. Um, you

> know, so, it, it was all, it was all, it was all spiritual… You know, uh, did I act on it? The spirit acted on it. Did I believe it was God? Yeah, certainly until this day I still believe it was God. And um, uh, I did try to kill my mom, and you know and um, everything that the voice told me would happen happened… You know, um, um, you know, at that time I was just like, committed to my duty, you know, I was just like God over my mom.

While one of these participants has since developed insight into his mental health issues and the other had not at the time of the interview, both were able to partially alleviate negative emotions caused by their actions by reminding themselves that they were obeying God's wishes. The participant quoted above went on to explain: "I also knew, like, that I did what I did for God… You know, and based on what I heard, so I acted out of faith." Other participants described their mental state at the time of their offences: "I was experiencing like, schizophrenia for sure, like, psychotic episodes" and "It basically all revolved around my kind of hearing voices." Some participants described having issues determining reality: "It felt so real, right? … I wasn't able to tell what was real and what was not real…" Several participants indicated that their psychotic symptoms were what led to their offence, stating that they would not have committed the offence without experiencing symptoms: "I can't honestly look at myself and say 'Hey listen I did it out of my own initiative.' Because fuck no" and "I know myself, like, when I'm healthy it's not something I would do." Others were able to relieve themselves from blame for their offences as a result: "I mean because it's like a mental health issue, … I don't take blame for it or anything." As another participant stated: "It wasn't really my fault." Either through their continued lack of insight, or their recognition that their psychotic symptoms led to their offences, participants were able to ease some of their guilt about their offences.

Dissonance

Due to the nature of committing an offence while experiencing psychosis, several participants relayed struggling to reconcile their actions with who they see themselves as people. This, at times, appeared to result in confusion, as stated by one participant, "I'm not the kind of person that would ever do things like that, but I did. So, it's like, I don't know." Another participant expressed confusion in addition to shock:

> It's like, I never knew I could do something like that. I know it's not me, right? Because I don't wanna kill nobody. I don't wanna hurt nobody, nothing like that. Because the bible says, "thou shall not kill," right? So, it's like, I, I don't feel like it's me… But I still feel, I still feel guilty about it, right? … Because I feel like, I did it, right? So, I'm like, I can't believe it … It's like every day I come to grips, I'm like, 'Oh my God, like I almost killed somebody!'

One participant expressed, "I was surprised I did it, to do something like that" while another stated, "I can't believe I did that." Some participants appeared to remind themselves of who they were and adjust how they see themselves:

> Like, I'm not violent! Honestly, I never was a violent person. I never got into physical fights… It just sorta like came out of nowhere and like, I don't know, they said that um, some people with schizophrenia have violent tendencies and I guess I'd be one of them after that.

As stated by another participant: "I'm reminding myself who like I really am because I'm not the offences, but like, you know, the things I can do, like the good things I can do still, so… I'm not a bad person or like… someone evil." One participant described the offence in similar terms to the participant quoted above: "I don't know what happened. I was just, don't know, man. Something came over me and I just hit someone. I don't know what happened." He went on to

say, “It was like some kind of possession, maybe I was possessed by some kind of like … demon to hit those people.” Here, he is expressing that something else possessed his body as he is not the type of person to act in that way. One participant described a similar sentiment: “I don’t know, it was like a different person.” Several participants described reconciling their person with their acts to be “difficult.” As stated by one participant:

> I was like, what is wrong with me, like, I’m not who I was at that moment in time. And like, like, I know I’m a very kind and loving person so like, I don’t know. It’s hard to like think about myself having done that.

Resolving this dissonance between their offence and who they perceived themselves to be is a part of the process of trying to make sense of their offence and coming to terms with it for many participants.

My Eyes Have Opened

While being found NCR has a major impact on individuals’ lives, several participants expressed that they experienced an awakening of some sort in the aftermath of their offences, having been exposed to situations not experienced by them previously, such as jail, progression through the court systems, being found NCR, and living under the auspices of the Ontario Review Board or Nunavut Review Board. For one participant, it was a process of learning through experience and developing an understanding of what others have gone through and why they may have behaved the way they did:

> I guess I’ve gotten to see a different side of like um, the world because like, now I’m like grouped with people who have been charged with stuff and I now actually know what it feels like to have been charged. And like, I’ve actually gone to jail. So, like, there’s like, there’s like this different side of me now, that like understands and like,

> respects like, to an extent all, all of like, the things that have happened in the world. I don't know…

The participant went on to describe looking back at her ex-boyfriend's actions in the past, to which she was able to draw a parallel with her own actions, and beginning to consider that he may have also been having mental health issues:

> Um, well, I guess like um, it affected me in like, the way that I, because when I was younger, I had one of my ex-boyfriends charged because he had trafficked me to one of his friends and he also like, held a knife to my throat so I was kind of, like, me with a knife and him with a knife and getting like a different perspective on it. And I'm like, he might not have been in a good frame of mind at the time, like… Yeah. I don't know…

Some participants expressed this opening of their eyes as a loss of naivety and a subsequently felt need to be more aware and less gullible in order to protect themselves, as one participant states: "I can't be as careless as I was before, you know, or as naïve, I'll say naïve. I can't be as naïve as I was before. I just have to be like, um, I guess more vigilant… You know, not everything is, not everybody is as they appear to be and not everything is as it appears to be." This participant went on to say that this naivety contributed to the events leading to his hospitalization:

> Because like, uh, I understand that if I was more vigilant in terms of like uh, more independent and more, more (to self) and not you know, easily trusting. You know, because I always had the idea, I always looked at people from a bright perspective. You know, I always was optimistic about people, you know? I was always like a people person… I was always like, you know? And, that, that there was a certain aspect of it that I was naïve, you know? To an extent I was naïve. And uh, as much as I didn't want to

> admit that I was naïve, you know? Because it's like I guess there was a part of me, the part of me being optimistic about people over-shadowed their flaws… You know, and uh, it caused, it affected me, it played a part in me being here. You know, like, not, not, not a part of like my index offence or anything, but just like gradually, you know?

While for other participants, the experience of their eyes opening was more about a change in their worldviews, and gaining a new understanding of the criminal justice system, knowledge, and the value of being educated. As stated by one participant, "It's like before where I was blind, my eyes are now opened … To the world in general." There was, for some participants, a sense of disillusionment and of being let down by society as a whole:

> I'm not trying to place myself on a pedestal, but I mean like, I'm greatly disappointed in society. [chuckles] Greatly disappointed … I expected the population to have more of a vested interest in how the government runs their life. And I just came to a realization that people generally don't care. People are too busy with the grind of their day-to-day life to actually invest time to broaden their understanding of how things work and function and to almost fact check … I can't really blame society for not having a vested interest because that's the way society's been conditioned. Um, but at the same time I can blame people because at what point do you start questioning why you do what you do? And if you contend with the quality of your life and you know, despite the deficiencies in the system. But at the same time maybe everyone is just a frog in a well and they don't see how vast the sky is.

Participants often conveyed a sense that the index offence and its aftermath irretrievably changed the way in which they view the world, both in terms of other people and the systems within it.

Facing the Music

Regardless of whether participants have been able to resolve any unpleasant emotions they have encountered stemming from their index offences such as shame, guilt, and regret, the offences and the subsequent NCR rulings have an immeasurable impact on their lives. As one participant stated, “It just seemed like a small thing at that time, but it’s changed, like, so much of my life.” They are presented with the challenge of facing the music, and dealing with being under the auspices of the ORB or NRB. As is symbolically portrayed by one participant, the offences harmed the participants as much, and in some cases, much more than the victims:

> Yeah, so I sprayed my dad in the face with bear spray and then the truth is I kind of got myself good too, right? … when I was walking away, I noticed I could feel my face kind of burn and it was really bad.

The subthemes subsumed under the *Facing the Music* theme detail the consequences with which the participants must grapple.

Injustice

Many of the participants discussed real or perceived injustices experienced following their offences. Participants detailed ways in which they perceive that their experience in the justice system has been deeply unfair. Some participants felt they were not treated fairly or appropriately by the courts. For instance, one participant believed the judge in his case was “crooked:”

> You know, and you have a judge who is, you know, you know, they’re supposed to be unbiased, but you can tell like, you know, like logically speaking like, I’m like, look at that, that judge is like smelling [inhales deeply through nose] promotion like a bacon and, and I’m just a sacrificial lamb. You know, so, it’s like, okay, it’s like, it’s like, when you

> see all these dealings are not honest, you know, and you're seeing all these, like, all the things happening that are put in place for, for, to sabotage you and whatnot.

Other participants described "unfairness" in the system and feeling "a sense of injustice" and being "wronged" after being deemed NCR. One participant claimed innocence, declaring that he had been "railroaded through the court" and had "never stabbed nobody or cut no one." A few participants felt they had been wrongfully found to be NCR, arguing that their offences were not a result of mental illness. As one participant stated, "I wasn't mentally ill at the time of the crime, I was upset, but I wasn't mentally ill at the time of the crime. I wasn't struggling with my thoughts… I was just mad." Another participant indicated, "I don't know that uh, that there was anything wrong with me in the first place, other than just, just uh, just reaching the breaking point of, of total frustration and anger." One participant stated that he was in the process of appealing the NCR finding in his case.

Some participants expressed perceived injustice at the hands of the psychiatrists and staff at the hospital. As stated by one participant about his criminal responsibility assessment:

> My assessment here, definitely do not agree with that, you know, it's like, um, how the assessment was done. It's like I wouldn't even speak to the doctor… but she still made an assessment… You know, it's like how presumptuous and how do, how do you respect that as a profession? You know, like, honesty, that's been my thing, how can I respect that lie, that blatant fucking lie, like, how do I respect that? You know, that is obscene, like, how do I respect that?

A similar sentiment was expressed by another participant: "It has to be up to the person to tell them they're having psychosis. And I feel like that's where the mental health system is flawed, is

that other people are telling you what's going on in your head." One participant expressed that the way in which patients on the unit are treated by staff is unjust:

> They always seem to get away with it, you know? So, it's like, if, if you have uh, if you have a staff that's disrespectful, or you know, doesn't treat you right or, you know, makes you like, you know, the way they treat you makes you feel this, that, and a third and whatnot, even if you take the appropriate concept to apply in terms of how to deal with it, and whatnot, you're always looked at as a villain directly. You know, it's always you're the problem.

This participant, who appears to have little insight into his illness, stated that patients need to "play the game" in order to progress through the forensic system, which he described as "You're not sick, but you have to admit that you're sick, and then you have to take medication." For those lacking insight, this could be perceived as unjust.

One participant questioned the appropriateness of the purview of the ORB and how it balances public safety versus her individual rights: "I already understand the goal is to protect the public, the goal is to protect the public from wrongdoers. But where does that start and where does that stop? That should be the ultimate question as far as rights." Several participants opined that their detainment under the ORB has been too long and compared the length of their hospitalization under the ORB with the likely length of their incarceration had they been sentenced under the criminal justice system. For example, one participant stated, "… if I did my time, I would be out already, like, last year," while another declared, "The crown only wanted 12 months for my charge and I've been here for 32 months." Finally, one participant expressed feelings of injustice with regard to her mental illness: "Everybody else is okay and I'm not feeling well. It's not fair."

Loss of Trust

A result of real and perceived injustices is a loss of trust. Some participants expressed a lack of trust with psychiatry. As previously mentioned, one participant was upset that a psychiatrist had completed a criminal responsibility assessment despite the participant refusing to speak to the psychiatrist. This participant also expressed the opinion that psychiatry is a dishonest profession: "I just think there's a whole, there's a bunch of lies in psychiatry, you know, it's like, it's just a bunch of lies, you know?" Another participant described his psychiatrist as dishonest:

> [She] was just trying to, trying to find all these different things on me to prove her side. She didn't like what happened, … and she wanted to prove with lies there's things in there that's not true about smearing feces on a wall and that it, that it took six police officers to, to get me into the police car. That wasn't true. That's nowhere in the police report, or that I, that I swung at the police with uh, with a broken bottle and that stuff. That's not in the police report, she just, she just put stuff in there …

A participant expressed a lack of trust in hospital staff and psychiatrists by discussing his fear of exposing himself to others: "if I do indulge in a conversation, … I'm sitting in a seat of fear." He went on to say, "You can easily be misinterpreted here, you know? … It's like, uh, it's fucked up. Like, for you to tell someone they're not what they say they are because you say so."

Several participants expressed a loss of trust in themselves after their offences. For instance, one participant expressed fear that he could become non-compliant with his antipsychotic medications and reoffend: "I just hope I don't fall back like that. I hope, I hope, I hope I can continue to take my medication even when I get absolute discharged. So nothin' like

that happens because I don't want to hurt somebody." A loss of trust in themselves, psychiatry, and the forensic system were common among the study's participants.

Loss of Connection

The majority of participants described experiencing a loss of connection with others. Many participants discussed losing relationships with friends and family subsequent to their offences. For some, the relationships were ended by the other parties due to the participants' actions. For instance, one participant shared: "And not just my dad and my aunt, even like some of my good friends, like … I ruined all the relationships that I have." This participant further indicated that his father, who was the victim, appears not to want contact with him:

> They said that he has to write a letter to the hospital if he wants to talk to me to give me permission to talk to him, so… He hasn't, so I don't really care, I don't call, I don't talk to him.

Another participant stated, "I'm pretty sure he told his lawyer he didn't want to see me no more…" Other participants are isolated from their family by the ORB or NRB. Another participant described being from a small, close-knit reserve and stated that he would not be permitted to return to his community:

> I miss being home and they won't let me go home … like they don't want me to like go back … Because, because of like, I don't know, they don't want me to live with my parents because they don't want me falling into the same habits, I guess.

One participant indicated that the most upsetting aspect of her offence was the effect her hospitalization was having on her son and her relationship with him:

> But um, biggest problem is being away from my son. My son is starting to develop some, some sort of a bit of a personality complex because his mom is away from him … He's

> not very happy. So, he's not always talking to me. And he stopped talking to me in July. Um, I sent him a gift for his birthday. He still hasn't thanked me personally, he doesn't want to go on Skype, he doesn't want to go on Facebook.

It was evident this participant was very concerned about her connection with her son during her hospitalization. Other participants discussed a lack of friendships on their units and feeling lonely: "I don't have that many people to talk to here. … Like I talk to people, but like, you can't say a joke to any of these people. It's ridiculous, this place is horrible, man." Loss of relationships and connections with others were frequently discussed during the interviews.

Diminished Self-Concept

While many participants did not report feeling differently about themselves as a result of their offences, some participants indicated that they had a more negative view of themselves subsequent to their offences. As one participant stated, "I think of myself differently, I'm a bad guy… I think I'm a bad guy for doing it." Another participant, when asked if she thinks about herself differently since her offence, stated, "Yeah, that's for sure. Like, I've changed on, on many different levels. And like…[pause] I don't know. Like, I just like, I look down upon myself more often." It is surprising that more participants did not endorse diminished self-concept during the interviews.

Stigma and Judgement

While they may not have altered perceptions of themselves, many participants were concerned about perceptions of others. Participants expressed awareness that forensic patients tend to be a stigmatized group in society. One participant expressed that in addition to feeling shame and guilt, she also feels "fear" about the way in which she would "be looked at," stating that her offence was on the news at the time. Another participant indicated that she is keeping her

hospitalization private, "I didn't put, put announcements that I'm in [hospital] on Facebook. So, some people still kind of talk to me or message me once in a while on Facebook have no idea what happened to me." A participant who enrolled in a college program feared being removed from the program as a result of stigma when he discloses his hospitalization, "I'm just worried that if I disclose to them that I am in a hospital, I might not, they might de-enroll me from the program."

One participant discussed extensively feeling a great deal of judgement from the doctors and staff at the hospital, particularly for his strong religious beliefs. As this participant shared:

> You know, because like I just kept being fucking judged. You know, I can't quote a scripture without being judged, you know. Because like every time I say God now, it's like, 'oooh this guy.' Every time I quote a scripture, 'oooh this guy.' And it's like documentation, documentation, write it up in my chart.

He stated that it is hard for him to "express" himself due to the judgement he feels from the staff for "having a different belief system." In addition to feeling judgement over his beliefs, this participant indicated that he also feels judged by staff as a result of his offence:

> And I'm being judged for my beliefs, and this, that and the third, you know. It's like they look at my index offence and they see that as like, … it's like a seed that they just plant on earth, you know, and they say 'we're going to grow something bad out of this.'

Participants were feeling and fearing stigma and judgement both from within the hospital and from community members.

Loss of Freedom

The majority of the participants expressed that their loss of freedom while in the forensic system has been a major consequence of their offences. Common sentiments included feeling

“cooped up,” “wanting to be free,” and “dealing with the same faces every day.” As stated by one participant, “I want to get the fuck out of here.” Several participants described being “stuck” in the system and not progressing due to their substance use, for example: “I find my uh, like, progression through the system hasn’t progressed. Mostly due to, like, substances. Like, I smoke cannabis. I know I’m not supposed to, but…” Participants noted that the restrictions regarding substance use placed on them by the ORB are challenging to deal with. As stated by one participant, “Following the rules I find the most difficult part… Substance use is my biggest problem. It’s why, like, I’ve been in the system so long.” The length of hospitalization and resulting loss of freedom was mentioned by several participants. For example: “I’ve been in here such a long time,” “It seems like a long time to be put away since the offence happened,” and “I’m still here and it’s indefinite.” Participants discussed the difficulty of receiving community living in their disposition or an absolute discharge. As stated by one participant, “I have to be better than perfect to get out.” Some participants likened their hospitalizations to prison: “I’ve been locked up ever since. Well, not locked up, but in the, in the hospital … It’s locked up, it’s the same thing. It’s not jail, it’s a hospital jail. … Still corrections.” As stated by another participant, “I’m not no patient, I’m a, I’m a prisoner.” One participant described finding it challenging to wake up each day in the hospital: “Sometimes mornings are hard, because I always wait until that automatic thought pops into my head where it’s like I, I’m in the hospital and I hate being here because I wake up and look at my room.” Loss of freedom was one of the most common grievances and challenges voiced by participants.

Sense of Loss

In addition to the loss of freedom, trust, and connection, participants described other losses. For instance, some participants indicated they had lost their apartments when they were

taken into custody after their offences. Another participant described her lost dreams for the future: "I still wanted to get married and have more children. I feel like I'm [age] now and I'm not sure if that's going to happen." Another participant expressed at length feeling a loss of himself while in the forensic system, stating: "You're not looked at as a person here, you're looked at as a patient." He went on to say, "… the system can make you stupid, you know, and it can belittle you, and, like, take away the man in you, and you become so dependent."

Life on Hold

There was a sentiment among some participants that their lives were on hold due to their involvement in the forensic system. Some participants expressed that they feel "frustrated" and unproductive due to their inability to work while they are in hospital. As stated by one participant, "I haven't been able to work in construction, haven't been able to work in social work. I feel unemployed. I feel a little bit bummed." Another expressed that he was unable to get a girlfriend and stated about his hospitalization: "It's … holding me back."

Moving On

In contrast to feeling as though their lives were on hold, many participants expressed forward motion in their lives and a desire to move on. For some, this means apologizing and being forgiven; for some it means learning to cope with their mental illness and circumstances; for some it involves using the supports provided, and for some it means growth and recovery.

Restorative Justice

Many participants described either a desire to apologize to their victims or indicated that they were able to apologize. Some participants indicated that they were prohibited from making amends due to no contact orders, while others had not had the opportunity to apologize to their victims. As one participant stated:

> Like, I think to myself, if I could only write another letter to [name] and say how great I thought he was, and I'm sorry about those awful letters I wrote you … Just write a nice letter, you know? But I don't really have that chance, you know?

Another participant declared: "I wish I can hold those people in my arms and say I'm sorry that that's happened to you. Give them money and spoil them, but I don't know, I don't know what to do." One participant stated, "… there's an order from the court that I can't talk to my dad." Some participants expressed a desire to repair their damaged relationships. One participant stated that she wishes she could suggest to her victim, "… let's get together for coffee at McDonald's or a banana split at Dairy Queen…" Another participant, who "ruined" his good friendships, discussed wanting to repair his friendships but realizing that the current time was not the ideal time to do so, both in terms of his inpatient status and mental health:

> There's friends like if I call them and talk to them, like I'm sure they'd be cool, but… To me it makes more sense to just wait until like I can do something about it. Because from here I can't do nothing but talk to them and be like, forgive me kind of thing… If there's a situation where we can go out somewhere to a bar, or go eat somewhere, or a birthday, or something like that… And like, I could like, try to rekindle relationships like that, you know? … I just want to make sure that I'm good too, like, before I… like, if I ran into them, I'll make up with them and then the next month, it's like, you know, I'm back to yelling at them or something. [laughs]

For some participants, forgiveness was an important part of their journey. One participant indicated that in order to deal with his shame and guilt regarding his offence, he prays for God to forgive him. As another participant stated about his mother, who was also his victim, "she forgave me, she still loves me… That's been like what has kept me, like, sane." He went on to

say, "I'm thankful for stuff like my mom for being uh, you know, being herself a woman of God that's like, and was able to like, forgave me." The participant mentioned above, who had a no contact order with his father, described a situation during which his father sent home-cooked food with the participant's sister as a sign of movement toward forgiveness:

> She came to visit me the other day, and she brought me some food that he made … He asked what kind of food I wanted… And I said what kind of food I wanted to her and then he made the food and I ate it here. So, I think it's like, it's pretty, it's ok. I don't know if he has like completely forgiven or what he feels with things but… So like, I guess he's ok now with it.

Another participant indicated that receiving forgiveness from the victim ameliorated his shame and guilt felt about the offence:

> Participant: So, I told him, I said, 'Look, dude, I'm sorry for what I did I was really stressed. I was hearing voices. I was paranoid.' And he said, 'Look you're forgiven. I forgive you. You can let all that crap just go.'
>
> Facilitator: Okay. So, like the guilt you were feeling—
>
> Participant: And shame has gone.

The participant went on to say, "I wanted forgiveness … And I got that … So, like, the closure I got made me feel a lot better." It was apparent during the interviews that many of the participants hoped to apologize and receive forgiveness. For those that received forgiveness, it was integral to the process of moving on.

Receiving Support

Participants discussed and expressed appreciation for support they are receiving from various parties. Some participants indicated that they received support from their families, in

terms of visits and guidance. For instance, one participant stated, “I’ve been getting good support from my mother and sister.” She went on to describe also receiving guidance from her sister, “Like, my sister’s a pharmacist and she’s very helpful. She’ll say, ‘Well [name] if you hear voices, just say I hear your voice and I let you go, I hear your voice and I say goodbye.’” Another stated about his mother, “She’s still my best coach, you know?” Participants also discussed receiving support from the staff in the hospital and expressing appreciation for the same. For example, one participant stated:

> I’m getting a lot of support from people, which I’m really thankful for … The social worker here these days, she’s terrific. She’s absolutely terrific. [Doctor’s name] is terrific. Everybody’s terrific… And they are all trying to help me out so I’m very happy.

Participants noted that receiving good support was important to them.

Unaffected

There were a few participants who indicated that they were unaffected in various ways by their offences. A couple of participants indicated they did not suffer from feelings of guilt and shame after their offences: “As far as me feeling guilt and shame? No, because that just takes too much time … I don’t mourn over any of that stuff … I mean, I could but I wouldn’t really see the point of it.” Another participant stated: “I don’t feel any guilt or remorse at all or uh, any social loss, or… Um, um, I don’t, I don’t like, I don’t even care… I don’t give a shit.” A participant, whose victim was not injured, stated, “In this situation there’s nothing necessarily that I would take back or you know, have to undo or I wish that I could, that I regret.” He then went on to justify his position in terms of not injuring the victim:

> It’s not, it’s not like a serious thing, you know, where you stabbed someone, or you killed someone, or you stole a kid, or you raped someone, or something like that. Something

> that I would feel regret for. I would feel really bad about it and I'd have to take time to get over it, and I would feel poor about myself for it.

A few participants indicated that they don't have any feelings about their offences. For instance, one participant stated that she does not "really think about it" or have feelings about her offence as it was "so long ago." Several participants who endorsed experiencing unpleasant emotions as a result of their offences indicated that the offence did not have an effect on their self-concept: "I don't think I look at myself very much differently."

Learning to Cope

Learning to cope with their emotions and circumstances is an integral part of moving on for many participants. They described a variety of ways in which they have learned to cope, ranging from taking PRN medication to "try[ing] not to think about it too much." As one participant stated, "I can get angry and upset, but I take a PRN or whatever to help me calm down." Another participant indicated, "It just sometimes it gives me a little memory, but then I try not to worry, just focus on what's now. And try to forget it." Other participants indicated that they have learned coping mechanisms while at the hospital. For instance, one participant stated, "we were doing this DBT stuff and, and that was really helping me like calm down and everything like that." Other participants mentioned mindfulness and CBT techniques they had learned were effective for them. Being productive, busy and distraction from thinking about their offences and emotions was helpful for others. As one participant described: "Just showing to the staff and, and to myself that I can be a sane, productive person helps me to cope with the negative way that I feel about what I've done." Another participant resumed coding a website that he had been working on in the period leading up to his offence and indicated during the

interview: "… just keeping busy is the best way I cope, I guess." Another participant indicated that she benefits from structure:

> I have a lot of coping mechanisms. I go, I have my breakfast at 8:30. I um … 8:30 I take a bath … I put my makeup on. Put my clothes on. Go to uh, the courtyard at nine… quarter to 10. And then at 10:00, I have my coffee.

She went on to describe keeping herself busy during the day by colouring, writing letters, beading, and listening to music. One participant described dealing with his situation by fasting:

> Sometimes it's overwhelming, when it gets like that, … I always go into fasting, you know, so. When I fast, I'm just able to just like humble myself, and just like get out of myself, just get my head out of my ass, you know? … So, it's like, there's a lot of the time where, like, things are really overwhelming, and I just like, … when I start fasting, it's just like [makes phew sound]. There's a shift, psychologically speaking, it's so, it's so different.

Many participants described methods that involved a 'just get over it' approach to dealing with their situation. These included seeing the offence as a "one-off thing," optimism, and having a future-oriented attitude. For example, one participant stated his approach was: "Move on. Try to get over it," while another indicated she coped with her emotions regarding her offence by the following:

> I just move on. Simple. I move on. Like, I, I'm great, I'm very good at moving on. I literally tell myself, 'Just move on.' Life goes forward. We only can go forward in the future and uh, you know, you forgive and you move on.

Several participants indicated engaging in radical acceptance of their situation was their way of coping. As one participant stated:

> You know what I'm saying, … if this is the hand that had been dealt with me, then I just have to accept it. And, and it's learning to accept that uh, has helped me … I'm not agreeing with it, because I don't agree, you know? But accepting it. It's like, 'Hey listen, I did what, I did what I could, and this is the hand that's been dealt with me.'

This participant also indicated that his relationship with God has helped him to cope.

Resilience

The participants displayed remarkable levels of resilience. Many participants described feeling self-efficacious in dealing with their situations after their offences. As one participant stated, "… if I lose, I know I can come back up again because I've had enough of that experience from back then. To lose and them come back up. All the time." Most participants indicated that they are able to cope with or "handle" their emotions resulting from their index offences. Participants discussed taking the opportunity to learn and "work on" improving themselves during their hospitalizations. Many participants discussed the importance of "growth" to them. As stated by one participant:

> You know, so I mean, it's a challenge to um, it's a challenge but I'm working on … I'm trying. I didn't give up on working on myself. Sometimes I feel like I've given up, but it's not in me, you know, so...

Another participant shared that he is learning how to file his own taxes. Some participants pointed out that they have developed a positive nature: "I definitely feel like a more positive person. Not from the index offence, but I mean like since the index." Others displayed optimism during the interview: "You know, I'm lucky to get back out there and get back to seeing my daughter all, every week and seeing my fiancé every day." Participants also discussed forgiving

themselves, "adapting," "not dwelling on it," and "moving on" as signs of resilience. One participant demonstrated her resilience by meeting her challenges head-on now:

> But like I guess my feelings are just like I'm more happy about facing life as the challenge that it, that it is. Because life is a challenge and even for some people the simplest things are a challenge but like for me it was a challenge, it's, it's a challenge and I, and I gladly face it now.

Participants displayed intact self-esteem, signifying resilience. One stated he has "a lot to offer still" while another was proud of the progress she has made: "And I must commend myself, I have done really well." One participant commented that he had not realized how resilient he is: "I guess like, you never know how strong you are until you have to be."

Focusing on the Future

The majority of the participants who displayed resilience demonstrated a focus on their futures. Participants commonly discussed their goals for the future unprompted during the interviews. Goals, or items to "strive for," that were discussed included moving through the forensic system to a less-secure unit, group home, or absolute discharge, having a romantic relationship, obtaining employment, returning to school, abstaining from substances, and purchasing a house. Participants appeared to be motivated in terms of achieving these goals, as stated by one participant, "I feel like, you know, more driven and just more like, relevant to myself that I can um, that I can uh, just focus on my goals." One participant's goals and ambitions are demonstrated in the following quotation:

> I've been uh, applying to jobs that are work remote from home, because due to COVID-19 a lot of offices are work from home. And some of them are staying that way. So, I got a job like, a couple of weeks ago. They offered it to me, but I couldn't take it because like

> if I was staying after September, if they like open up again, they say I have to go back like into the office and work. … So, there's two other companies that I got an interview with last week and they went well. And they're going to give me technical assessments this week they said. And they have full time work from home no matter what. So even if, [at the] end of COVID, it would still be work from home. That's what I need to find. So, I have two potential jobs I can get.

One participant expressed that she is planning to change her social circle and surround herself with positive influences when she moves into the community: "I'm gonna like, choose to find good people to be around. Like I can't, you know, I'm not going to meet somebody that is going to lure me back into the badness, you know?" Some participants commented on their desire to maintain their recovery and the importance of being proactive in the future to do so. Finally, some participants shared their optimism about their futures, with one participant stating he has "a lot to live for" and another stating, "I just have a good outlook on life … things are going to go well."

Better Times Now

Many participants shared the various ways in which they have improved since their offences. For these participants, better times now encompassed different aspects of their growth and recovery. Some participants discussed positive changes in their mood, for example: "Pretty much here I'm very consistently like, in good moods." Others noted this with decreased anxiety, depression, and by "lashing out" less. As one participant stated:

> I feel like a completely different person … Like, uh, I'm not, I'm not depressed. I'm not scared out of my mind. I don't need Valium. Like, I have, like, I can ask for one anytime and I never have. And like, I just feel so much better, you know.

Others mentioned developing insight into their illness and experiencing a decrease of psychotic symptoms, for instance: "It did take me a while to accept my diagnosis and to come to terms with that and develop insight. Uh, I would say probably my doctor would say I've come a long way," "I don't have delusions or anything anymore," and "I'm on proper medications. I'm not feeling paranoid anymore. I'm not hearing these voices." One participant indicated: "I don't hear the voices no more, my mood is level, like I'm not mad or angry or anything like that. Like, it's like very stable kind of." Another participant stated:

> I feel more at peace. I feel more calm. I don't feel like nobody's out to get me. I feel, I feel safe where I'm at. I feel, I feel relaxed. I feel like a weight has been lifted off my shoulders because I don't have, I don't have to kill nobody for my mom. She doesn't want me to kill nobody … because it's all in my head.

Many participants indicated that they are benefiting from getting back to productivity, with some returning to work, school, or hobbies. Several participants indicated that they were returning to school. One participant indicated she had registered for online classes for a college diploma program and was preparing for classes:

> So, I haven't done math in over a year since I've been here, so I worked with my journaling and writing and kept that up but now I'm working the math side of my brain and doing review until school … I'm just um, starting my course and getting excited and doing math.

For one participant, his increased productivity is partially due to his remitted symptoms:

> But when I'm having like the racing thoughts and conspiracy theories and all kinds of stuff, like, it's hard to focus and like, get anything done. It's not as fun either. Also, now,

> like I have a laptop and stuff so I work on websites and apps … And like, it's cool to like be able to build and do stuff like that with my thoughts like, clear.

Abstaining from substances was mentioned by a few participants as part of their recovery. For instance, one participant stated: "I don't drink anymore. But I used to be a heavy drinker. I drank every day for years. And I quit, I've been sober three years." Many participants indicated that they have forged close connections while in hospital, which for some, was a change from the community. One participant stated: "I've developed more networking skills than I used before … In terms of meeting people and keeping friends and stuff. I've never really had many friends in my life," while another stated, "I made some real close friends. And I have some real, real, real special people in my life." Participants described feeling more "independent," "grounded," "balanced," "secure," "safe," "alert," "normal again," and "better" about themselves. One participant stated she now has higher standards for herself: "I don't want to be a prostitute on the street. And I don't want to be crazy. Uh, I don't want to just flip out on people for no reason you know, because I'm delusional or losing my mind, you know?" Another stated that she has "more to lose" now: "When it came down to uh, to today uh, I would say, when it comes down to today, I would say I have something to lose, so I don't want, I don't want to lose my progress." Several participants indicated that their lives are better, they have changed for the "better," and experienced "growth."

Chapter 5: Discussion

The primary objective of the current study was to explore the effects of the index offence in a group of forensic psychiatric patients to determine whether they experienced moral injury. Secondary objectives were to explore the ways in which the index offences have impacted forensic patients, to explore the ways in which forensic patients cope with their offences, and to determine whether participating in the interview had an effect on participants' state shame and guilt.

The participants' interview responses were extremely heterogeneous and demonstrated that each individual is unique in their assessment and experiencing of their offences. The reflexive thematic analysis produced five themes and 23 subthemes, representing a wide range of experiences.

Interview Effect on State Shame and Guilt

While the mean shame and guilt scores were lower at the post-interview timepoint than the pre-interview timepoint, the differences were not statistically significant. The small sample size (n = 19) may have contributed to the lack of a significant finding. Additionally, many of the interviews were short, with 14 interviews lasting less than 30 minutes. The brevity of the interviews may have impacted the degree of change in state shame and guilt scores pre- and post-interview. Participants' subjective accounts of the interviews aligned with the VAS trends, with most participants indicating that they felt the interview was helpful.

Moral Injury

The themes and subthemes generated provide a rich description of the impact the offence had on the participants' lives, their experiences of moral injury, and how they have coped with

the negative impacts of the offence. The reflexive thematic analysis was not intended to solely focus on the potential for moral injury but on the participants' experiences as a whole and as such many of the themes do not relate to moral injury. Despite this, many of the participants endorsed experiencing many of the symptoms in Jinkerson's (2016) syndromal definition of moral injury. According to Jinkerson (2016), the core symptoms of moral injury are shame, guilt, spiritual/existential conflict, and loss of trust, while the secondary symptoms are depression, anxiety, anger, re-experiencing, self-harm, and social problems.

The core systems of shame, guilt, and the secondary symptoms of anger and anxiety resulting from the offences were endorsed by many of the participants and contained in the theme *Living with the Emotional Aftermath*. Shame and guilt over the offences were frequently endorsed together and are encapsulated under the subtheme *shame, guilt, and regret*. It is possible that participants used these terms interchangeably as is a common tendency in both casual and academic discourse. Some participants indicated they also feel shame regarding their illness and hospitalization in addition to or instead of their offences. Shame, guilt, and regret have been found to be common reactions of forensic patients to their offences (Askola et al., 2015, 2018, 2020; Maddocks, 2021; Møllerhøj, 2021; O'Donahoo & Simmonds, 2021; Rew et al., 2022; Roth et al., 2021; Schoppmann et al., 2021). Participants' expressions of anxiety were included in the *shattered and shaken* subtheme and included fear about becoming symptomatic again and reoffending in addition to anxiety about the index offence. This finding is consistent with the Roth et al. (2021) finding that many participants discussed experiencing anxiety around relapse and reoffence. Roth et al. (2021) indicated that participants also expressed fear of victim retaliation. Anxiety was not part of the themes generated in Maddocks (2021) study of forensic patients, but Maddocks' paper indicated that a practitioner noted that patients experience anxiety

around developing close relationships. Without using the term moral injury, Adshead et al. (2015) discuss their participants' fear and anxiety around the formation of their new identities after their offences, or the process of reconciling who they are with their actions. Askola et al. (2020) found that forensic patients experienced anxiety while processing their offences, while another study found forensic patients experienced anxiety after their offences about having an uncertain future (Olsson et al., 2014). Finally, similar to results of the current study, Laithwaite & Gumley (2007) reported that participants felt anxious about their ability to cope while living in the community. The data under the subtheme *Anger and Frustration* depicts participants' anger directed at themselves, others, and the forensic and criminal justice systems. One participant's expression of his anger included angry outbursts, throwing objects, and physically assaulting others. Again, these findings are in line with other research examining the impacts of the offences on forensic patients, with anger frequently cited as an effect (Adshead et al., 2015; Ferrito et al., 2012; Maddocks, 2021; O'Donahoo & Simmonds, 2021; Rew et al., 2022; Roth et al., 2021; Stanton & Simpson, 2006; Williams et al., 2011).

Just one participant endorsed experiencing the core symptom of spiritual/existential conflict which is subsumed under the theme *Trying to Make Sense and Coming to Terms*. This participant described a period of spiritual conflict during which he questioned his relationship with God during the period immediately after his offence. It is noted that this participant believed that God instructed him to kill his mother, and the resulting questioning was more about God's reasons for His instructions than whether the participant still believed in Him, or related to the participant's morality. It is possible that should the participant's offence have been related to psychotic symptoms that did not involve command hallucinations from God that this spiritual conflict may not have occurred. Maddocks (2021) indicated one patient participant described

experiencing spiritual conflict after his offence, while Roth et al. (2021) indicated that spiritual/existential conflict was the only symptom specified by Jinkerson (2016) that did not emerge as a theme. In addition to the participant Maddocks (2021) describes as experiencing spiritual conflict, he indicated that some participants experienced an existential crisis as result of repeatedly questioning their actions. Several studies examining recovery discussed forensic patients finding meaning in their lives as part of their recovery processes (Dorkins & Adshead, 2011; Ferrito et al., 2012; Lumén et al., 2024; Møllerhøj, 2021; Olsson et al., 2014). Recovery in these papers consisted of recovery from both mental illness and from committing the offence. It is entirely possible that recovery from moral injury, though not named, is subsumed in this recovery process for forensic psychiatric patients. It is noted that the authors do not indicate explicitly that the participants experienced an existential conflict. It cannot necessarily be assumed that the participants experienced this conflict, as the development of new meaning and purpose in life is part of the widely accepted concept of personal recovery from mental illness defined by Anthony (1993). Askola et al. (2018) noted that one participant reported having lost their faith in God as a result of observing the treatment of fellow forensic patients. Regardless, spiritual/existential conflict does not appear to be as common as the other symptoms of moral injury, raising the possibility that it is not as prevalent in the forensic patient population, or perhaps that this population has difficulty recognizing or articulating this symptom.

Several participants described experiencing a loss of trust, including in themselves and in others. As stated by one participant experiencing a general loss of trust in others, "I can't be as naïve as I was before. I just have to be like, um, I guess more vigilant… You know, not everything is, not everybody is as they appear to be and not everything is as it appears to be." Several participants expressed a lack of trust in hospital staff and psychiatrists in particular,

while several others described a loss of trust in themselves after their offence, in terms of being compliant with medication or committing another offence. This finding is in line with the results of the other studies exploring moral injury in forensic patients which found that participants experienced a loss of trust in both themselves and others (Maddocks, 2021; Roth et al., 2021).

While the subtheme *Loss of Connection* details issues with social connection subsequent to the offences, it does not reflect the social problems present with moral injury, which typically develop due to a loss of trust in others, self-harm, or isolation (Jinkerson, 2016) and are the morally injured person's own actions or changes in cognition. The loss of connection detailed by the participants was often a direct result of the offence: for instance, the victims of the offence may choose to no longer be in contact with the participant. Other participants explained the loss of connection resulting from their hospitalization and being away from their communities. This isolation due to hospitalization was also a major theme in a study by Williams et al. (2011). O'Donahoo & Simmonds (2021) discussed a participant who was unable to form new relationships due to the feelings remorse and shame stemming from his offence. Roth et al. (2021) found participants experienced social problems in the form of initiating new and maintaining existing relationships due to feelings of distrust, anger, betrayal and fear of being judged. This result was not replicated in the current study, possibly due to differences in interview questions. For instance, Roth et al. (2021) specifically asked about any impacts moral emotions had on the participants' relationships. Maddocks (2021) indicated that the loss of trust experienced as a result of other's transgressions affected his participants' relationships. It is noted that self-transgressions, or committing the index offence, were not included in this theme in Maddocks' study. Themes of distrust, anger, and fear of judgement were in generated in the current study and it is possible these symptoms may have impacted the participants' relationships

but the participants did not verbalize the impacts. Lastly, while participants did not report issues in their relationships caused by feelings of distrust, anger, and fear of being judged, several reported avoiding or fearing others learning about their offence and hospitalization. That these participants did not report social problems may be due to their avoidant or dishonest behaviour. While the participants in the current study did not explicitly indicate a loss of trust in others impacted their existing or the creation of new relationships, it would not be unreasonable to make this assumption.

Some of the participants in the current study reported having a more negative view of themselves subsequent to their offences. This finding is in line with results of other studies (Askola et al., 2018; Ferrito et al., 2012; Laithwaite & Gumley, 2007; Maddocks, 2021; O'Donahoo & Simmonds, 2021; Rew et al., 2022; Roth et al., 2021; Stanton & Simpson, 2006; Williams et al., 2011). There has been support for self-deprecation as a symptom of moral injury, which has been partially characterized by loss of self-worth (Drescher et al., 2011; Flipse Vargas et al., 2013; Jinkerson, 2016). This is congruent with Tangney et al.'s (2007) assertion that feelings of shame are associated with a sense of worthlessness.

According to Jinkerson (2016), reexperiencing of the moral conflict, depression, and self-harm (including suicidal behaviour and ideation, substance abuse, and self-sabotage) are secondary symptoms of moral injury. One participant indicated that he "relives" the experience of his arrest. While no participants reported engaging in non-suicidal self-injury after their offences, several reported engaging in cannabis use which has prevented them from moving through the forensic system. In each instance, the cannabis use preceded the offence and is not necessarily a response to, or a method of, coping with the offence. Interestingly the current results differ from those found by Roth et al. (2021), as their participants reported engaging in

self-harm behaviour and suicidal ideation, with the self-harm behaviour most notably consisting of substance abuse as a method to cope with negative emotions resulting from the index offence. Depression presented in some participants through descriptions of feeling sadness and having a diminished self-concept. Similarly, descriptions of depression subsequent to the offence were present in other studies (Maddocks, 2021; Revelj et al., 2023; Roth et al., 2021).

While not a symptom included in Jinkerson's (2016) syndromal account of moral injury, cognitive dissonance is an integral part of the widely used definition of moral injury by Litz et al. (2009) and was found to be present in several participants. These participants expressed a sense of shock and that they had difficulty reconciling who they believed they were prior to their offences with their actions, indicating that they did not have a violent nature. This identity disturbance was a common finding among other studies, including those investigating the concept of recovery in forensic patients (Adshead et al., 2015; Ferrito et al., 2012; Maddocks, 2021; Rew et al., 2022; Roth et al., 2021).

The current study provides additional evidence that moral injury appears to be present in and relevant to individuals involved in the forensic system. These findings are in line with results from a quantitative study (Steen et al., 2023) and two qualitative studies (Maddocks, 2021; Roth et al., 2021) conducted during the same timeframe as the current study. While Steen et al.'s (2023) quantitative study found moral injury to be present in the sample of forensic patients, it is possible that for some respondents the potentially morally injurious event (PMIE) was not the index offence as the mean event age exceeded the length of hospitalization by nine years. Additionally, ratings on the Transgression-Other and Betrayal subscales were higher than those on the Transgression-Self subscale, indicating that the PMIEs were often transgressive acts of others. Likewise, the analysis in Maddocks' (2021) study indicated that committing a criminal

offence was just one type of PMIE encountered, and that betrayal by others, childhood abuse, and perceived failure by services were also considered to be relevant PMIEs for the participants. The interview questions queried both transgressive acts of others and self and the participants' experiences of the criminal justice system. The interviews conducted by Roth et al. (2021) probed the participants' feelings resulting from their index offences in addition to their opinions on the treatment they received through the justice and health care systems. Interview questions in the current study probed impacts of the index offences on participants' emotions and cognitions and how they have coped with the impacts. Participants were not asked directly about their experiences within the criminal justice system. Similar to the results obtained by Roth et al. (2021), the current study found that many participants experienced moral injury symptoms, (for example, shame and guilt) directly as a result of the offence. Both studies found mixed origins of loss of trust, as some participants in each study experienced a loss of trust in themselves or others directly as a result of the offence, while others endorsed a loss of trust resulting from their treatment in the forensic system, an indirect result of the offence. Interestingly, qualitative studies that were not exploring moral injury in forensic patients nonetheless described aspects of moral injury in the participants in the ways noted above (Adshead et al., 2015; Askola et al., 2015, 2018, 2020; Dorkins & Adshead, 2011; Ferrito et al., 2012; Laithwaite & Gumley, 2007; Lumén et al., 2024; Møllerhøj, 2021; O'Donahoo & Simmonds, 2021; Olsson et al., 2014; Revelj et al., 2023; Rew et al., 2022).

While most participants experienced some aspects of moral injury as noted above, the experience of symptoms was not uniform across participants, with some participants strongly endorsing many symptoms of moral injury and others discussing fewer symptoms. Notably, one participant indicated that he experiences no guilt, shame, or regret regarding his offence and does

not “give a shit” that the offence occurred. While the participant noted that he finds it challenging to deal with the restrictions placed on him, he does not appear to be suffering from moral injury. While some other participants did not express shame or guilt regarding their offences, they did express remorse. According to Jinkerson’s (2016) syndromal formulation of moral injury, in order for moral injury to be present, the individual must have: (1) a history of morally injurious event exposure; (2) guilt; and (3) at least two additional core or secondary symptoms. By these standards, individuals in the forensic system must feel guilt to be considered to be suffering from moral injury, and those experiencing anger, shame, loss of trust, and other symptoms without guilt are not considered to be suffering from moral injury. It is notable that several participants endorsed moral injury symptoms but did not endorse experiencing guilt and therefore, according to Jinkerson’s (2016) criteria, not experiencing moral injury. This highlights a major limitation in Jinkerson’s diagnostic criteria. Jinkerson’s model notwithstanding, the majority of participants in the current study endorsed several symptoms of moral injury, a finding consistent with other research examining moral injury in forensic patients. A high proportion (89.5%) of the forensic patients included in Steen et al. (2023) study endorsed experiencing moral injury. While Roth et al. (2021) and Maddocks (2021) do not quantify the levels of moral injury found in their samples, they indicate that moral injury symptoms occurred across their samples. Similar to the current study, two participants in R. Askola et al.’s (2018) study reported feeling no remorse for their offences, while Askola et al. (2015) found that a group of their participants did not regret their offences.

Moral injury is believed to belong on a continuum, ranging from moral frustration to moral injury, with moral distress falling in the middle (Litz & Kerig, 2019). Moral frustration involves experiencing ‘moral challenges,’ which do not have a direct impact on the person, for

example, concern about the failure of governments to act to rectify or slow climate change. Moral distress results from experiencing ‘moral stressors,’ for example hurting a loved one or misappropriating intellectual property. In moral distress, moral emotions become dominant and the psychological sequalae are stressful and impairing, but not disabling (Litz & Kerig, 2019). Finally, moral injury results from the experience of a PMIE and involves very strong moral emotions and more impairing behavioural and psychological sequalae (Litz & Kerig, 2019). While some participants in the current study may not have experienced moral injury, they may have experienced moral distress as a result of their offences and experience in the forensic system.

It is noted that participants in the current study were not asked specifically about moral injury symptoms; any symptoms they discussed during the interview were spontaneous except perhaps for guilt and shame which may have been primed by the pre-interview administration of the VAS. More moral injury symptoms may have been reported had the interview enquired about them specifically, as Roth et al. (2021) did in their study. Roth et al. (2016) asked about guilt and shame specifically, and both Maddocks (2021) and Roth et al. (2021) enquired about their participants’ moral code and thoughts about morality.

Other Experiences of Forensic Patients

One objective of this study was to explore the lived experiences of individuals found by the courts to be NCR and to further examine the psychological impacts of their offences. Participants in the current study described a wide range of experiences and ways of making meaning, both on an individual level and across individuals. The themes generated during analysis contain similarities to those found in other studies.

The *Living with the Emotional Aftermath* theme encompasses subthemes detailing the emotional impact the participants' offences had on them and contains the subthemes *Shame, guilt, and regret*, *Anger and frustration*, and *Shattered and shaken*. Similar to results found in other studies, including those examining moral injury (Maddocks, 2021; Roth et al., 2021), many of the participants experienced shame, guilt, and regret for their offences.

A common theme across the participants is that they are *Trying to Make Sense and Come to Terms* with their offences. Indeed, other studies demonstrate that coming to terms or making sense of their offences is an important part of recovery for forensic patients (Adshead et al., 2015; Askola et al., 2015, 2018, 2020; Clarke et al., 2016; Ferrito et al., 2012; Laithwaite & Gumley, 2007; Maddocks, 2021; Møllerhøj, 2021; A. Shepherd et al., 2016). It is noted that often the individuals must come to terms not only with their offences, but also with their diagnosis of mental illness (Møllerhøj, 2021). Many participants chose to view their offence as *rough lessons* whereby they are planning to learn from their experiences so as not to repeat them. Rough lessons, or considering the offence as a learning opportunity, does not appear to be a theme generated in other studies. Ferrito et al. (2012) described one participant feeling hopeful that he will learn from his experience. Interestingly, the participants in the current study who chose to see their offences as a lesson tended to endorse fewer moral injury symptoms. In a similar vein, many participants in the current study demonstrated that they were *finding the positive angle* in their offences either by noting the offences could have been worse, or by stating they are now receiving needed treatment for their mental illnesses. Again, these participants tended to endorse fewer moral injury symptoms. Searching for the positive is possibly a coping mechanism for some to aid in dealing with their current circumstances. This desire to find some positive in a generally negative situations has been found in other qualitative research with

forensic patients (Askola et al., 2018; Ferrito et al., 2012; Laithwaite & Gumley, 2007; Mezey et al., 2010) and is a common quality among individuals with who are highly generative (McAdams & Bowman, 2001). It is possible that these individuals simply have a personality trait driving them to attempt to bring good from bad. This is important to note, as research has shown that this tendency to create redemption stories to cope with adversity, or find good in the bad, is associated with higher levels of life satisfaction and self-esteem, and negatively associated with depression (McAdams et al., 2001). Alternatively, or additionally, these individuals may have spent more of their time since their offences reflecting and in treatment to overcome the negative moral emotions associated with moral injury. It was common for participants with less harm to victims to recognize that there are various positive aspects to their offences and subsequent NCR findings.

Similar to participants in other studies (Askola et al., 2015, 2018, 2020; Roth et al., 2021), some participants in the current study lamented that their offences *could have been prevented* had loved ones intervened or they received appropriate healthcare. Two Canadian descriptive studies found that high percentages (83.1% and 72%) of patients in the forensic system had prior psychiatric hospitalizations (Chaimowitz et al., 2022; Crocker et al., 2015b). Many participants in the current study acknowledged as part of their coming to terms and making sense process that their *symptoms are to blame* for their offences. Notably, this subtheme was relevant only for those participants who had attained a certain level of insight.

Interestingly, much of the data subsumed under the theme *My Eyes Have Opened* is not found in other studies with forensic patients. This is most likely due to the questions asked during the interviews rather than differences between the samples. It is possible that the

questions and prompts in other researchers' interviews did not encourage the participants to reflect on how they see the world in general subsequent to their offence.

The *Facing the music* theme encompasses subthemes explaining the negative impacts of the offence and contains the subthemes *injustice*, *loss of trust*, *loss of connection*, *diminished self-concept*, *stigma and judgement*, *loss of freedom*, *sense of loss*, and *life on hold*. Participants in both the current study and in other qualitative studies described feeling a strong sense of injustice (Askola et al., 2015, 2018; Maddocks, 2021; Møllerhøj, 2021; Roth et al., 2021; Schoppmann et al., 2021). In the current study, this was particularly true for the participants who had not developed insight into their mental illness. Similar to feeling injustice, it was common for forensic patients to endorse feeling stigma and judgement in the current study which has overwhelmingly found to be the case in other research with forensic patients (Adshead et al., 2015; Askola et al., 2018, 2020; Clarke et al., 2016; Dorkins & Adshead, 2011; Ferrito et al., 2012; Maddocks, 2021; Mezey et al., 2010; Møllerhøj, 2021; Rew et al., 2022; Roth et al., 2021; Schoppmann et al., 2021; A. Shepherd et al., 2016; Simpson & Penney, 2011; Williams et al., 2011). Forensic patients need to contend with a two-fold stigma: both of their mental illness and of their offending. Research with criminal offenders has determined that offenders' perceived stigma predicted worse community adjustment through anticipated stigma (Moore et al., 2016). It is expected that similar, if not more severe, effects would be experienced by forensic patients upon returning to their communities. Given the high levels of stigma reported across the studies and what is known about its deleterious effects, attention should be given to forensic patients' perceptions and reactions to stigma, both within the forensic system and from society in general.

The majority of the participants expressed that their *loss of freedom* has been a life-changing consequence of their offences and often a source of anger. This has been a frequent

finding in other qualitative research with forensic patients (Askola et al., 2015, 2018; Barnao et al., 2015; Clarke et al., 2016; Ferrito et al., 2012; Marklund et al., 2020; Roth et al., 2021; Schoppmann et al., 2021) It is not surprising given the indeterminate and often lengthy hospitalizations for at times relatively minor offences. In addition to experiencing *loss of freedom* as a major consequence of their offences, participants described that their *lives are on hold* due to their hospitalization and restrictions placed on them while under the purview of the ORB and NRB. Forensic patients in other studies have also indicated that they feel as though their lives are on hold while they are in the forensic system (Laithwaite & Gumley, 2007; Marklund et al., 2020; Schoppmann et al., 2021). It is clear from the current study, in addition to previous research, that individuals in the forensic system must contend with many life-altering impacts after their offences and entry into the forensic system.

Coping

An objective of this study was to explore the ways in which forensic patients cope with their offences. The resilience demonstrated by the participants throughout the interviews was striking. Despite their mental illness, participants proved to be resourceful and had many methods of coping with their offences and current life situations. As discussed above, participants attempted to *Come to terms and make sense* of their actions by viewing their offences as *rough lessons*, and *finding the positive angles* in their situations. Under the *Moving on* theme, which includes descriptions of the participants' efforts to cope, are the *resilience*, *focusing on the future*, *unaffected*, *learning to cope*, *restorative justice*, *receiving support*, and *better times now* subthemes.

Under the *restorative justice* theme, participants discussed either their desire to apologize or that they were able to apologize to their victims, and receiving forgiveness has been an

important part of their coping. Other research teams have found similar sentiments among forensic patients in terms of the desire to apologize and receive forgiveness (Askola et al., 2015; Ferrito et al., 2012; Maddocks, 2021; Mezey et al., 2010; Møllerhøj, 2021; O'Donahoo & Simmonds, 2021; Roth et al., 2021; Stanton & Simpson, 2006). Participants frequently discussed the importance of *receiving support* from various sources, including family and hospital staff, subsequent to their offences. They relied on this support as part of their coping mechanisms. These findings are similar to results of other qualitative studies conducted with forensic patients (Askola et al., 2015, 2018, 2020; Barnao et al., 2015; Clarke et al., 2016; Ferrito et al., 2012; Laithwaite & Gumley, 2007; Marklund et al., 2020; Mezey et al., 2010; Møllerhøj, 2021; O'Donahoo & Simmonds, 2021; Olsson et al., 2014; Revelj et al., 2023; Schoppmann et al., 2021; A. Shepherd et al., 2016; Stanton & Simpson, 2006), highlighting the importance of familial and therapeutic support for this population during recovery. Research with veterans has demonstrated a negative correlation between PMIEs and self-reported social support (C. J. Bryan et al., 2018; Chesnut et al., 2020; Flipse Vargas et al., 2013; Nash et al., 2013), indicating that it may be prudent in terms of lessening the burden of moral injury to bolster the social support received by forensic patients.

Participants discussed their various ways of *learning to cope* with their unpleasant emotions and situations, including focusing on the present, learning and utilizing DBT and CBT skills, staying busy, distraction, and radical acceptance. Similar strategies were found in the majority of qualitative studies examining recovery in forensic patients, emphasizing the amazing *resilience* displayed by many of these individuals. The presence of resilience is notable in this population as in other populations it has been negatively correlated with exposure to PMIEs

(Crane et al., 2015; Williamson et al., 2018). Treatment focusing on increasing forensic patients' resilience may be valuable in attempts to alleviate moral injury symptoms.

Focusing on the future, or future orientation, is another coping mechanism described by many of the participants in the current study, a common finding among studies of recovery in forensic patients (Askola et al., 2015, 2018, 2020; Ferrito et al., 2012; Lumén et al., 2024; Mezey et al., 2010; Olsson et al., 2014) which included feeling hope for their futures. In line with *finding the positive angle* in their offences and detainment in the forensic system, some participants described experiencing *better times now*. This theme describes the sense given by some participants that their lives are better now, while receiving treatment and living at the hospital, than prior to their offences. Forensic patients participating in other qualitative studies have also indicated that their lives have improved or that their hospitalization is a positive occurrence (Ferrito et al., 2012; Laithwaite & Gumley, 2007; Mezey et al., 2010; Olsson et al., 2014).

An unexpected finding of the study is that there were a few participants who reported that they were *unaffected* in various ways by committing their offences, including a couple of participants who indicated they did not feel guilt, shame, or remorse. There are several possible explanations for this finding. It is possible and indeed logical, that those who are less affected by their offence in terms of moral emotions and remorse lean more toward antisociality, and the individuals experiencing higher levels of moral emotions are more prosocial and engaging in criminal behaviour is out of the norm for them. Previous research has demonstrated that levels of guilt are negatively associated with psychoticism scores (similar to psychopathy; Fox et al., 2003), diagnoses of antisocial personality disorder and psychopathy (Johnsson et al., 2014). It is possible that these findings may be similar to other moral emotions, such as shame. Another

potential explanation for those who are unaffected by their offences is that they have lower levels of insight into their mental illness. Without insight into their mental illness, the participants potentially still believe the psychotic symptoms, such as delusions, that led them to commit the offence, and therefore may not realize the enormity of their behaviours. It was clear to the researchers that several of the participants had limited insight into their mental illness. These participants tended to have less remorse and more anger and loss of trust due to their involvement in the forensic system. Similar results were found by Roth et al. (2021). O'Donahoo & Simmonds (2021) found in their study examining remorse in forensic patients that the development of insight into their illness and offence was a pivotal juncture in the development of remorse, and noted that it was also a period when feelings of shame, guilt and remorse were frequently overwhelming. A third possible explanation for those who were unaffected by their offence is that they are engaging in self-preservation from negative moral emotions. As Drennan & Alred (2012) write, often the offences of forensic patients are rationalized, justified, minimized, or outright denied due to "a great number of psychological mechanisms that protect the self from knowing about what drives it to transgress interpersonal and societal boundaries through an offence" (p. 16). A few participants in the study engaged in justification and minimization of their offences. The process of moral disengagement (Bandura, 1999; Knoll et al., 2016) may also be relevant for these forensic patients resulting in them being unaffected by their offences. Lastly, some of the participants' offences were several years prior to the interviews and the participants had received significant psychological treatment during their hospitalization. It is possible that any moral injury experienced had been previously addressed and no longer felt by the participant.

Research has returned mixed results in terms of how the severity of the offence impacts the effect of the offence on the forensic psychiatric patient and specifically with regard to whether the victim of a violent offence is a stranger or known to the perpetrator. For instance, Fox & Leicht (2005) found that individuals with mental illness felt more guilt when their victims were well-known to them, but the severity of the offence confounded the relationship between guilt and how well the individual knew their victim. Conversely, Crisford et al. (2008) found that levels of offence-related guilt were not associated with the severity of the offence and individuals whose victims were unknown to them had higher levels of guilt. Differences between the two studies include groupings of relationship to the victim, how murder was treated relative to other offences, and the number of sex offenders in each group (it is proposed that sex offenders experience higher levels of guilt; Crisford et al., 2008; Gudjonsson & Sigurdsson, 2000; Singer, 2004). Non-forensic violent male offenders have been found to be more likely to experience trauma symptoms when they have a close relationship with their victim (Ternes et al., 2020). Practitioners have opined that the closer the relationship with their victims (Maddocks, 2021; Roth et al., 2021) and the more severe the offences (Roth et al., 2021), the more likely forensic patients are to experience moral injury. In the current study, based on the information provided about the offence and the victims by the participants, no relationships between offence severity, relationship with the victim, and moral emotions were observed. In fact, one participant indicated that he felt better that his victim was family and not a stranger, while another stated the opposite, declaring it would have been easier had the victim be a stranger. It appears that levels of offence-related guilt are related to other factors possibly including but not limited to offence severity, such as guilt-proneness and other personality traits, personal history, and cognitive style. The

current study did not clarify the association between guilt or moral injury and offence severity or relationship to the victim.

Several treatment paradigms have been developed for treating moral injury in military veterans (Burkman et al., 2019; Farnsworth et al., 2017; M. J. Gray et al., 2012; Litz et al., 2009, 2021; Williamson et al., 2023; Yeterian et al., 2017). Clinicians have argued for the importance of having patients work through their offences in a narrative-based manner (Adshead, 2011, 2015; Adshead et al., 2015; Askola et al., 2015, 2020; Dorkins & Adshead, 2011) as part of treatment in the forensic system. To our knowledge, no treatment models have been established to treat moral injury in forensic patients. Research has shown that offence-related shame is associated with treatment readiness and offence-related guilt is associated with both treatment readiness and motivation in male forensic patients (Fuller et al., 2019). Evaluating these moral emotions may be advantageous not only for determining the course of treatment but also its timing.

Participating in the interview and having their stories heard may have provided the participants with a sense that they and their stories matter. Rosenberg & McCullough (1981) posit that the "conviction that one matters to another person is linked to the feeling that: (a) one is an object of his attention; (b) that one is important to him; and (c) that he is dependent on us" (p. 163). Attention is the most basic form of mattering and refers to the feeling that one is an object of interest and notice of another person (Rosenberg & McCullough, 1981). Perceived mattering is manifested in the impression that one is relevant to another person and a recipient of his or her concern. The previously discussed narrative-based treatment for forensic patients would instill within the patients a sense that their stories matter while at the same time lessen their shame and guilt.

The scores for the SCL-90-R suggest that the participants' symptoms are largely in remission, although while still below the norm mean, the Paranoid subscale mean T-score was elevated compared to the other subscales. This suggests that there may be some continuing paranoid ideation among some participants. The HCR-20v3 scores of the participants in the current study are comparable to those of other samples of forensic patients (Green et al., 2016; Neil et al., 2020). The missing PCL-R scores cause characterizing the sample in terms of psychopathy challenging. The PCL-R scores available (*M* = 15) are lower than typical scores of forensic psychiatric patients (M = 20; Hare, 1996). Scores are missing for two of the four participants with antisocial personality disorder diagnoses; it is likely that should the PCL-R scores for those two participants be available the sample mean would be higher and therefore closer to the typical mean.

The participants' mean PCL-5 scores are indicative of moderate PTSD symptomatology. It is noted that PTSD has been found to be underdiagnosed in individuals with psychosis due underreporting and the symptom overlap between the two disorders (Lommen & Restifo, 2009). In addition, it is possible that the diagnosing physicians are focusing on identifying diagnoses that are more likely to impact NCR findings and less focused on diagnosing other psychiatric disorders, such as PTSD, upon admission. This is despite the fact that the lifetime prevalence of PTSD is higher in individuals with psychotic disorders (Grubaugh et al., 2007; Penney et al., 2023). In fact, samples of psychiatric outpatients without a PTSD diagnosis have been found to have higher levels of PTSD symptoms on the PCL-5 (*M* = 33.6) compared to the current sample (*M* = 21.2; Boyd et al., 2022). Furthermore, a sample of individuals with diagnoses of psychotic disorders had substantially higher PCL-5 scores than the current participants (M = 36.6; Penney et al., 2023). The participants were instructed to the use the index offence as the stressful

experience. It is likely that the PCL-5 scores would have been higher had the participants been considering any stressful experiences and therefore may have had higher levels of PTSD symptomatology.

Limitations, Future Directions, and Conclusion

Several limitations exist in the current study. First, purposeful sampling was used which was comprised of snowball and convenience methods. It is unknown whether the patients that did not choose to participate in the study are substantially different in terms of experiences of moral injury than those who volunteered. The individuals that volunteered to participate in the study may be those that have experienced lower levels of unpleasant emotions regarding their offences and thus feel more comfortable discussing its emotional ramifications. Cultural data were not collected in error. The sample was extremely heterogeneous in many ways, including levels of insight, severity of offence, and ability or willingness to articulate emotional states. That stated, the population from which the sample was drawn is also likely very heterogeneous in similar ways and the data should not necessarily be discounted due to the heterogeneous sample. The varying levels of insight among the participants and varied offence severity likely made finding substantive moral injury in the sample difficult. Of the 19 participants, only one participant had murder as an offence. Individuals are potentially less likely to endorse moral injury from the offence itself if the victim was not seriously injured. Missing data from the participants' electronic health records was problematic, preventing us from gaining a full picture of the sample. Finally, while the researchers purposefully did not enquire about symptoms of moral injury during the interview, prior to the interview participants completed the VAS for state shame and guilt, possibly priming them to consider these emotions when they would not have otherwise done so.

The current study contributes to the evidence of the presence of moral injury in forensic psychiatric patients. Regardless of whether the PMIE is the offence itself or the treatment received in the health care and forensic systems, it is clear that moral injury is an issue for some forensic patients. No theme was present across the entire sample, highlighting that among forensic patients there is no standard way to feel, think, or act, and that each individual's journey is unique. It is also important to note the presence of dialectics; that the same individual can endorse seemingly opposite emotions such has remorse and impenitence, anguish and hope. It is notable that there are varying degrees of insight within the forensic patient population. A possibility for future research examining offence-based moral injury may be to conduct the study with participants who have developed significant insight into their mental illness. The gender mix of the sample was six (31.6%) females and 13 males, which is a higher proportion of females than in the forensic psychiatric population in Ontario (15.6% female; Nicholls et al., 2015). Compared to male forensic psychiatric patients, female patients are more likely to have charges of murder or attempted murder (Nicholls et al., 2015), and may be more susceptible to moral injury as a result. While no gender differences were found in mental health symptoms and substance use in veterans experiencing moral injury (Kelley et al., 2019), male healthcare workers experiencing moral injury were more likely to abuse prescription drugs and alcohol than their female counterparts (Campbell et al., 2024). Gender differences have, however, been found between types of PMIEs and suicide attempts and functional impairment in veterans, with female veterans more likely to attempt suicide and experience functional impairment after betrayal-type PMIEs and whereas for men the risk was higher after experiencing perpetration-type PMIEs (Maguen et al., 2020, 2023). It is possible that moral injury presents differently in males and

females in the forensic psychiatric population, and it may be prudent to examine each gender's experiences separately.

Effective treatment currently exists for moral injury in the veteran population and offence-related concerns (largely narrative-based) in forensic patients. Elements of these existing treatments for forensic patients should be combined with those of treatment for moral injury to assist in alleviating the harmful moral emotions and psychological sequelae associated with the offences of forensic patients. Additionally, these treatments should be adapted to harness the tremendous resilience of forensic psychiatric patients.

This study confirmed the presence of moral injury and in forensic patients and through their lived experience highlighted the massive impact the offence has on their lives. It also demonstrated the incredible strength and resilience of this stigmatized population through illuminating their stories which have to date been rarely listened to and which help to truly see the 'people behind the label' in forensic psychiatric hospitals.

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Appendix A

Study Poster

PARTICIPANTS NEEDED

FOR STUDY ABOUT HOW YOU HAVE BEEN IMPACTED BY THE EVENT THAT LED TO YOU BEING IN HOSPITAL

If you are interested, please contact
Sarah Atkey at sdewdney@yorku.ca
or Dr. Krystle Martin at 905-430-4055 X 6846.

You will be compensated $10 for your time.

Appendix B

Study Consent Form

Moral Injury Among Forensic Patients

Principal/local investigator:	Krystle Martin, Ph.D., C.Psych.
Contact information:	905-430-4055 x 6846
Principal investigator:	Sarah Atkey, PhD Candidate, Clinical Psychology, York University

What is the purpose of the research? We are interested in exploring how people who are found not criminally responsible (NCR) following a criminal offence make meaning of their illegal act and how it has impacted them. Your participation is valuable as it will help us understand how you understand the event that led to being found NCR and explore if the event has or has not changed you. Moral injury describes the possible negative effects of behaving in a way that is not in line with your moral beliefs.

Why have You been chosen?
All forensic inpatients at Ontario Shores are being invited to voluntarily participate in this research project. We are hoping to recruit 25 people in total. Only those participants who meet eligibility criteria will be included in the study.

Do You have to take part?
Your participation in this study is completely voluntary. Whether you agree to participate or not, the care you receive at Ontario Shores will not be affected. You may stop participating in the study at any time, for any reason, if you so decide. Your decision to stop participating, or to refuse to answer particular questions, will not affect your relationship with the researchers, York University, or any other group associated with this project. If you want to stop, you can let the researcher know. Any information collected until this point will remain with the researcher.

What is involved in the study?
If you agree to participate, you will take part in an interview with the researcher. The interview will take up to 1 hour. The researcher will ask you about the event that led to being found NCR and how it has affected your thoughts and emotions. These interviews will be audio-taped. Right before the interview, you will given a questionnaire that asks two questions about how you are currently feeling. After the interview, you will be asked to complete questionnaires about problems that can be experienced after a stressful event and how you are currently feeling. The interview and the questionnaires will take approximately 90 minutes of your time. Lastly, researchers will access your electronic

health record to obtain your year of birth, diagnoses, recovery assessment scale score, and the results your psychological testing completed as part of your Ontario Review Board report.

What are the possible risks or benefits if you take part?
There are no serious risks or anticipated benefits to participating in the study. However, it is possible that the content of the interview may be distressing for some people. Should you become distressed by your participation in the study, the researchers will assist you with receiving support from your attending nurse or a member of your clinical team. Overall, this information is very important for the current study and future planning and improvement of mental health services. To thank you for your assistance in this project, you will be compensated in the amount of $10.00. Should you decide to withdraw from the study, you will still be compensated in the amount of $10.00.

Will the research information be kept confidential?
Yes, confidentiality will be provided and maintained to the highest level as permitted by law. No one outside of the research team at the hospital will know the answers you provide should you decide to participate. With regard to the audio-tape from the interview, only the research team will have access to this recording and it will not be used for any other purpose than the current research study. Once it is transcribed, the recording will be deleted.

In addition, neither your name nor any other personal identifiers will be used in any reports or publications arising from this study. It is possible that word-for-word excerpts from your discussions and comments may be used in presentations and reports. Were this to occur, your identity would be concealed and protected. However, it is possible that you (or people who know you well) might recognize words-in-print or spoken in a presentation as belonging to you. Electronic data will be stored in password protected files on the Ontario Shores secure server. Completed paper questionnaires will be kept in a locked filing cabinet located in a locked office at Ontario Shores. Only members of the research team will have access to the data. Non-identified information will be shared and used for Sarah Atkey's York University doctoral dissertation. If any privacy breaches occur, Ontario Shores Privacy Officer and Research Ethics Board will be notified. Study material that is collected will be destroyed by October 1, 2031. Anything you say will not impact the Ontario Review Board process or be fed back to the clinical team unless it involves imminent harm to other people or yourself.

Additional Information
If you have any questions about the research in general or your role in the study, you can call the principal investigator at the number above, or you can contact me, Sarah Atkey,

at the same number. As well, this study has been reviewed and approved by the Research Ethics Board (REB) at Ontario Shores. You may contact Ms. Natascha Kozlowski, the REB chair, should you have any questions concerning your rights as a participant or ethical issues at 1-800-341-6323 x 6996. You will be given a copy of this signed consent form for your own records.

Consent

I understand the purpose of the study and the risks and benefits. I understand that my participation is voluntary and I can stop at any time. I understand that my legal rights cannot be waived by signing my name. I understand that by signing my name below I am agreeing to participate and:

1. I confirm that I have read and understand the above information explaining the research project, what is being asked of participants, and I have had the opportunity to ask questions about the project.

2. I understand that participation is voluntary and that participants are free to withdraw at any time without giving any reason and without there being any negative consequences. In addition, should I not wish to answer any particular question or questions, I am free to decline.

3. I understand that participants' responses will be kept strictly confidential within the research team including the Research Ethics Board. I understand that participants' names will not be linked with the research materials, and they will not be identified or identifiable in reports that result from the research.

4. I understand that the interview will be audio recorded for the purpose of later data analysis. I understand that this recording will be deleted after the participants' answers have been written out.

______________________	______________	______________
Person Providing Consent	Date	Signature
Person Obtaining Consent	Date	Signature
Impartial Witness Consent (if necessary)	Date	Signature

Appendix C

Interview Questions

Will you please briefly explain what was happening for you during your index offence? For example, how were you feeling? What were you thinking?

How long ago was your offence?

What has and has not changed since your offence?

How have you changed or stayed the same since your offence?

What are your feelings about your offence? What feelings has your offence brought up for you?

Do you think about yourself differently since your offence?

Have your beliefs about the world changed since your offence?

How have you coped with or handled the thoughts and feelings after the offence?

What has your experience of this interview been?

Appendix D

Study Measures

Date: ______________ Study ID: _______________

Pre-interview Visual Analog Scale

Please place a mark on the line that indicates how you are currently feeling in terms of shame.

Shame

____

Not at all Extremely

Please place a mark on the line that indicates how you are currently feeling in terms of guilt.

Guilt

____

Not at all Extremely

Date: ____________ Study ID: _____________

Post-interview Visual Analog Scale

Please place a mark on the line that indicates how you are currently feeling in terms of shame.

Shame

____

Not at all Extremely

Please place a mark on the line that indicates how you are currently feeling in terms of guilt.

Guilt

____

Not at all Extremely

The PTSD Checklist for DSM-5 (PCL-5)

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:	**Not at all**	**A little bit**	**Moderately**	**Quite a bit**	**Extremely**
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4

In the past month, how much were you bothered by:	**Not at all**	**A little bit**	**Moderately**	**Quite a bit**	**Extremely**
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4

13. Feeling distant or cut off from other people?	0	1	2	3	4

In the past month, how much were you bothered by:	**Not at all**	**A little bit**	**Moderately**	**Quite a bit**	**Extremely**
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "superalert" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

(Weathers et al., 2013).

RECOVERY ASSESSMENT SCALE

Date: ______________________________

INSTRUCTIONS: Below is a list of statements that describe how people sometimes feel about themselves and their lives. Please read each one carefully and circle the number to the right that best describes the extent to which you agree or disagree with the statement. Circle only one number for each statement and do not skip any items.

	Strongly Disagree	**Disagree**	**Not Sure**	**Agree**	**Strongly Agree**
1. I have a desire to succeed.	1	2	3	4	5
2. I have my own plan for how to stay or become well.	1	2	3	4	5
3. I have goals in life that I want to reach.	1	2	3	4	5
4. I believe I can meet my current personal goals.	1	2	3	4	5
5. I have a purpose in life.	1	2	3	4	5
6. Even when I don't care about myself, other people do.	1	2	3	4	5
7. Fear doesn't stop me from living the way I	1	2	3	4	5

want to.					

	Strongly Disagree	**Disagree**	**Not Sure**	**Agree**	**Strongly Agree**
8. I can handle what happens in my life.	1	2	3	4	5
9. I like myself.	1	2	3	4	5
10. If people really knew me, they would like me.	1	2	3	4	5
11. I have an ideal of who I want to become.	1	2	3	4	5
12. Something good will eventually happen.	1	2	3	4	5
13. I'm hopeful about my future.	1	2	3	4	5
14. I continue to have new interests.	1	2	3	4	5
15. Coping with my mental illness is no longer the main focus of my life.	1	2	3	4	5
16. My symptoms interfere less and less with my life.	1	2	3	4	5
17. My symptoms seem to be a problem for shorter periods of time each time they occur.	1	2	3	4	5

	Strongly Disagree	**Disagree**	**Not Sure**	**Agree**	**Strongly Agree**
18. I know when to ask for help.	1	2	3	4	5
19. I am willing to ask for help.	1	2	3	4	5
20. I ask for help when I need it.	1	2	3	4	5
21. I can handle stress.	1	2	3	4	5
22. I have people I can count on.	1	2	3	4	5
23. Even when I don't believe in myself, other people do.	1	2	3	4	5
24. It is important to have a variety of friends.	1	2	3	4	5

(Giffort et al., 1995).

Psychopathy Checklist – Revised (PCL-R)

Item 1: Glibness/superficial charm

Item 2: Grandiose sense of self-worth

Item 3: Need for stimulation/proneness to boredom

Item 4: Pathological lying

Item 5: Conning/manipulative

Item 6: Lack of remorse or guilt

Item 7: Shallow affect

Item 8: Callous/lack of empathy

Item 9: Parasitic lifestyle

Item 10: Poor behavioral controls

Item 11: Promiscuous sexual behavior

Item 12: Early behavior problems

Item 13: Lack of realistic, long-term goals

Item 14: Impulsivity

Item 15: Irresponsibility

Item 16: Failure to accept responsibility for own actions

Item 17: Many short-term marital relationships

Item 18: Juvenile delinquency

Item 19: Revocation of conditional release

Item 20: Criminal versatility

(Hare, 2003).

The Historical, Clinical, Risk Management-20: Version 3 (HCR-20V3)

Historical Factors: History of Problems With…

H1. Violence

H2. Other Antisocial Behaviour

H3. Relationships

H4. Employment

H5. Substance Use

H6. Major Mental Disorder

H7. Personality Disorder

H8. Traumatic Experiences

H9. Violent Attitudes

H10. Treatment or Supervision Response

Clinical Factors: Recent Problems With…

C1. Insight

C2. Violent Ideation or Intent

C3. Symptoms of Major Mental Disorder

C4. Instability

C5. Treatment or Supervision Response

Risk Management Factors: Future Problems With…

R1. Professional Services and Plans

R2. Living Situation

R3. Personal Support

R4. Treatment or Supervision Response

R5. Stress or Coping

(Douglas et al., 2013).