

Violence, Aggression and Therapeutic Relationships: Understanding the Lived Experiences of
Females within Low and Medium Secure Forensic Mental Health Units.

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Statement of Terms

The term patient is my preference, accordingly throughout this thesis I refer to female users of secure forensic mental health (FMH) services as ‘patients’, or FMH users. The terms patient, service-user, client, and FMH users may be used interchangeably in reference to the works of other authors, or participants’ accounts.

The term ‘forensic mental health’ has been abbreviated throughout the thesis using the acronym ‘FMH’. Unless explicitly specified otherwise, this term is used to signify secure, as opposed to community, FMH services, or patients.

The term ‘therapeutic relationship’ has been abbreviated throughout the thesis using the acronym ‘TR’.

Research Summary

Aims: To explore female secure forensic mental health (FMH) patients' therapeutic relationship (TR) quality; the impact of witnessed, or perpetrated, violence upon psychological wellbeing and TRs; and perceived beneficial support following exposure to violence within the units.

Background: Female FMH patients possess unique vulnerabilities, psychological and offending profiles; have commonly experienced early childhood trauma, attracted Borderline Personality Disorder diagnoses, and by definition appear highly likely to witness or perpetrate violence. In other settings, strong TRs are consistently associated with positive outcomes, their significance is highlighted within FMH literature yet it is unknown how female FMH patients experience TRs with their clinical teams, or how witnessing or perpetrating violence affects these relationships.

Methodology: Qualitative methodology was employed within an interpretivist paradigm. 8 females were recruited through purposive homogenous sampling, across low and medium secure units. In-depth semi-structured interviews were conducted. Data was analysed by means of thematic analysis.

Results: Twenty themes, and accompanying subthemes, were extracted from participants' data. TRs are experienced as challenging, complex, multi-faceted; and impact upon wellbeing and recovery. Violence is perceived as 'normal', however incidents have a profoundly negative psychological impact, and affect journeys of recovery. Managing exposure to violence involves the need for patients to take care of themselves. Staff were perceived as trying their best but often getting it wrong, participants expressed the need for pro-active staff involvement. Participants perceived the damage caused to TRs by incidents, as predominantly due to negative changes in staff behaviours.

Conclusions: TRs serve a variety of important functions for female secure FMH patients. Witnessing or perpetrating violence negatively impacts upon TRs, wellbeing and recovery. Findings are discussed in relation to previous research, psychodynamic and systemic theories.

Implications are discussed regarding: the development and maintenance of TRs, improving psychological containment, FMH workforce development, and the broader management of violence.

CHAPTER ONE: INTRODUCTION

Within the present study, the lived experiences of female secure forensic mental health (FMH) patients are explored in relation to: therapeutic relationships (TR), witnessed or perpetrated violent incidents within the units, and the impact of incidents upon TRs. This chapter comprises six sections: the clinical context of secure forensic mental health (FMH) care, nature of therapeutic relationships (TRs), nature of violence and aggression, results of two systematic reviews exploring FMH patients' experiences of TRs and inpatients' lived experiences of violence and aggression. This chapter concludes with an overview of research questions and aims.

1.0 Part I: Secure Forensic Mental Health (FMH) Services

1.1 Nature of FMH Services

Secure FMH services offer containment and treatment for males and females within high, enhanced medium, medium, and low secure hospital settings (NHS Commissioning Board, 2013). Each security level reflects differing degrees of relational, procedural and physical security deployed to effectively manage risk (Department of Health, 2010); ensuring patients are detained within 'least restrictive' environments possible (Mental Health Act, 1983, 2007) while maintaining a therapeutic milieu conducive to promoting recovery. High secure services in England are provided within three 'special' hospitals for individuals who "require treatment under conditions of high security on account of their dangerous, violent or criminal propensities" (NHS Act, 2006). Medium secure FMH services provide a lower level of security than high secure services, in accordance with patients' needs. Low secure FMH services are less secure than medium secure FMH services but offer greater security than acute psychiatric wards. Within England and Wales, commissioners purchase approximately 795 high secure beds, 3192

medium secure beds, and 3732 low secure beds (NHS Commissioning Board, 2013b) The present study focuses upon female medium and low secure services.

The overarching objective of secure services is to facilitate patients' recovery through comprehensive and highly specialist multi-disciplinary assessment and evidence-based treatment of mental disorder, and reduction or management of the risk patients pose to themselves and others (NHS Commissioning Board, 2013). The delivery and provision of care is underpinned by extensive national standards and frameworks; criminal, civil and mental health legislation, best practice evidence, and National Institute for Health and Care Excellence (NICE) guidelines for disorder-specific treatment (for example: Criminal Justice Act, 2003; Department of Health, 2007, 2010; Joint Commissioning Panel for Mental Health, 2013; Mental Capacity Act, 2005; Mental Health Act, 1983, 2007; Tucker & Hughes, 2007; Tucker, Iqbal & Holder, 2012). Staff within secure services undertake extensive training mandated both by professional regulatory bodies, and internal FMH services, to ensure they are equipped with appropriate knowledge and competencies to maintain security, fulfil complex clinical duties, and realise service priorities (NHS Commissioning Board, 2013). All patients within secure services are detained under either civil or criminal sections of the Mental Health Act (1983, 2007), contingent upon patients' involvement with the Criminal Justice service.

1.1.1 Gender segregated care. Following the 1997 General Election, it became a political objective to eliminate the provision of mixed-sex psychiatric wards (Hillyer, n.d.). The Department of Health (DoH) pledged to ensure mixed-sex accommodation would be eliminated by 2002, thereby ensuring: "all patients are protected from physical, psychological or sexual harm...in recognition that the needs of male and female patients may be different" (Aitken & Noble, 2001, p. 75). Baroness Corston (Home Office, 2007) presented a key report at this time,

outlining concerns and observable shortcomings, regarding the treatment and experience of women within traditionally male-oriented Criminal Justice services, noting “high prevalence of institutional misunderstanding...of the things that matter to women and...[a] shocking level of unmet need” (Home Office, 2007, p.19). Secure services now tend to be gender specific, catering for the unique needs of males and females (Rethink Mental Illness, n.d.).

1.1.2 Relational, procedural and physical security. A defining feature of secure service provision is the approach adopted by staff to managing security, and promoting a therapeutic milieu. In addition to adhering to mainstream policy guidance (DoH, 2007), staff manage security across three key domains: physical, procedural, and relational (DoH, 2010). Management of physical security is achieved through measures designed to keep individuals physically safe, such as locks, fences, and personal alarms. Procedural security is managed through observance of institutional procedures and policies designed to promote safety and security. Relational security is managed through “the knowledge and understanding staff have of a patient and of the environment, and the translation of that information into appropriate responses and care” (DoH, 2010, p. 5). Relational security translates into factors such as the staff-to-patient ratio, and the amount of face-to-face time spent with patients. This encompasses an interpersonal balance between staff and patients (Kennedy, 2002) and appropriate clinical boundaries. Both patients and professionals emphasise the particular importance of relational security within female secure services (Parry-Crooke & Stafford, 2009).

1.1.3 Care-control dichotomy. Secure staff experience two opposing dimensions within their professional responsibilities; balancing custodial obligations alongside caring responsibilities (Reeder & Meldman, 1991). FMH staff may therefore represent both agents of care, and agents of social control (Jacob, 2012). Navigating these contradictory mandates means

FMH staff frequently also face unique challenges (Martin & Street, 2003; Mason, 2002; Willmott, 1997) affecting their ability to establish TRs, detrimentally impacting upon multidisciplinary team working, and increasing staff burnout (Ewers, Bradshaw, McGovern & Ewers, 2002; Volstead, 2008). FMH staff often experience tension and discomfort regarding the power they possess over patients' lives (Gillespie & Flowers, 2009; Jacob, 2012; Price & Wibberley, 2012).

1.1.4 Recovery. The meaning of 'recovery' within mental health lacks general consensus. Broadly, 'recovery' signifies hope and empowerment; that patients may live meaningful and fulfilling lives despite serious mental illness (Mental Health Foundation, n.d.). Repper and Perkins (2003) suggest 'recovery' comprises three key elements: hope, control, and opportunity. While the 'recovery' movement has been established within mainstream mental health services for some time, its application within secure FMH services has, until recently, received little attention. Incorporating the principles of 'recovery' within secure services is particularly challenging, for as Drennan and Wooldridge (2014) observe:

forensic settings are probably among the most difficult places to think of applying recovery principles. People in forensic services are doubly stigmatised with repeated or prolonged contact with the criminal justice system in addition to mental health problems (p. 1).

Unlike patients within general mental health services, FMH patients are typically tasked with 'recovering' from feelings of personal guilt resulting from crimes preceding their detention (Drennan & Alred, 2012). Nonetheless, there is evidence of emerging interest regarding how the recovery paradigm may be incorporated within FMH settings, (for example: Aiyegbusi & Clarke-Moore, 2008; Drennan & Alred, 2012) signifying the importance and relevance of understanding TRs within such services (Roberts & Boardman, 2014; Schinkel & Dorrer, 2007).

1.1.5 Female FMH populations. Females represent a growing minority within secure services, constituting approximately 20% of low and medium secure populations (Bartlett & Hassell, 2001; Rutherford & Duggan, 2008). Compared to males, female patients are more likely to be detained in secure services under civil, rather than criminal, sections of the Mental Health Act (1983, 2007); representing more of a risk to themselves than others (Bartlett, Somers, Fiander & Harty, 2014). Females tend to receive more psychiatric admissions under Part II of the Mental Health Act prior to entry into FMH services, and are typically admitted from NHS settings rather than the Criminal Justice Service (Lambert & Turcan, 2004). Females appear twice as likely to receive personality disorder (PD) diagnoses compared to males, predominantly borderline personality disorder (BPD), whereas males tend to receive diagnoses of antisocial or schizoid personality disorders (Coid, Kahtan, Gault & Jarman, 2000). Some commentators suggest male and female patients possess similar core vulnerabilities, but that females characteristically attract BPD – rather than antisocial - diagnoses owing to culturally shaped attitudes towards females (Paris, 1997). Females within secure services who have attracted BPD diagnoses tend to have a poorer prognosis compared to females treated within general psychiatric services, and display more disturbed behaviour, such as deliberate self-harm (DSH), compared to other patient populations (Coid, Kahtan, Gault & Jarman, 2000). Estimates suggest approximately 55% of female secure patients have been victims of childhood sexual abuse (Dolan & Whitworth, 2013); a substantially higher prevalence than for males (Maden, Skapinakis, Lewis, Scott, Burnett & Jamieson, 2006). Female patients also appear significantly more likely than males to have experienced abuse, relationship problems and coercion within their routes into secure services, be primary carers of young children, and be placed greater distances from their families (Home Office, 2007). Consequently, females present unique challenges and vulnerabilities within secure FMH services.

1.2 Part II: Therapeutic Relationships

1.2.1 Nature and Importance of Therapeutic Relationships

1.2.2 Defining Therapeutic Relationships. The concept of TRs, formally rooted within early psychodynamic literature (Freud, 1912), describes the relational dynamics between a provider and recipient of psychoanalysis, and healthcare more generally. Also referred to as the ‘helping alliance’, ‘working alliance’ and ‘therapeutic alliance’, TRs are viewed as comprising three elements: the ‘working alliance’, transference and countertransference, and the ‘real’ relationship (Gelso & Carter, 1994). In contrast with social relationships, TRs involve: functional and deliberate selection, formal initiation, duration, and termination boundaries, goal-directed and purposeful interactions, professional emotional distance and objectivity, the absence of dual-relationships, adherence to clearly defined legal, ethical and professional guidelines, confidentiality, non-judgemental positive regard, and boundaries relating to professionals’ self-disclosure (Knapp, 2007).

TRs are traditionally constructed and researched within one-to-one therapeutic contexts. While Peplau (1952) is credited with first delineating TRs within nursing practice, and Altschul (1972) later explored ‘special’ relationships between patients and nurses, the history of TRs between patients and teams of healthcare providers may be traced to the Asylum era of the 19th Century (O’Brien, 2001). Institutional policies of non-restraint, acknowledgement of the reparative significance of interpersonal relationships (Weir, 1992) and observation that asylum attendants functioned as therapeutic agents (O’Brien, 2001) suggests the importance of TRs was recognised within even the earliest examples of institutional mental health care provision.

1.2.3 The power of TRs. Consistently, TR quality has been found to influence outcomes and patient satisfaction across wide-ranging mental health conditions and contexts (Castonguay

& Beutler, 2006; Gilbert, Rose & Slade, 2008; McGuire-Snieckus, McCabe, Catty, Hansson & Priebe, 2008; Priebe & McCabe, 2008). Within one-to-one contexts, perceived TR quality correlates more highly with positive treatment outcomes than treatment interventions themselves (Lambert & Barley, 2001); indeed:

decades of research indicate that the provision of therapy is an interpersonal process in which a main curative component is the nature of the therapeutic relationship. Clinicians must remember that this is the foundation of our efforts to help others (Ibid, p. 1).

Within high secure populations TRs serve as catalysts for effecting therapeutic change, and positive TR experiences may promote patients' engagement with wider FMH team members (Willmot & McMurrin, 2014). TR satisfaction has been found within medium secure services to moderate the therapeutic milieu (Bressington, Steward, Beer & MacInnes, 2011). Moreover, the development of TR building competencies is emphasised within FMH professionals' core training (Kettles, Woods & Byrt, 2008; Nursing & Midwifery Council, 2004).

1.2.4 TRs within secure FMH services. Within secure FMH services, the importance of TRs is emphasised within policy literature (DoH, 2007, 2007b, 2010). However FMH patients' TRs may differ from traditional conceptualisations (Skeem, Loudon, Polaschek & Camp, 2007). As professionals within FMH services simultaneously fulfil therapeutic and criminal justice obligations, TRs may be uniquely challenging (Bowring-Lossock, 2006). Effectively balancing dual-role responsibilities is experienced as the most challenging, yet significant factor, determining successful TRs within secure services (Trotter, 1999). Despite moves towards implementing 'recovery' principles within secure services, the nature of compulsory detention complicates TRs, as patients often do not genuinely collaborate within treatment processes. FMH patients may also perceive treatment as more coercive compared to patients within mainstream mental health services (Kallert, 2008). While coercion may not necessarily influence patient

satisfaction (Sorgaard, 2007), satisfaction correlates highly with TR perceptions (Bressington, Stewart, Beer & MacInnes, 2011).

A number of models have been theorised, and applied, within secure services, to define and conceptualise the nature and goals of TRs, barriers to TR formation, and functional value of TRs for facilitating patients' recovery (for example: Barker, 2002; Ross, Polaschek & Ward, 2008). However, such models are constructed from the perspective of FMH professionals, and little to no research exists, or theoretical conceptualisations have been proposed, exploring TRs from patient perspectives. The lived experiences, views and preferences of patients within secure services remains under-researched, markedly so in comparison to patients within mainstream mental health services (Coffey, 2006; Long, Knight, Bradley & Thomas, 2012). Available research findings indicate that good communication skills, empathy, compassion, respect, a collaborative stance, and the ability to foster motivation and hope, are qualities patients value in TRs (Craik et al 2010; Jacobs, Bruce, Sonigra & Blakesley, 2010; Long et al, 2012). However patients may experience difficulties in forming trusting and collaborative TRs, and appear sensitive to FMH professionals' power (Morrison, Burnard & Phillips, 1996; Schafer & Peternelj-Taylor, 2003).

1.2.5 TRs with female FMH patients. Several documented gender differences exist between males and females within secure services, all of which may influence TRs with staff. Females tend to perpetrate fewer crimes, target violence towards individuals with whom they already have an established relationship, and appear proportionately more likely to be detained within higher levels of security (Sarkar & Di Lustro, 2011). Females also typically demonstrate higher rates – and severity – of trauma-related and affective disorders. Failure to attend to

gender-differences in TRs with female patients has historically preceded deplorable boundary violations and gross professional misconduct (DoH, 1992).

TRs with female FMH patients are complicated by the nature of presenting mental health difficulties, specifically the high prevalence of personality disorder (PD)¹ and experiences of childhood and adulthood abuse. Survivors of abuse may be wary of establishing collaborative TRs, fearing they may be taken advantage of. Female patients may perceive TRs as potentially dangerous and threatening, and be sensitive to the power staff possess, compounding feelings of shame and anger (Bender, 2005; Haskell, 2004). Sarker and Lustro (2011) argue childhood abuse may trigger an interaction between predisposing biological factors and evolutionary life stressors at a crucial period for women, installing a disordered attachment template affecting all subsequent relationships. The association between early childhood abuse and a spectrum of trauma-related and interpersonal disorders, including BPD, is well established (Baird, 2008). PDs, by definition, are associated with considerable interpersonal impairments, and TRs with this patient population possess a unique emotional intensity, and high levels of expressed anger. Herman (1997) observed:

[relationships] are driven by the hunger for protection and care and are haunted by the fear of abandonment or exploitation...she may seek out powerful authority figures who seem to offer the promise of a special care taking relationship...Inevitably, however, the chosen person fails to live up to her fantastic expectations...she may furiously denigrate the same person whom she so recently adored. Ordinary interpersonal conflicts may provoke intense anxiety, depression, or rage...even minor slights evoke past experiences of callous neglect, and minor hurts evoke past experiences of deliberate cruelty. These distortions are not easily corrected...thus the survivor develops a pattern of intense, unstable relationships, repeatedly enacting dramas of rescue, injustice, and betrayal (p. 111).

¹ As a clinician, I do not believe labelling patients is necessarily helpful. Nonetheless, I work within - and this study was conducted within - a context in which psychiatric diagnoses are the primary language by which professionals communicate (Allen, 2004). Psychiatric diagnoses are adopted within the present study for ease of labelling groups of individuals who appear to share similar psychological, emotional, and behavioural characteristics; in keeping with the dominance of medicalised language within FMH services. However, see Bentall (2009) or Zigler and Phillips (1961) for a comprehensive psychological review regarding the validity and reliability of psychiatric diagnoses.

Within this context, abundant research highlights FMH professionals' dissatisfaction in working with patients diagnosed with PDs (Bowers, McFarlane, Kiyimba, Clark & Alexander, 2000). Patients with BPD evoke strong counter-transference and judgement from staff as being manipulative, hostile, uncooperative, and boundary-pushing (Noak, 1995). As a result of professionals' emotional reactions, patients are at risk of alienation within TRs, precipitating relationship breakdown (Hamera & O'Connell, 1981; Smith & Hart, 1994) and increasing suicide risk (Gunderson, 1984).

The importance and significance of establishing strong TRs when working with patients who have attracted BPD diagnoses is emphasised within disorder-specific treatment guidance (NICE, 2009); and FMH policy for females (DoH, 2007b). The reparative power of TRs for restructuring historical relationship patterns is recognised (National Institute for Mental Health, 2003), and relationship building has been identified as particularly important within female FMH settings (Batchelor & Burman, 2004). Research suggests that TRs are of central importance to females journeying through secure services, and that feeling understood as an individual, having someone to talk to, and having their emotional experiences validated, is a fundamental cornerstone of recovery (Parry-Crooke & Stafford, 2009). However limited research has considered the lived experiences of females diagnosed with BPD within FMH services, or their experiences of TRs with staff.

1.3 Part III: Violence and Aggression

1.3.1 Defining Violence and Aggression

Difficulties in defining violence and aggression are evident within psychological discourse (Duxbury, 2002; Rippon, 2000). Aggression has been conceptualised as a heterogeneous concept, incorporating a wide range of behaviours (Conner & Barkley, 2004).

Broadly, aggression is defined as a range of harmful behaviours which defy social customs and reflect the objective of injuring another person physically or psychologically, or of harming an object (Bandura, 1973; Berkowitz, 1993). Researchers differentiate between two forms of aggression: affective, and instrumental. Affective, or hostile, aggression typically occurs in response to intense emotions in a reactive, rather than pre-meditated manner, and involves high levels of autonomic arousal (Lindsay & Anderson, 2000; Meloy, 2002). Instrumental aggression involves the pre-meditated use of aggression as a means of achieving a superordinate goal, (Bushman & Anderson, 2001). Definitions of violence appear more concrete, perhaps reflecting the more frequent use of this term within FMH services, although differences within definitions are apparent (Douglas, Hart, Webster & Belfrage, 2013; WHO, 2015). Standard FMH risk assessment tools, such as the Historical Clinical Risk Management-20 (HCR-20) scale, favour a broad definition, defining violence as “actual, attempted, or threatened harm to a person or persons” (Douglas, Hart, Webster & Belfrage, 2013). Congruent with the context of the current study, the definition offered within the HCR-20 is adopted. Violence may be self-directed, collective, or interpersonal; and violent acts may be: sexual, psychological, physical or emotional in nature (WHO, 2015). Violence may also be perpetrated through affective or instrumental means (Daffern, Jones & Shine, 2010). While the terms aggression and violence are often used interchangeably, the two concepts represent different psychological phenomenon. Individuals exhibiting aggression do not necessarily act out their feelings through violence, whereas all acts of violence are inherently aggressive.

1.3.2 Violence and aggression within female secure FMH services. Within offending pathways, females appear less likely than males to have involvement in: serious violence, violent or sexual crimes against the person, indecent assault, murder, robbery, and firearm offences (Coid, Kahtan, Gault & Jarman, 2000), and appear more likely to have an index offence of arson

(Gorsuch, 1999). Females appear proportionately as likely, or more likely, as males to commit acts of violence within FMH services (Peloula, Mela & Adelugba, 2013; Rix & Seymour, 1988).

In examining the nature and occurrence of violent incidents within medium secure units, Gudjonsson, Rabe-Hesketh and Wilson (2000) found that females perpetrated a spectrum of violent behaviours across comparable levels of severity to males, and violence was more likely to be directed towards nursing staff if the patient was female and detained on a civil section. PD diagnoses, substance abuse difficulties, and early childhood trauma are prevalent risk markers within females who perpetrate violence (Weizmann-Henelius, Viemero, & Eronen, 2004). The relationship between early childhood trauma and propensity to commit adulthood violence has been examined extensively (Whitfield, Anda, Dube & Felitti, 2002; Van der Kolk, 1989).

Within females, PD diagnoses appear to predict repeated acts of violence (Owen, Tarantello, Jones & Tennant, 1998), and patients possessing histories of violence and victimisation appear more likely to commit violence and require restraint (Flannery, 2002). Females appear less likely to exhibit aggression whilst involved in an 'event' (Nicholls, Brink, Greaves, Lussier, & Verdun-Jones, 2009) and more likely to commit self-directed acts of violence (Bland, Mezey, & Dolan, 1999). Female secure services have been referred to as "hot beds" of self-harm (Favazza, 1998), and within high secure services 94% of female patients have been found to self-harm (Bland, Mezey & Dolan, 1999). The coercive nature of FMH services may indeed increase the likelihood of female self-harm (Shaw, 2002).

Staff miscommunication (Mellesdal, 2003) and provocation (Cooper, Brown, McLean, & King, 1983) are associated with increased violence. Professionals appear more likely to explain violence involving females as resulting from 'attention-seeking behaviour' (ibid). Patient

accounts indicate threatening staff negatively influences quality of care (Arnetz & Arnetz, 2001); and research with FMH professionals indicates exposure to violence may influence staff attitudes and behaviours towards all patients aside from violence-perpetrators (Wright, Gray, Parkes & Gournay, 2002). FMH professionals have been found to employ a range of interpersonal coping strategies to manage the effects of violence such as: distancing, avoidance, and confrontive coping, wherein aggression and hostility are used to alter situations (Whittington & Whykes, 1994a). Such attempts to cope may serve to provoke further violence (Whittington & Whykes, 1994b) and activate a breakdown in TRs through a process of malignant alienation (Watts & Morgan, 1994).

Research conducted with prison populations highlights exposure to violence may trigger individuals to re-experience earlier traumas, and precipitate self-harm (Hochstetler, Murphy & Simons, 2004). Detention itself may provoke anxiety, the urge to self-harm, withdraw, and mistrust others (Cooke, Baldwin & Howison, 1990). Females within prisons classically exhibit poorer health outcomes compared to males (Douglas & Plugge, 2006), and females who have experienced abuse appear prone to re-traumatisation following regular criminal justice procedures (Moloney, Van Den Bergh & Moller, 2009). However, female patients' lived experiences regarding the impact of witnessing or perpetrating violence upon psychological wellbeing, and TRs, has not – to the best of the author's knowledge - received any research attention to date.

1.3.3 Risk management within secure FMH services. The need to protect patients from violence is established (National Institute for Health and Clinical Excellence, 2015), yet the complexities and challenges faced within FMH services results in high numbers of incidents (Green, McIntosh & Barr, 2008; Bowers et al, 2011). Violence within secure settings is

widespread (Gudjonsson, Rabe-Hesketh & Wilson, 1999; Green & Robinson, 2001; Agarwal & Roberts, 1996), reflecting the degree of risk posed by patients qualifying for secure care. It is unknown how female FMH patients experience professionals' risk management strategies, or the support they would find valuable following witnessed or perpetrated incidents within secure services.

1.4 Part IV: Theoretical Links

1.4.1 Theoretical Conceptualisations of TRs and Violence

Theoretical understandings of TRs within secure services are presented from developmental, psychodynamic and systemic perspectives. FMH policy and initiatives reflect psychodynamic and developmental concepts, for example relational security is based upon the principles of attachment theory (Bowlby, 1988; DoH, 2007). Systemic perspectives help to address relational dynamics within complex human systems like secure units. Psychodynamic and systemic perspectives complement one another in providing individualistic versus broader systems focused theoretical understandings, both orientations are commonly referenced within FMH literature (for example: Aiyegbusi, 2009; Bartlett & McGauley, 2010).

1.4.2 Attachment Theory. Bowlby (1988) theorised infants are born pre-programmed to form attachments with caregivers, to guarantee basic survival. The internal attachment representations, infants form in relationships with primary caregivers imprints internal working models, or cognitive templates, which shape their view of themselves, the world, and others. Ainsworth (1970) empirically refined Bowlby's theory, constructing four attachment styles: secure, insecure-avoidant, insecure-ambivalent, and disorganised; with each pattern hypothesised as resulting from different attachment experiences. Pat Crittenden later expanded upon the work of Bowlby and Ainsworth, proposing the Dynamic Maturational Model (DMM). Within the

DMM, patterns of ‘attachment’ describe interpersonal differences regarding strategies individuals deploy for self-protection, and obtaining a reproductive mate. The DMM is underpinned by five central ideas: attachment patterns are self-protective, and learned through interactions with attachment figures, ‘symptoms’ of psychopathology are functional, attachment strategies change according to context, and the treatment of ‘pathology’ should focus upon attachment strategy and context synergy (Crittenden, 2005).

While an individual’s attachment style may be modified through positive relational experiences (Hendrix & Hunt, 2004) and therapeutic re-parenting (Archer & Gordon, 2013), attachment styles are thought to remain relatively stable across the lifespan (Collins & Read, 1994) and become ‘activated’ when an individual feels threatened (Crittenden & Landini, 2011). Early attachment relationships imprint infants’ capacities for emotional regulation (Sroufe, 1990), resulting in different capacities for emotional regulation and mentalisation within adults (Cooper, Shaver & Collins, 1998; Fonagy, 1999). Problems here are implicated in the development and presence of various psychopathologies (Riggs, Sahl, Greenwald, Atkison, Paulson & Ross, 2007).

BPD can be conceptualised as the manifestation of psychopathology resulting from problematic early attachments. Attachment theory can account for the impulse and affect dysregulation, dysfunctional relationship patterns, and propensity towards high conflict characteristic of BPD (Fonagy, 1999). The parallels between trauma, neglect, early attachment issues and BPD symptomatology are well established (Fonagy, 1999; Mosquera, Gonzalez & Leeds, 2014). Strong associations exist between BPD and insecure-anxious attachment representations. Estimates suggest between 50-80% of patients diagnosed with BPD exhibit insecure-anxious or insecure-disorganised attachments (Agrawal, Gunderson, Holmes & Lyons-

Ruth, 2004). Within secure FMH services, this carries implications for the manner with which patients ‘attach’ to the FMH system, and form TRs with the staff within it. Due to early experiences of unavailable, inconsistent and distrustful attachment figures, female FMH patients with insecure-anxious attachments may appear highly rejection-sensitive and hypervigilant towards perceived or actual rejection by staff; and deploy pre-emptive strategies to avoid abandonment. Such individuals may require substantial reassurance and validation, and experience intense anger if reassurance is not provided. Patients may fear expressing themselves, anticipating rejection, in turn leading to extreme emotions such as anger, which may precipitate aggressive behaviours (Catlett, 2009).

Within early attachment relationships, female patients displaying insecure-disorganised attachments are theorised as having developed working models of caregivers as simultaneously sources of love and abuse. Through the experience of inconsistent parenting, such females may have failed to develop an ‘organised strategy’ for keeping themselves safe in frightening situations. As adults, such patients may struggle to make sense of, and form a coherent narrative of their experiences, find it difficult to approach staff for help, and find it extremely difficult to establish trust and sustain TRs over long periods. Patients with disorganised attachments may struggle to self-soothe in times of distress and due to poor distress-tolerance they may be prone to ‘acting out’ violent behaviours (Firestone, 2009).

Attachment theory offers valuable information FMH staff may draw upon to inform their work with female patients. For example: the provision of a ‘safe base’ from which patients may resolve intrapsychic and interactional conflict (Adshead, 2011). Attachment theory may beneficially inform the work of nursing staff when attempting to understand and manage

problems arising in TRs (Pfafflin & Adshead, 2004). More broadly, attachment theory underpins the concept of ‘relational security’ (DoH, 2007).

Primary attachment relationships may serve evolutionary purposes, by socialising infants to aggression and taming destructive impulses (Fonagy, 2003). In infancy children learn capacities for emotion regulation with support, modelling and guidance from primary attachment figures (Schore, 1996). If these capacities fail to develop, infants may grow into adults who possess maladaptive strategies for dealing with distress (Briere, 1992). A propensity towards violence may consequently represent a failure within normal developmental processes (Fonagy, 2003).

Experiences of a rejecting attachment figure may mean infants fail to learn adaptive techniques for managing frustration, developing anger as a primary response for challenging others (Fonagy, 1999b). Violence within FMH patients may therefore be conceptualised as stemming from maladaptive regulation of negative feelings, wherein overwhelming emotions translate into maladaptive action (Fonagy, Target, Steele & Steele, 1997). Anger appears to manifest differently according to attachment style. FMH patients displaying preoccupied attachment styles may express anxiety and irritation, and blame others for their distress; finding it difficult to be soothed by others. Patients with anxious attachment styles may express anger through targeted aggression and violence, both internally against themselves and externally towards others (Mikulincer & Shaver, 2007). Patients with dismissive/avoidant attachment representations may express anger in reactive ways, by devaluing others and deploying anger instrumentally to achieve relational distance and control (Ibid).

1.4.3 Psychodynamic links.

1.4.4 *Transference and countertransference.* Transference and countertransference are psychodynamic concepts, first coined by Freud (1912). Transference describes the unconscious, and inappropriate, transfer of an individual's attitudes and feelings from a figure in the past on to a person in the present (Hughes & Kerr, 2000). Within the context of the present study, this relates to the transfer of patients' feelings onto FMH professionals. Countertransference describes the emotions and thoughts elicited within individuals as a result of transference projections (Hughes & Kerr, 2000). This relates to the feelings evoked within FMH staff as a consequence of patients' transference projections. Transference is elicited more strongly in situations where individuals feel vulnerable, have 'borderline' features, have frequent contact with carers, and fear for aspects of their physical and emotional safety (Hughes & Kerr, 2000). Consequently, intense transference projections are likely abundant within FMH patients' TRs.

Little is known regarding patients' experiences of transference within secure FMH services, however as many have histories involving abusive and exploitative attachment figures, and display a tendency towards misattributing negative qualities within neutral situations (Donegan et al, 2003), they may likely project inappropriate feelings of anger, anxiety, avoidance, dependency, and sexual interest (Bradley, Heim & Westen, 2005). Transference and countertransference between FMH staff and patients is often complex and 'toxic' (Moore, 2012). Recipients of transference projections may experience stressful, painful, intense and angry countertransference (Hughes & Kerr, 2000). Within TRs staff may additionally experience vicarious traumatisation (Perlman & Saakvitne, 1995) through confrontation with the intensity and extent of patients' trauma. Working with high risk offenders may elicit 'perverse' transference and countertransference (Mason, 2002), and while politically and socially undesirable it is considered by some almost inevitable that FMH staff experience hate in the

countertransference (Kay, 2009; Winnicott, 1994). The difficulty of managing such feelings may be compounded by the reluctance of FMH staff to acknowledge intensely negative feelings they experience, as this conflicts with traditional role conceptions. Nonetheless, feelings experienced by FMH staff within the countertransference are likely to manifest, for example through verbal slips or behaving uncharacteristically (Kay, 2009).

In order to manage intense transference and countertransference FMH nursing staff appear overreliant upon procedural methods to regain interpersonal ‘control’ (Maier & Van Rybroek, 1995). Blindness to issues of transference and countertransference within TRs may lead to the unconscious ‘acting out’ of roles projected on to FMH staff by female patients, reinforcing patients’ maladaptive relationship patterns, reducing treatment efficacy, and potentially catalysing a breakdown in TRs. Following incidents of violence, FMH staff may experience challenging split-countertransference, wherein they simultaneously hold in mind the subject and object of ‘perpetrator’ and ‘victim’ (Mizen, 2003). For example:

at one moment you are upset on their behalf and sympathetic because they have been terribly abused as children themselves, and the next minute you are loathing them for what they are doing (Alvarez, 1997, p.431).

Fear in the countertransference may warp FMH professionals’ perceptions of patient dangerousness, and influence clinical management (Lion & Pasternak, 1973).

1.4.5 Psychodynamic defences. Psychodynamically, ‘defence mechanisms’ are theorised as unconscious defences of the ego, deployed in times of distress to reduce and manage anxiety (Freud, 1937). Valliant, Bond and Valliant (1986) proposed a hierarchy of defences, categorised within 4 levels from the unhealthiest to healthiest responses, termed: pathological, immature, neurotic, and mature. Typically, individuals diagnosed with BPD, rely upon deploying ‘immature’ defences (Zanarini, Frankenburg & Fitzmaurice, 2013), which may be observable

within TRs with FMH staff. Within a specialist forensic PD service, Huband, Duggan, McCarthy, Mason and Rathbone (2014) observed depressive functioning was typically less 'mature' within patients compared to a non-clinical control sample, and identified Axis II severity negatively correlated with overall defensive functioning. Immature defences signify emotional impairment but do not distort reality in the same way as the lowest level of defences, and include strategies such as: 'acting out', fantasy, idealisation, introjection, passive aggressiveness, projective identification, projection, somatisation and wishful thinking. Used within a normative frequency, defence mechanisms are considered adaptive 'survival tools' (Fine, 1988) essential for everyday functioning (Cramer, 2006). However an over reliance upon, and limited repertoire of, defences, associated with Axis I and Axis II psychopathology (Watson, 2002), can bestow wide-ranging negative consequences (Galor, 2014), and a lack of genuineness, honesty and intimacy within relationships. Consequently, over-reliance on immature defence mechanisms by female FMH patients may inhibit the formation and maintenance of genuine and meaningful TRs (McGauley & Humphrey, 2003).

Violence may represent an act of 'splitting' and 'projection', wherein patients split off unwanted parts of the mind and project violent aspects of their internal worlds through their behaviour (Mizen, 2003). Mizen (2003) suggested violence:

performs the function of evacuating undifferentiated affects, which are felt to be violating and for which there is felt to be no satisfactory internal object or internal object relationship available as a container (p.301).

Patients therefore may project unwanted parts of their internal worlds, seeking metaphoric 'holding' or containment of negative affective states by staff. Within psychiatric inpatients, mechanisms of displacement have been found to differentiate between violent and non-violent patients. Patients deploying mechanisms of repression are associated with internalised violence whereas denial and projection are associated with externalised violence (Apter, Plutchik, Sevy,

Korn, Brown & Van Praag, 1989). Defences of projection and denial have also been associated with violence against strangers within non-clinical populations (Porcerelli, Cogan, Kamoo & Leitman, 2004).

1.4.6 Systemic links. The application of systemic theory to TRs has been markedly under-researched (Flaskas, 1997; Fredman, 2008). To the best of the author's knowledge, systemic theories have not been applied to conceptualising TRs or violence and aggression within FMH contexts. Within systemic thinking, 'problems' are viewed as intrinsically relational. Relationships are emphasised as central within the development of individuals' identity and experiences (Dallos & Draper, 2010). As individuals interact with one another, they engage in a 'creative process' which leads to the co-construction of behaviour and meanings. Consequently, the nature and experience of TRs, and incidents of violence, between FMH patients and staff can be said to represent evolving processes, as opposed to being pre-determined by individual characteristics each party may bring to the relationship (Ibid). Based upon feedback, 'circularities' may emerge within TRs, representing mutually determined patterns of action over time. Dallos and Draper (2010) argue systems theory represents a theory of stability, and suggest that once relationship patterns are established certain 'homeostatic tendencies' compel a system to remain the same. Ingrained relational patterns, and acts of violence, between patients and staff may serve a homeostatic function within the wider FMH system; perhaps in reaffirming power structures and roles.

1.4.7 Family Systems Theory (FST). Bowen (1993) outlined that within families, members have both adopted roles, and rules to follow. Family members interact with one another in accordance with roles, and within the family system interactional patterns develop whereby family members' behaviours mutually influence each other. Maintenance of relational patterns

within the system create homeostasis (Dallos & Draper, 2010) but may also precipitate dysfunction. Parallels may be drawn between the nature of families, and TRs within secure FMH units; wherein both patients and staff have clearly defined and boundaried ‘roles’ and ‘rules’ both groups may relationally act out. The nature of, and difficulties within, TRs may represent patients’ enactment of the ‘role’ they have been ascribed internally from the FMH system (Katz & Kahn, 1966) and externally from socio-political discourse emphasising ‘badness’ and ‘madness’ (West, Yanos & Mulay, 2014; Prins, 2015). By behaving and relating in recognisably dysfunctional ways, patients’ interactions with FMH staff may affirm staff custodian roles and power, maintaining balance within the FMH system. This would suggest ‘dysfunction’ within TRs possesses functionality (Dallos & Draper, 2010).

Microsystem factor theories, such as the Intrafamilial Stress Theory, focus upon the stresses inherent within social structures (Hyde-Nolan & Juliao, 2011). Certain stressors may create situations which place significant burden upon systems, especially when resources and time are limited, precipitating violent behaviour (Malley-Morrison & Hines, 2004). For instance, within FMH services, austerity cuts and diminished time and resources may interact with staff and patient beliefs to influence the likelihood of either group behaving violently (Crouch & Behl, 2001).

1.4.8 Relationship to help-seeking. Social constructionism, the language upon which systemic theory relies (Fredman, 2008) implies the beliefs FMH patients and staff construct about what is involved in ‘helping’ relationships may impact upon TRs, and violence. Patients’ and professionals’ experiences and constructs regarding what it means to be the receivers, and providers, of help, invariably influences the nature of their interactions, or the TR (Fredman, 2008). FMH patients with destructive experiences of help seeking may anticipate that FMH

professionals will behave in withholding, abusive, rejecting or incompetent ways. Similarly, FMH staff may possess beliefs about the nature in which ‘help’ is appropriately given, and experience frustrations if patients do not fulfil expectations for receivers of care. The constructed beliefs FMH staff bring to TRs may be further influenced by the proscribed nature of ‘appropriate’ relationships and boundaries imposed by the wider FMH system (Aiyegbusi & Kelly, 2012; DoH, 2007). Beliefs and expectations held by FMH patients and staff may congruently complement one another, resulting in positive and adaptive working dynamics, or appear mismatched thereby creating dynamics of conflict.

1.5 Part V: Systematic Reviews

Two systematic reviews are presented. The first review examines FMH patients’ experiences of TRs. The second review examines acute psychiatric inpatients’ lived experiences of violence and aggression.

1.5.1 Article Identification

Four databases were systematically searched to identify appropriate papers for each review. Search limiters and expanders were applied to identify appropriate articles. Initially identified articles were evaluated for relevance against specified inclusion criteria. The article search strategy and inclusion flow charts for reviews one and two are outlined within Appendices A and B respectively.

1.5.2 Article Review Procedure

1.5.2.1 Promoting quality. Measures to enhance trustworthiness were adopted, through engagement in the area to promote credibility, the provision of ‘thick’ descriptive accounts

(Ryle, 1949), and reflexively ‘bracketing’ (Ahern, 1999) assumptions and preconceived ideas, promoting confirmability and transferability (Lincoln and Guba, 1985).

It has been argued that only high-quality articles should be included within systematic reviews (for example: Slavin, 1987), with researchers referencing the analogous risk of ‘garbage in, garbage out’. Other researchers argue all appropriate studies should be included (for example: McPherson & Armstrong, 2012, Scruggs & Mastropieri, 1998). Regardless of the position adopted, Schlosser (2007) conveyed a review of quality should always be offered; affording readers a context within which to interpret findings. Articles were not excluded from review based upon quality appraisal.

Approaches to evaluating quality within qualitative research lack common consensus due to methodological and paradigmatic diversity (Gomez, 2009). All appropriate articles for both reviews were screened against two recognised quality appraisal tools, through systematic application of the Critical Appraisal Skills Programme (CASP) (CASP, 2010) and the QualSyst tool (Kmet, Lee & Cook, 2004). Quality appraisal information is viewable within Appendices C and D for reviews one and two respectively.

1.5.2.2 Data identification and analysis. What constitutes appropriate ‘data’ for extraction and analysis within qualitative syntheses is debated within academic discourse (Thomas & Harden, 2008). The approach of Thomas and Harden (2008) was adopted whereby all information labelled as ‘findings’ or ‘results’, relevant to the areas of review, was extracted and analysed. Each reviewed article, for both systematic reviews, was read twice to achieve immersion within the review process (Cruzes & Dyba, 2011). Relevant data was extracted from each article, copied and saved within individual word documents, and transferred for review

within the MAXQDA qualitative analysis package (VERBI Software Consult. Sozialforschung GmbH, 2012). Two MAXQDA files were created, one for each systematic review.

1.5.2.3 Data synthesis. Data synthesis followed the principles of thematic synthesis outlined by Thomas and Harden (2008). Thematic analysis (TA) methodology was deemed appropriate for synthesising data, for allowing identification, analysis and interpretation of rich descriptive accounts (Cruzes & Dyba, 2011). TA is congruent with the project's epistemological and ontological positioning.

Data was systematically coded, and preliminary descriptive themes were developed. An inductive approach to code development was adopted, to remain 'close' to the original data (Thomas, 2003). Codes were compared within and across datasets to ensure they reflected similar content, through a process of 'constant comparison' (Cruzes & Dyba, 2011). Coded segments were compared to develop analytic themes, 'going beyond' the original data, characterising thematic synthesis (Thorne, Jensen, Kearney, Noblit & Sandelowski, 2004). Some articles explored both staff and patient experiences; only results explicitly pertaining to patients' experiences were extracted, analysed and synthesised. The majority of articles' research aims focused upon issues unrelated to the focus of the systematic reviews; only findings related to the areas of review were analysed.

A summary of reviewed articles for reviews one and two are presented within Appendices E and F respectively. The prevalence of identified themes across reviewed articles is summarised for reviews one and two within Appendices G and H. respectively, adapted from McPherson and Armstrong (2012).

1.6 Systematic Review One: FMH Inpatients' Experiences of TRs.

Twelve articles were synthesised and reviewed to explore FMH inpatients' lived experiences of TRs. Figure 1 presents a hierarchical model highlighting the frequency with which themes were extracted from articles (adapted from: Van Wesel, Boeije, Alisic and Drost, 2012).

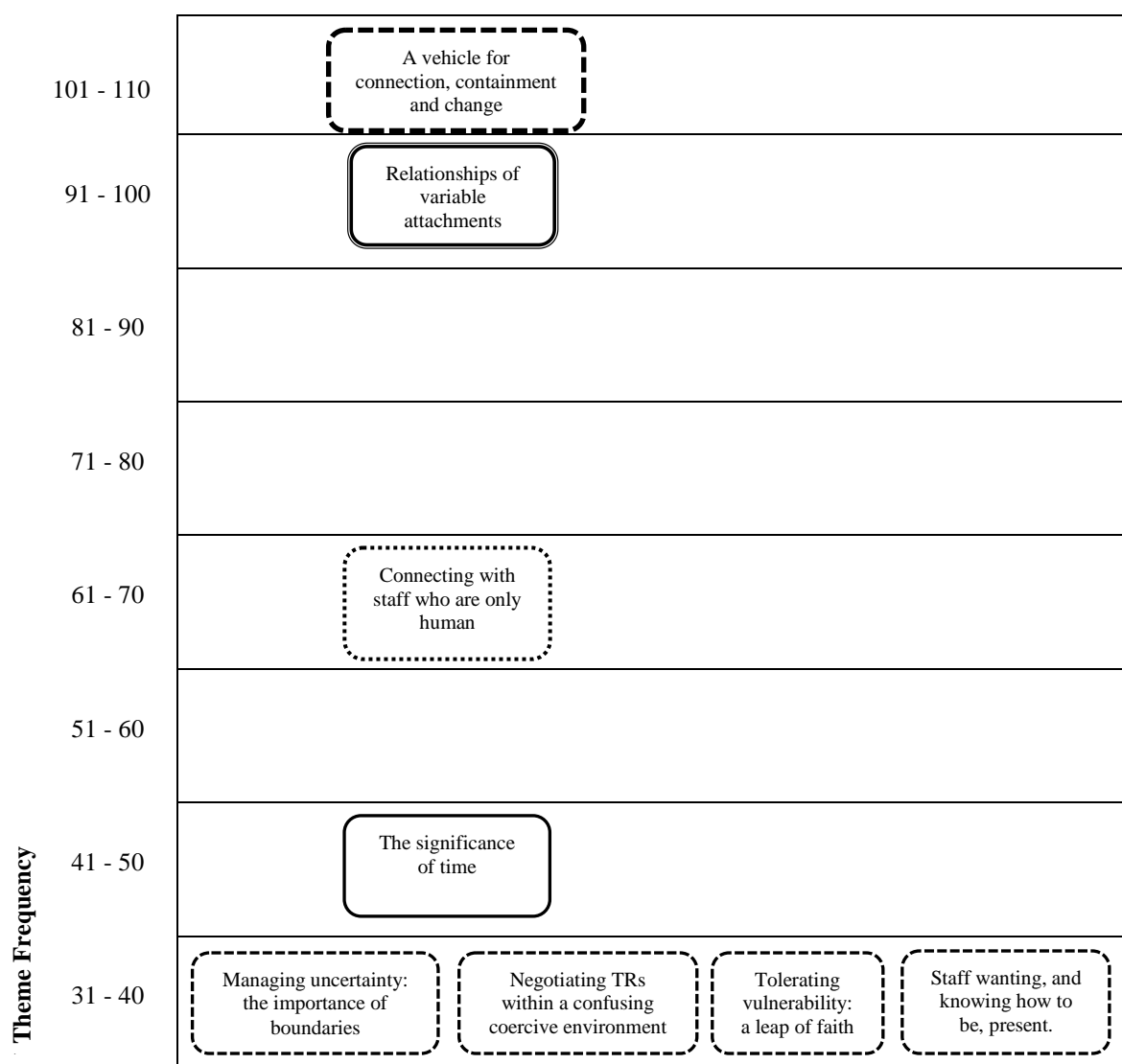


Figure 1. Systematic Review One: Hierarchical Model of Themes

1.6.1 Systematic review one: themes. Eight major themes were identified. An overview of the content and scope of identified themes is presented.

1.6.1.1 Theme one: negotiating TRs within a confusing coercive environment. Forming and sustaining TRs within a coercive environment requires observance of institutional ‘rules’ and role-messages. Patients cannot exercise freedom of choice in the nature of TRs, or with whom they are established. Fear of retribution means patients may conceal their true selves to conform to professionals’ expectations. Patients are expected to meet implicit expectations placed upon them by FMH staff, and continuously adjust to different staff interaction styles. In order to establish TRs and progress, patients need to learn the ‘rules’ of the FMH system, and adjust to their assigned roles within the environment. Patients are sensitive to the care-control dichotomy and power FMH professionals possess. While the FMH ‘system’ seems to discourage strong attachments, patients feel forced to trust staff and subjugate genuine feelings to avoid punishment. TRs may consequently appear superficial.

1.6.1.2 Theme two: tolerating vulnerability, a leap of faith. Patients fear forming TRs, and may emotionally disengage as a means of self-protection; adopting strategies to avoid and shield their vulnerability. Patients also fear TRs for potential abuse repetition, of being pre-judged based upon their clinical notes, of staff misunderstanding or failing to understand them and their experiences, and of being dismissed. The notion of entering into a dependent relationship itself evokes anxiety. Patients embark on a process of re-learning trust within TRs, which involves managing feelings of vulnerability and powerlessness, confronting and managing suspicious feelings and lingering fears that staff may abuse the confidence placed in them. Re-learning trust is complicated by the nature of the FMH system, and patients’ awareness that any information they divulge may be used against them. Patients value feedback from staff, to gauge their progress. A lack of positive feedback and acknowledgement of change detrimentally impacts upon patients’ motivation to modify destructive behaviours.

1.6.1.3 Theme three: managing uncertainty, the importance of boundaries.

Interpersonal and therapeutic boundaries promote a sense of certainty, safety, and predictability within TRs, and the FMH environment. Patients appreciate limits being set on their own, and others', behaviour, however the nature with which staff enforce boundaries affects compliance and TRs. Rigidly enforced boundaries detrimentally affect TR quality, whereas respectful and empathetic enforcement is viewed positively.

1.6.1.4 Theme four: staff wanting, and knowing how to, be present. TRs are influenced by the willingness of staff to connect in an emotional capacity; and whether staff are perceived as possessing appropriate knowledge and skills to be 'present' in a meaningful way. Patients differentiate between staff who work because they care, and those who they perceive as only being 'in it for the money', the latter being perceived as emotionally unavailable within TRs. Some staff are experienced as being emotionally unable to form TRs, while others do not appear to want an attachment relationship and actively avoid exposure to patients' feelings. Patients value TRs with staff who are equipped with sufficient experience, knowledge and skills to manage the difficulties patients experience; there is an implicit need for value in what staff 'bring' to TRs. Patients devalue youth, and perceive inexperienced staff as easily manipulated.

1.6.1.5 Theme five: relationships of variable attachments. TRs resemble attachment relationships. Patients expect staff to be attuned and responsive to their needs, and to be treated compassionately as valued individuals. Patients experience varying degrees of attachment strength within both positive and negative TRs. Patients experience TRs as positive, negative, and variable; with varying degrees of attachment. Patients tend to form exclusive TRs with small numbers of FMH staff, with one or two staff they feel particularly bonded with. Being treated like a human being is a prerequisite for forming TRs. Patients appreciate efforts by staff

demonstrating they act in patients' best interests, show that patients are valued, and treated like people rather than 'objects.' Being treated like a person requires efforts by staff to provide equitable care, treat patients with dignity, and engage in a collaborative manner. Patients 'test' staff before establishing TRs, evaluating their genuineness, trustworthiness, and ability to keep information confidential through a variety of sources. Patients desperately want to feel understood by their treatment team. Not being understood, listened to, or 'heard' impedes TR formation and results in feelings of neglect and abandonment, whereas feeling understood contributes to the development of strong affective bonds. Staff who are able to listen and attentively meet patients' needs foster appreciation and trust. Some patients expect staff to 'hear' them through their non-verbal language.

1.6.1.6 Theme six: the significance of time. Time is significant for the formation and maintenance of TRs, particularly staff's willingness to 'make time.' The passage of time facilitates dynamic changes within TRs. Patients yearn for consistency and stability within TRs, to increase TR quality. Patients value staff who make efforts to spend time with them, both casually and in a formal one-to-one basis. Such moments allow patients to express their feelings, and deepens staff understanding of patients. TRs reflect a dynamic process, and grow stronger with the passage of time. The process of TR improvement results from a deepening of understanding between patients and staff, in addition to general improvements in patients' mental states. Patients struggle to form TRs with transient or irregularly present staff members, and demonstrate a strong preference for stability and consistency within TRs. Patients experience TR endings as upsetting and traumatic. A lack of stability within TRs and staff team composition can precipitate feelings of unsettledness within the wider FMH environment, disrupting patients' consistency of care.

1.6.1.7 Theme seven: a vehicle for connection, containment and change. TRs fulfil multiple functions. Other than offering an attachment relationship providing human connection, companionship and comfort, TRs serve as a means of protection for patients, and provide a medium for emotional expression and distress containment. Honesty and trust are essential ingredients for these functions. Due to the multiple functions served, strong TRs assist recovery-improvement. Patients experience, and value, mutual honesty within TRs; and require FMH staff to be direct, explicit, and genuine in their communications. A lack of honesty may breed frustration and precipitate violence. Honesty and openness promotes a sense of relational transparency, crucial for patients learning to trust staff. Trust is experienced as the ‘bottom line’ for establishing TRs, and accelerated through patients feeling ‘heard’, staff self-disclosure, and time spent with staff. While patients are cautious in trusting staff, experiences of positive, trusting TRs serve to restructure patients’ attachment representations. TRs ameliorate power differences between patients and FMH staff, and offer patients physical and emotional protection through staff having a good understanding of patients and acting in their best interests. Protectiveness was often experienced as mutual, with patients feeling protective over staff they had strong TRs with. TRs provide a safe and secure context for patients to experience, express and contain intense emotions. Being able to express emotions within the context of TRs allows staff to become increasingly attuned and sensitive towards patients’ needs. TRs provide patients with emotional nourishment and a sense of being connected to another human being, and are valued for companionship purposes. TRs act as a vehicle within which patients may receive motivating, encouraging praise and support from staff, which facilitates self-reflection, challenges patients’ views of themselves, and promotes recovery. Strong TRs improve patients’ mood and self-esteem, and facilitates emotional growth; all of which positively influence recovery. Conversely, negative TRs serve to reverse patients’ progress and inhibit growth.

1.6.1.8 Theme eight: connecting with staff who are only human. TRs are invariably influenced by FMH staff's individual qualities, traits and attributes. Key positive traits increase patients' willingness to establish TRs, enhance affectionate bonds, and improve outcomes. Negative traits inhibit TR formation, negatively impact upon patients' wellbeing, and detrimentally affect recovery outcomes. Some staff are perceived as abusive, which eradicates TR formation. Patients struggle to connect with staff who treat them badly. Patients can experience staff as: provoking them to 'act out', threatening, nasty, arrogant, lazy and moody. Staff who appear unwilling to help are devalued, for failing to meet patients' needs and also contributing to the workloads of 'better' staff. Staff who behave in an authoritarian manner and lack humility, alienate and anger patients. Patients value TRs with staff with whom they can establish a genuine relationship, achieved through open, honest, forthright, genuine communication. Patients appreciate staff who are respectful, compassionate, helpful, and tolerant, and identify 'genuine' carers within the staff team. Staff temperament impacts upon TRs. Being calm, easy-going, and tolerant is received well; patients value humour highly and enjoy TRs with playful staff. Patients experience abuse at the hands of FMH staff. Abuse may assume the form of degrading treatment and humiliation, and physical assaults. For some patients, abuse within their relationships with FMH staff strengthens bonds with other patients.

1.7 Systematic Review Two: Inpatients' Experiences of Violence and Aggression within Acute Services

Fifteen articles were synthesised and reviewed to explore acute psychiatric inpatients' lived experiences of violence and aggression. Twelve themes were categorised. Figure 2 presents a hierarchical model highlighting the frequency with which themes were extracted from articles (adapted from: Van Wesel, Boeije, Alisic and Drost, 2012).

	Antecedents	Feelings and Experiences	Managing the Aftermath	
61 – 70	We're ill, violence is inevitable	Intensely negative emotional impact		
51 – 60	Staff bring it on themselves			
41 – 50				
31 – 40	Violence is the product of a broken system		We're ill, we need staff to make it better	
21 – 30			Prevention is better than cure	
11 – 20	We get something from it	Gender sensitivity	Help us to make sense of it	Taking responsibility and facing the consequences
1 – 10		Affects our relationships and our progress	Offers a chance for self-containment	

Figure 2. Hierarchical Model of Themes

1.7.1 Systematic review two: themes. Twelve major themes were identified. An overview of the content and scope of identified themes is presented.

1.7.1.1 Theme one: we're ill, violence is inevitable. Illness narratives dominated. Commentators emphasised links between 'madness' and 'badness', suggesting mental illness sufficiently explains the occurrence of violence. Other commentators conceptualised violence as stemming from compromised emotional regulation abilities, and an intolerance of vulnerability, causing individuals to attack as means of self-defence. Some commentators lacked empathy for patients' psychological experiences, perceiving 'illness' is sometimes used as an excuse to

perpetrate violence. Mental illness was further conceptualised as causing violence through loss of self-control. Seemingly innocuous factors trigger aggressive outbursts and create a sense of violence as unpredictable. Intense complex emotions and high levels of distress combine with poorly developed emotional regulation strategies, increasing the likelihood patients will act upon aggressive impulses for the purpose of: communication, symptom relief, and frustration management. Associations between intense emotions and difficult early experiences are emphasised, suggesting aggressive behaviours were environmentally fostered in childhood. Vulnerability and experiences of feeling under threat precipitate acts of violence; patients sometimes feel they have little choice but to attack staff, or others, as a means of self-defence.

1.7.1.2 Theme two: we get something from it. Violence is sometimes goal-oriented and deployed instrumentally to alleviate boredom and frustration, achieve an enhanced ‘power’ status, or gratify care needs.

1.7.1.3 Theme three: staff bring it on themselves. The causes of violence are located within the behaviour and attitudes of staff; and neglectful or abusive care provision. Some observers hinted that violence is a language by which patients may communicate with controlling and abusive staff; whom patients perceive as deliberately provoking them. Routine staff duties, such as physical restraint, are perceived as reflecting abusive acts of individuals rather than institutional management strategies. Poor staff communication is experienced as precipitating acts of violence due to staff failing to heed patients’ warnings regarding deteriorating mental health, inconsistencies in communication between staff, ineffective de-escalation skills, and patients’ sense of not being ‘heard.’

1.7.1.4 Theme four: violence is the product of a broken system. Violence is caused by the inherent nature of acute mental health services. Patients experience an unsettling sense of powerlessness through staff making decisions about their lives without their awareness or consultation. This reinforces lack of agency and self-determination, evoking strong feelings of anger which precipitates violence. Situations reinforcing lack of personal control, and inability to escape difficult situations, arouses a general tendency towards violence. Volatile and tense ward atmospheres, caused by high concentrations of unsettled patients within limited physical space contributes to violence occurring. Such atmospheres elicit hypervigilance, cause strained interpersonal dynamics, and heightened sensitivity towards oppressive institutional practices. Such experiences predispose patients to managing their frustrations in aggressive and impulsive ways.

1.7.1.5 Theme five: offers a chance for self-containment. Symptomatic relief and a sense of regaining control is achieved through internalised violence, namely acts of deliberate self-harm (DSH).

1.7.1.6 Theme six: affects our relationships and our progress. Witnessing acts of violence generates long-lasting negative consequences in terms of patients' interpersonal relationships, perceptions of safety, and engagement with others. This compromises established trust, detrimentally impacts upon journeys of recovery, reduces self-esteem, and depresses unit morale.

1.7.1.7 Theme seven: we are sensitive to gender dynamics. A sense of cognitive dissonance permeated patients' experiences of gender. Females reported the presence of males (patients and staff) was often distressing, for example: feeling unsafe in restraints, under threat in

mixed-sex units, and perceiving male patients as more aggressive. Conversely, females also experienced the presence of males as increasing a general sense of safety; and articulated a preference for mixed-sex wards.

1.7.1.8 Theme eight: intensely negative emotional impact. Violence within inpatient settings bestows deeply distressing and intense, complex emotions in observers. Strong emotional reactions were associated with fear, rage, shame, powerlessness, and experiences of feeling abandoned by staff. For some, witnessing violence also proved re-traumatising.

1.7.1.9 Theme nine: we're ill, we need staff to make it better. Illness narratives dominate patients' discourse regarding the antecedents of violence, manifesting in a sense of helplessness, and dependency upon staff to actively 'fix' difficulties following incidents. Patients expect staff to keep them safe, from their own DSH and violence from others. Consequently, a heavy staff presence is valued, preferably with staff members patients have existing relationships of trust with. To fulfil their roles as protectors, patients express a clear preference for staff who appear authoritative, which necessitates a certain degree of distance within TRs. Consistently enforced boundaries, and a sense of staff being 'in control' is experienced as reassuring. Following exposure to violence, patients expressed a need for staff nurturance, in the form of emotional support, and application of other techniques such as therapeutic interventions, medication, and formal de-escalation to regain a sense of emotional equilibrium, and manage intense negative feelings. Some individuals felt such support could be facilitated by peers, but the majority conveyed an expectation that staff provide this support. One patient suggested a need for the role of post-incident 'patient mediator' for bridging the division between staff and patient groups.

1.7.2.1 Theme ten: prevention is better than cure. Striving to curtail violence from

occurring rather than dealing with the aftermath was favoured. If this was not possible, commentators favoured quick and decisive staff input. Introducing and maintaining consistent and firmly enforced limits upon patients' behaviour, in empathetic and respectful ways, bestows a reassuring sense of structure, control, and containment. Commentators reported mixed experiences regarding the effectiveness of therapeutic interventions for improving distress-tolerance and emotional regulation skills. Supporting patients to foster positive relationships external to the FMH system is beneficial for reducing violence. An element of predictability was conveyed within accounts of perpetrated violence, with patients suggesting that by staff adopting a pro-active, rather than reactive, approach to managing violence, they may prevent the majority of incidents from happening.

1.7.2.2 Theme eleven: help us to make sense of it. Communication is an essential requirement for effective post-incident support: discussing and making sense of incidents, clearing tense atmospheres, and fostering a different perspective regarding individuals' behaviours.

1.7.2.3 Theme twelve: taking responsibility and facing the consequences. The need for perpetrators to take responsibility for their actions and potentially face prosecution is emphasised as significant in its own right, to boost unit morale, and as a deterrent against future violence. Coercive and insidious forms of retribution delivered by staff, such as the punitive use of seclusion and medication, was perceived as constituting abusive treatment.

1.8 Summary of Systematic Reviews

1.8.1 Review 1: FMH patients' experiences of TRs. Institutional 'rules' and role-messages influence the nature of TRs. While the nature of coercive care restricts patients' agency

and behaviour within TRs, this does not inhibit the formation of strong and meaningful relationships. Fear of retribution and punishment may however result in some patients concealing their 'true selves', meaning TRs may assume a superficial quality. Forming TRs, and learning to trust staff, evokes intense anxiety; patients require considerable encouragement to persevere, or may withdraw from TRs as a means of self-protection. Empathetically enforced boundaries regarding the nature of TRs and permissible behaviour within the FMH environment provide patients with a sense of certainty, to contain anxieties. Patients sometimes perceive staff as unwilling, or unable, to form TRs, and may reject staff's attempts to connect if they do not possess sufficient expertise to navigate relationship complexity. Patients experience a spectrum of positive and negative TRs, and expect staff to be attuned and responsive to their needs. TRs are conceptualised as occurring between patients and a small number of FMH professionals. TRs require time to foster, develop, and maintain; consistency over time increases relationship quality. TRs serve multiple purposes in offering human connection, protection, and emotional containment; of which honesty and trust are vital constituents. The qualities and traits FMH staff bring to TRs influence relationship quality, patients' wellbeing, and recovery.

Participants within reviewed articles were predominantly male, given the differences males and females bring to – and experience within – FMH services, it is unknown whether synthesised findings accurately reflect the experiences of female FMH populations. It is unknown how patients set about forming TRs with FMH staff, and how violence and aggression impacts upon patients' experiences of TRs.

1.8.2 Review 2: inpatients' experiences of violence and aggression within acute services. Patients perceive a range of internal and external antecedents to violence within secure mental health, and FMH, services. Internal antecedents related to: patient mental health,

compromised emotional regulation strategies, self-defence, characterological 'badness', enactment of early childhood experiences, and gratifying needs. External antecedents were perceived in relation to abusive and neglectful staff behaviour, and attempts by patients to regain control and manage the impact of residing within secure mental health services. Self-directed violence evokes feelings of self-containment. Externally directed violence bestows a complex range of intensely negative emotions within observers, and impacts upon patients' mental wellbeing, interpersonal relationships, and recovery. Sensitivity towards gender dynamics is particularly evident within female patients' accounts. Patients favour passive roles within post-incident management processes, and expect staff to actively repair situations. Staff are expected to protect patients, and act in authoritative – yet empathetic – ways to retain control. The power of communication is emphasised for helping patients to process and make sense of violence. Patients require nurturing, kindness, and emotional support, and feel preventing incidents is more effective than managing the aftermath. Patients believe perpetrators of violence should take personal responsibility, and face natural legal consequences.

Seven reviewed articles sampled acute inpatient populations; findings obtained from these contexts may lack transferability to females within FMH services as the two populations may likely have different histories of aggressive behaviours, interpersonal styles, and illness severity; all of which likely manifests in different experiences of violence and aggression. It is unknown how, or whether, the frequency, and varied nature, of violent incidents impacts upon patients, emotionally and psychologically, or the impact of perpetrating, or witnessing, violence upon therapeutic – and wider - relationships. It is unknown whether suggestions for support provision in the aftermath of violence are transferable within female secure services, or the practical and emotional impact violence has upon patients' abilities to receive support. It is unknown whether patients perceive changes effected within staff teams as a consequence of

violence. Considering the paucity of research examining patients' lived experiences of violence and aggression, there is a clear need for further exploratory research to better understand the experiences, and needs, of female secure forensic populations.

1.9 Part VI: Focus of the Present Study

1.9.1 Problem Statement

Female patients appear highly likely to have experienced childhood abuse, attracted BPD diagnoses, and experience severe and entrenched interpersonal difficulties. FMH staff report many challenges in working with this population, which impacts upon patient outcomes, yet despite the importance of TRs, emphasised within policy literature, little is known regarding female patients' experiences of TRs. Female patients have often experienced multiple degrees of trauma, and appear highly likely to witness and/or perpetrate violence within secure services, with negative psychological and treatment consequences. It is unknown how perpetrating or witnessing violence impacts upon patients' TRs, and broader psychological and emotional wellbeing. It is also unknown how patients experience attempts by FMH professionals to manage such incidents. It is difficult to see how progress may be made with regard to improving TRs, and the broader management of violence, without the contribution of FMH patients' experiences within academic discourse.

1.9.2 Aims and Research Questions

The main aims of the present study are:

1. To gain a deeper understanding of female patients' lived experiences of TRs with FMH staff in secure FMH services.

2. To gain a deeper understanding regarding how patients experience witnessed or perpetrated incidents of violence within secure FMH services, and how violence develops.

The aims of the present study will be explored through the following research questions:

1. How do patients develop TRs with FMH staff?
2. How do patients experience TRs with FMH staff?
3. How do patients experience incidents of violence and aggression within secure FMH services?
4. How do patients experience TRs following incidents of violence?
5. What support do patients require following exposure to incidents of violence and aggression within secure FMH services?

CHAPTER TWO: METHODOLOGICAL AND PHILOSOPHICAL FRAMEWORK

2.1 Introduction to Chapter

The remaining chapters are written in first person narrative, acknowledging the impact of my beliefs and values upon data analysis and interpretation (Reid, 1991). Within this chapter I outline my beliefs, values and experiences in relation to the current study. I present and justify methodological, epistemological and philosophical positioning, and discuss ethical considerations and review processes.

2.2 Self-Reflexive Statement

The importance of self-reflexivity within qualitative research is widely acknowledged (see for example: Shaw, 2010). Reflexivity deepens understanding of how a researcher's interests, beliefs and values impact upon decisions throughout the research process, and how participants' descriptions are perceived and interpreted (Primeau, 2003). It is important, particularly within an interpretivist paradigm, for qualitative researchers to reflect upon how they influence the research process. As Finlay (2003) noted: "our understanding of 'other-ness' arises through a process of making ourselves more transparent: without examining ourselves we run the risk of letting our unelucidated prejudices dominate our research" (p. 108).

I am a white, 30 year old, British female. I have one older step-brother, one younger step-sister, and one younger sister. I left home at the age of 18 years old to study Psychology at University, which I completed with first class honours. I completed an MSc in Research Methods in Psychology, then worked for 5 years within charitable and NHS mental health services, before commencing Clinical Training aged 27 years old. I am a lone parent to one son. My previous clinical experiences were predominantly within adult and older adult mental health

services. Clinically, I lean towards integrative ways of working, and value systemic, humanist, and psychodynamic models. Prior to Clinical Training I worked as a support worker for two years within a supported housing project with patients who had journeyed through high, medium and low secure forensic mental health (FMH) services.

I became interested in research within the area of forensic mental health during pre-training clinical experiences. During this time I became curious about high levels of expressed emotion, and sense of hopelessness and frustration, dominating the discourse surrounding FMH patients, users of women's secure services in particular. Staff often pejoratively commented women within FMH services were all "PD" or "personality disordered", and suggested these women were untreatable, and unbearable to be in the presence of. It has been my experience that it remains somewhat commonplace for mental health professionals to discriminate against female users of FMH services, unlike other client groups I have encountered, which I find simultaneously intriguing and irksome.

I perceived a sense of resigned hopelessness reflected within academic researchers' attitudes. I noted how considerable research had been conducted examining the experiences of staff working within FMH services. I was shocked to discover so few published accounts exploring patients' experiences and perspectives, almost as if everyone had paternalistically agreed what to do with such patients, and what was 'best', without thinking to ask patients themselves about their perceptions, needs, and experiences. This was compounded for me by the widespread trend towards understanding patient experiences within mainstream mental health services. I wanted opportunity to give voice to these patients, to hear and understand how things looked from their perspective.

My exposure to, and impatience for, the voiced prejudices surrounding this client population by qualified and informed staff, who I considered should reflect upon and manage their countertransferential feelings, has undoubtedly formed assumptions about secure services and the women who use them. As such, I am of the opinion that professionals deploy a range of institutional and personal defences designed to avoid painful confrontations with the trauma and realities of patients' experiences, and the frustrations staff face in working with them. I assume staff maintain distance through avoidance of interpersonal intimacy and human connection; and that patients within these services feel rejected, re-victimised, shamed, and stigmatised. With these assumptions in mind, I anticipated patients would be keen to voice their 'side of the story', but considering the nature of the coercive care environment within which they resided they would be wary of how their data would be used, and whether their accounts would be personally identifiable. I suspected patients may also wish to use research interviews as a platform upon which they could complain about perceived maltreatment, or the coercive nature of their detention.

I was seven months pregnant at the time of recruiting and interviewing participants. I required multiple risk assessments to undertake the study. It became apparent to me that staff within the units did not think it was safe, even when following clear risk management protocols, for me to conduct the research. Within this context, my own internalised sense of fear, and the irrefutable need for the careful management of risk, I was moved by the women's treatment of me before, during and after research interviews. Patients' interactions with me were protective, tender, and maternal. For example, one participant went to great lengths to ensure I had sufficient water to drink in the heat, and at the end of interviews most participants I interviewed insisted on checking the corridors outside of the interview rooms to ensure no 'risky' patients were present who may endanger my safety. The irony being that participating individuals were

the very people I was deemed in need of protection from. It struck me that while undoubtedly the risks were clear and present; everyone, myself included, had neglected to account for the possibility that my pregnancy may have paradoxically been beneficial during my interactions with patients. It was my impression that my mutual vulnerability may have helped somewhat to redressing obvious power imbalances, and in combination with my independence from unit staff and the wider FMH system, this positioned me as non-threatening, allowing patients to ‘open up’ and share their experiences freely. I further reflected that my surprise at participants’ behaviour towards me may have represented internalisation of the pervasive pathologising, often dichotomous discourse surrounding them; viewing patients solely in terms of risk and problems and failing to appreciate the human qualities they also possessed.

While I have tried to hold my assumptions in mind, in a balanced and non-biased manner during data analysis, my experiences and assumptions have invariably influenced my appraisal of participants’ data.

2.3 Philosophical Framework and Research Design

It is important to consider my philosophical assumptions underpinning the study, to provide transparency and enhance credibility. I provide the reader with an overview of my ontological and epistemological positioning, corresponding philosophical paradigm, and justify methodological choices.

2.3.1 Ontology

Ontology is the study of “the kind of things that exist, the conditions of their existence and the relationships between these things” (Blaikie, 2007; Morgan, n.d.) and “the nature of reality and its characteristics” (Creswell, 2013, p. 20). An ontological position therefore

represents a researcher's perception on the nature of reality. Qualitative research is conducted from a range of ontological positions, such as: positivism/post-positivism, critical theory/emancipatory research, constructivism, pragmatism, postmodernism, and realism (Denzin & Lincoln, 2005), however even within these positions considerable diversity exists. One way of conceptualizing divergent ontological positions is along a continuum. At one end, proponents of realism believe reality is something which exists in and of its own right, the 'truth' of which is waiting to be naively 'discovered'. On the other end proponents of relativism perceive knowledge as inter-subjectively constructed through experiential and social meanings and understandings. Critical relativism is positioned between these two points, and posits knowledge and 'truth' exist but a researcher's presence impacts upon what is measured (Guba, 1990; Denzin & Lincoln, 1994). I assumed a relativist ontological position within the current study. I do not believe there is an objective 'truth' to be discovered. I believe that individuals perceive different realities, and knowledge about individuals' experiences is influenced by the joint-construction of meaning.

2.3.2 Epistemology

Epistemology is conceptualised as "the study of knowledge, the acquisition of knowledge, and the relationship between the knower [research participant] and would-be knower [the researcher]" (Ponterotto, 2005, p. 127). Like ontology, epistemological positioning may be conceptualised along a continuum, from representational to subjective stances (Cohen & Crabtree, 2006; Condie, 2012). A representational epistemology is rooted in empiricism and the positivist paradigm, proposing valid knowledge is derived from rationality and logic (Ponterotto, 2005). Positivists favour dualism, the belief that researchers and participants are independent of one another, therefore researchers do not influence obtained knowledge (Scotland, 2012), and knowledge of an objective reality may be measured and obtained representationally. Conversely,

a subjectivist or transactional epistemology is advocated within the interpretivist paradigm. Embedded within the traditions of phenomenology and hermeneutics, interpretivism proposes the existence of multiple realities and acknowledges researchers' beliefs and values invariably influence how they understand the experiences of others. A subjectivist epistemology proposes knowledge is constructed through social interactions, and represents the by-product of a dynamic and transactional process between participants and researchers; a process which is central to understanding participants' 'lived experiences' (Ponterotto, 2005). A subjectivist epistemology therefore assumes participants cannot perceive a 'reality' separate from their individual experiences of it. I believe knowledge is gained through the mind, and gaining knowledge of the world is achieved primarily through introspection; that participants in the current study may hold multiple corroboratory or conflicting perceptions of 'reality.' Consequently, I adopted a subjectivist epistemology.

2.3.3 Overarching paradigm

A paradigm is defined as "patterns of beliefs and practices that regulate inquiry within a discipline by providing lenses, frames and processes through which investigation is accomplished" (Weaver & Olson, 2006, p. 460). Guba (1990) states paradigms are characterised by three key elements: ontology, epistemology, and methodology, which together form a comprehensive understanding of how researchers: perceive knowledge, see themselves in relation to knowledge, and apply methodological techniques to obtain knowledge. Several paradigms exist to guide researchers, each incorporating diverse schemas (see Ponterotto, 2005). Along a continuum, paradigms stretch from positivism to interpretivism².

² Key differences in the underlying assumptions of these paradigms are presented within Appendix I (adapted from Neufeldt, 2007).

Adopting a relativist ontological position and subjectivist epistemological stance positions the current study within the interpretivist paradigm (Cohen & Crabtree, 2006). Interpretivism is rooted within phenomenology, sociology and anthropology, and developed within the social sciences as a reaction against positivism (Willis, 2007). However, the origin of interpretivism may be traced earlier to Immanuel Kant's Critique of Pure Reason, which emphasised a central tenet of interpretivist thinking, namely that "you cannot partition out an objective reality from the person (research participant) who is experiencing, processing, and labelling the reality" (Ponterotto, 2005). Interpretivists postulate no separation exists between 'reality', and the perceiver of reality, consequently "researchers' values are inherent in all phases of the research process" (Cohen & Crabtree, 2006). Furthermore, 'truth' and interpretations of 'truth' are context, time and situationally dependent; and therefore changeable.

I consider the women within the low and medium secure FMH services to be the experts of their individual experiences, and their perceptions of violence, aggression, and therapeutic relationships (TRs) are uniquely situated within context and time. Further, this study seeks to understand, rather than obtain causal inferences or predictive knowledge; therefore an interpretivist framework best reflects the aims and philosophy of the current study.

2.3.4 Methodology

Ontological and epistemological positions are intrinsically linked to choice of research methods (Scotland, 2012). Methodology represents a plan of action, justifying a researcher's selection and use of specific research methods (Ibid). Guba and Lincoln (1994) explain methodology essentially represents a question, chiefly: how can a researcher best find out whatever they believe can be known. Approaches for discovering knowledge vary, and are generally determined by the underlying paradigm with which researchers are aligned, as

Scotland (2012) states “each paradigm has its own ways of realising its aims.” Quantitative methodology is aligned with a positivist paradigm; and seeks to uncover objective knowledge through direct observation, experimental design, and empirical measurement (Krauss, 2005). The primary goal of research within an interpretivist paradigm is to gain insights and deepen understanding of examined phenomena; which tends to be achieved through application of qualitative methodology (Patton & Cochran, 2002; Denzin, 2009). Qualitative research seeks to describe and characterise, rather than predict, participants’ behaviour, perceptions, and experiences. Data yielded from qualitative methods requires researchers to organise and interpret meaning, and is not suitable for statistical analysis (Maxwell, 2012). I sought to understand the lived experiences of women within the FMH units, and gain insight into their collective thoughts, feelings and experiences. I did not seek predictive power, consequently I considered qualitative methodology appropriate for investigating the study aims.

2.3.4.1 Obtaining data. The most common methods for obtaining data in qualitative studies, are focus groups, participant observations (ethnography), and in-depth interviews (Mack, Woodsong, Macqueen, Guest & Namey, 2005). I present an overview of these techniques, and justify why in-depth interviews are best suited to the study aims.

The history of focus groups has been traced to Emory Bogardus who first referred to group-based interviews in 1926 (Wilkinson, 2004; Liamputtong, 2011). Initially developed for the purpose of academic research, focus groups became ubiquitous with market research from the 1950s but have gained popularity in recent times within the social sciences (Liamputtong, 2011). Focus groups facilitate a context within which a group of individuals may engage in the focused collective activity of informal discussions, or ‘collective conversations’ about an examined topic (Wilkinson, 2004; Kitzinger, 2005). The data obtained from focus groups can be

said to represent negotiated meanings developed through intra- and inter-personal debates (Crang & Cook, 1995). Members of a focus group assemble and discuss specific issues with facilitation from a moderator (Liamputtong, 2011). Developing a safe, non-threatening environment is essential for successful discussions; participants should not feel inhibited in discussing their experiences (Hennink, 2007). I did not deem focus group methods appropriate for several reasons. Firstly, I aimed to explore individual, rather than collectively constructed accounts of experiences. Secondly, I considered dynamics between patients may inhibit the development of a non-judgemental and safe environment for topics to be discussed, particularly given the sensitive and evocative focus of the study. I feared issues may ‘spill’ into the unit environment, elevating risk. Due to the nature of risks posed, sufficient numbers of participants would not have been able to participate in a focus group without staff additionally being present to manage risk; compromising patients’ confidentiality.

The modern day origins of ethnography have been traced to Bronislaw Malinowski’s 1914 fieldwork with Trobirand Islanders (Ellen, 1984). Malinowski first articulated ethnographic methods, and promoted the concept of using descriptions of everyday behaviours and actions to make sense of societies (Ibid). Brewer (2000) defines ethnographic research methods as:

the study of people in naturally occurring settings or ‘fields’ by means of methods which capture their social meanings and ordinary activities, involving the researcher participating directly in the setting, if not also the activities, in order to collect data in a systematic manner but without meaning being imposed on them externally (p. 10).

From an ethnographic perspective, the aim of research conducted within the social sciences is to make sense of individuals’ behaviour and experiences, and the relationship between actions and experiences (Liamputtong, 2011). Ethnographic methods seek to observe participants and collect naturally occurring data regarding their behaviours within a real-life situation (Liamputtong, 2011). Proponents of ethnography suggest knowledge is obtained through close engagement with participants’ social worlds. Several data collection methods are adopted to gather information

about participants' social meanings, such as: observations, in-depth interviews, discourse analysis, and reviewing personal documents (Liamputtong, 2011). I aimed to explore individuals' experiences and perceptions rather than collect information on naturally occurring data, therefore I did not consider ethnography appropriate. Furthermore, it would have been impractical, from a risk management perspective, for me to have spent extended periods of time within the FMH units with a mandate of observing violence.

In-depth interviews gained popularity within educational research in the 1980s (Berry, 1999), and now represent the most commonly deployed strategy for obtaining data within qualitative research (Legard, Keegan & Ward, 2003). In-depth interviews are considered best positioned to gather information about participants' experiences and perspectives, especially when examining sensitive issues (Mack, Woodson, Macqueen, Guest & Namey, 2005). Hammersley and Atkinson (1995) emphasise the centrality of language for highlighting individual's personal meanings about their experiences:

[T]he expressive power of language provides the most important resource for accounts. A crucial feature of language is its capacity to present descriptions, explanations, and evaluations of almost infinite variety about any aspect of the world, including itself (p. 126).

In-depth interviews grant researchers both flexibility and structure, are interactive in nature, allow opportunity for probing to achieve depth within accounts, and are generative as new insights may be created (Legard, Keegan & Ward, 2003). Within an interpretivist paradigm, researchers utilising in-depth interviews can be viewed as 'travellers', who journey with participants, and develop meanings through the interpretation of participants' accounts. Kvale (1996) emphasises a transformative aspect to the journey between the traveller (researcher) and participant within interviews. In-depth interviews may be structured, or unstructured. Structured interviews typically comprise closed-ended questions, and are administered in a pre-determined rigid manner; this enables interviews to be easily replicated, but participants' accounts may lack

sufficient depth and detail (McLeod, 2014). Conversely, unstructured interviews may be aided by an interview schedule of pre-determined questions, but questions are open-ended and flexibly applied; enabling participants to offer more information about their experiences, but meaning interviews can take longer to conduct and analyse (McLeod, 2014). In order to gain rich insight into patients' experiences, I deemed semi-structured in-depth interviews to be appropriate.

2.3.5 Why Thematic Analysis?

Egan (2002) argued approaches to data collection and analysis should be driven by the nature of the research question. A wide range of techniques exist for the analysis of qualitative data, I present an overview of the most common methods and justify why thematic analysis is best suited to the study aims.

2.3.5.1 Grounded theory. Grounded theory seeks to systematically develop inductive theories, grounded in methodically obtained data and conceptual categories (Strauss & Corbin, 1994). Glaser and Strauss first described grounded theory in their 1967 book *The discovery of grounded theory*. Grounded theory may be conducted in a variety of ways, and the processes and scope involved is said to lack general consensus (Charmaz, 2006). Grounded theory provides opportunity to conceptualise data, offers a systematic approach to data analysis, and permits depth and richness in data description, however theories are often limited in their generalisability, and grounded theory is criticised for potential methodological inaccuracies (Hussein, Hirst, Salyers & Osuji, 2014). Grounded theory appears poorly delineated, with many researchers claiming use of this approach when their analysis could simply be described as thematic analysis (Suddaby, 2006). Essentially, grounded theory involves: identifying an area of research interest, collecting data through methods such as interviews, integrated open-coding of data with use of memos, selective coding and theoretical sampling, sorting memos and

identifying theoretical codes (Scott, 2009). I did not deem grounded theory appropriate for analysing data within the current study for two reasons. Firstly, the goal of the present study was to describe participants' lived experiences rather than construct theories regarding their experiences. Secondly, due to the nature of the participant population, I did not deem it probable that sufficient numbers of patients could be recruited in order to undertake theoretical sampling (Draucker, Martsolf, Ross & Rusk, 2007).

2.3.5.2 Conversation analysis. Conversation analysis is commonly used within the sociological approach of ethnomethodology (ten Have, 1990), and has been described as “the most precise and systematic of sociolinguistic approaches” (Psathas, 1995). Conversation analysis has clearly defined conceptual framework, transcription practices and analytic conventions (Psathas, 1995). The primary aim of conversation analysis is to create a model or set of rules designed to describe patterns, and the incidence of patterns. ten Have (1990) outlines conversation analysis can be defined as a “specific analytic trajectory” designed to access information about the manner in which individuals of a particular group “do interaction.” The aim of the present study is to explore the subjective, and reported, nature of participants' experiences; not the manner with which they interact, consequently conversation analysis was not deemed appropriate.

2.3.5.3 Interpretive phenomenological analysis. Interpretive phenomenological analysis (IPA) was developed by Jonathan Smith for the purpose of exploring individuals' idiographic subjective experiences; and is widely used within psychological research (Biggerstaff & Thompson, 2008). IPA offers a complete framework within which research may be conducted (Smith, Flowers & Larkin, 2009), detailing: ontological and epistemological underpinning, theoretical framework, nature of research questions, sampling strategy, and

methods for data collection³. IPA aims to make sense of participants' lived experiences; by recruiting a small homogenous sample and seeking to identify themes within and across participants' data sets. Superficially, it would appear as though IPA may mirror thematic analysis conducted within a phenomenological paradigm, as the analysis outputs may be similar (University of Auckland, n.d.). However whereas thematic analysis seeks to describe themes identified across datasets, IPA is primarily an interpretive approach (Hefferon & Gil-Rodriguez, 2011). Hefferon and Gil-Rodriguez (2011) argue "IPA also appears to have become the 'default' option for many students at many levels. This tends to result in poorly constructed, primarily descriptive projects that do not reflect good-quality IPA" (p. 756). While some degree of interpretation is inherent within thematic analysis, the aim of the current study was to obtain and describe, rather than interpret, participants' experiences; consequently I deemed thematic analysis preferable to IPA.

2.3.5.4 Justification for thematic analysis. The aim of thematic analysis (TA) is to recruit a homogenous participant sample and identify, analyse and describe themes, or patterns, across data sets; and interpret these themes in relation to research questions (Daly, Kellehear & Gilksman, 1997; Braun & Clark, 2006). In contrast to techniques such as grounded theory or IPA, researchers using TA do not need specialist technological knowledge or training. The development of guidelines for conducting TA, such as the six-stage process outlined by Braun and Clarke (2006) additionally makes this approach well-suited to novice qualitative researchers. Braun and Clarke (2006) argue that while some authors perceive TA as merely a tool for conducting other more popularly 'branded' forms of qualitative analysis (Boyatzis, 1998; Ryan & Bernard, 2000), TA is a method in and of its own right. Indeed, TA is believed to be the most frequently used method of qualitative data analysis (Guest, 2012). Unlike other approaches, TA

³ For a comprehensive overview of IPA, see Smith and Osborn (2007).

is considered a method rather than a methodology; and is therefore flexible in the theoretical paradigm it can be applied from. TA offers a systematic approach to data analysis, allowing the researcher to understand issues across data sets (Alhojailan, 2012). TA permits inductive, or deductive, semantic or latent, approaches to coding and the development of themes, and can generate rich, detailed, and complex descriptions of data (Cruzes & Dyba, 2011). However, using TA prevents researchers from asserting claims about the use of participants' language (Braun & Clark, 2006), and may miss nuances within datasets (Guest, 2012). Many of the disadvantages levelled at TA are however attributable to inappropriately focused research questions, or poorly conducted analyses (Braun & Clark, 2006; Hayes, 2000). TA may be applied within an interpretivist paradigm to generate detailed description of themes related to participants' lived experiences within the FMH units. It represents a well demarcated and accessible method, and allows identification and interpretation of key themes across individuals' accounts. TA has also commonly been used to explore individuals' experiences within FMH settings (for example: Baker, Wright & Hansen, 2013; Long, Knight, Bradley & Thomas, 2012; Mason, 2002). I therefore considered TA appropriate for meeting the study aims.

2.4 Ethical Considerations

I adhered to professional guidance for conducting ethical human research (The British Psychological Society, 2014).

2.4.1 Anonymity. Participants' data was made anonymous, and contextual identifiers removed, to facilitate research dissemination (Kaiser, 2009). Although it has been argued modifying contextual identifiers may affect data validity (Wiles, Crow, Heath & Charles, 2008), I considered it ethically preferable to compromise data validity over potential harm resulting from individual identification. Participants were advised that specific personally identifiable

information, for example their name, would be disguised within findings. However, as direct quotations would be used, there was a risk participants may still be personally identifiable within findings, which was discussed within the informed consent process. Participants were advised that other patients and members of staff were aware of their participation due to research interviews being conducted within the naturalistic setting of the FMH units. Participants were advised to contact the independent Patient Advice and Liaison Service should they experience negative consequences from staff or other patients as a result of participating. Participants were additionally encouraged to discuss any distress experienced as a result of participating with the psychologist within the units. Participants were instructed to inform me, as Chief Investigator, if they experienced any negative effects as a result of their participation in the study. None of the participants reported or exhibited any signs of distress following research interviews; none of the participants informed me subsequently that they had experienced negative consequences due to their participation.

2.4.2 Informed consent. The mental health statuses of detained patients may negatively affect their ability to protect their own interests. Such individuals have commonly been detained owing to the very reason they lack decision-making competence required to be accountable. This complicates the process of obtaining informed consent, necessitated by professional research standards (Munthe, Radovic & Anckarsater, 2010; The British Psychological Society, 2014).

Obtaining informed consent comprises a number of components: counselling, information, understanding and free decision (Munthe, Radovic, & Anckarsater, 2010). While the vulnerability, mental health status, legal status, and restricted freedom of FMH patients may jeopardise freedom of decision to consent within research projects; it has been argued that proper design of the counselling and information giving components of informed consent procedures

may ameliorate such difficulties (ibid). Through careful communication of the research context and methods, employing dialogue-type counselling techniques to minimise potential misunderstandings, researchers may be *reasonably* certain patients do not confuse potential participant status with that of their role as patients. Individuals who may be considered legally unaccountable may nevertheless possess competence to veto participation so long as specific methods to ensure freedom of their decision have been implemented (Munthe, Radovic & Anckarsater, 2010).

To assert my independence as a researcher, and avoid being confused as a FMH professional, I approached participants directly for recruitment by attending community meetings to introduce myself and the research project. I deemed this approach preferable to identifying potential participants through FMH staff. Once potential participants expressed an interest I liaised with unit management and the psychologist available within the service to establish whether there were any specific difficulties individuals may experience with decision-making, enabling me to formulate ways of communicating project's aims to promote freedom of decision.

I employed counselling techniques within discussions, and ensured patients were given the opportunity to discuss participation with other people prior to consenting. When meeting with patients, I asked them to describe, based upon reading of the participant information sheet (Appendix J) their understanding of: the project aims, broad research procedure, potential harm and benefits, use of their data, potential for compromised anonymity, and reasons for participation; mirroring core principles of the Mental Capacity Act (2005).

Adopting an approach evident within a similar study (Ryan, Moore, Taylor, Wilkinson, Lingiah, & Christmas, 2002) participants were assured that their decision to participate would

have no bearing on their treatment, and assured all information obtained within the interviews would be treated in the strictest confidence. Written informed consent was then obtained.

In the event of uncertainty regarding whether potential participants possessed capacity to consent I planned to terminate the consent process and discuss my concerns with responsible clinicians, or the psychologists available within the service. This situation did not arise during the course of recruitment. I judged all participants as possessing capacity to consent. If I suspected during the course of interviews a participant lost capacity to consent, I planned to assess this by following the procedures outlined in the informed consent process, and terminate the interview if a lack of capacity was presumed; however this situation did not arise.

2.4.3 Confidentiality. Potential participants were informed it would be necessary for me to break confidentiality if they disclosed information indicating: they or others were at risk of imminent harm, the security of the unit was threatened, or a crime had been committed (The British Psychological Society, 2014); based upon my clinical judgement of potential future risk. Participants were asked to provide informed consent acknowledging my duty to share such information. I emphasised that only the minimum necessary information pertaining to the highlighted risk would be shared (Department of Health, 1997) and I would discuss any need to break confidentiality beforehand. Participants were advised should they disclose information indicative of professional misconduct, this information would be shared with appropriate authorities, adhering to relevant NHS trust policies. Some participants described incidents of violence perpetrated by staff, however I was satisfied from their accounts these incidents had been investigated. I deemed it necessary to breach confidentiality on one occasion wherein a participant disclosed information pertaining to alleged historical misconduct by a member of staff. I explained at the end of the participant's interview that I would need to report the

information she had disclosed, which she acknowledged and was happy for me to do. I shared this information with the lead psychologist within the service, who investigated the claims made. No further action was taken.

2.4.4 Right to withdraw. Participants were informed of their right to withdraw at any time during the research process (The British Psychological Society, 2014) and acknowledged this within consent forms. Participants acknowledged any data collected up until the point they withdrew would be used within the project write-up.

2.4.5 Data storage. Interview data was digitally audio-recorded, transcribed, anonymised, and stored on the University of Essex computer system. Digital recordings were destroyed following transcription. Only I had access to view identifiable participant data, and data was not transferred outside of the United Kingdom, and will not be used in future research projects. Participants were made aware of data storage procedures, and provided consent acknowledging their data would be managed in accordance with the Data Protection Act 1998.

2.4.6 Giving advice. If participants provided information indicative of a health problem they were unaware of, which I believed may endanger their future wellbeing, I planned to encourage them to notify their clinical team (The British Psychological Society, 2014). If a participant requested advice during the course of the research process, I planned to encourage them to talk to the clinical psychologists available within the service. None of the participants requested advice, nor provided information indicative of a health problem they were unaware of.

2.4.7 Protection from harm and debriefing. Although participants were not deceived, it was anticipated that participants would be exposed to questions which in themselves may have

posed a risk of harm due to thoughts and associations these inspired (Munthe, Radovic, & Anckarsater, 2010). Discussing violence may have induced anger, anxiety or a negative mood. Mirroring ethical guidance (The British Psychological Society, 2014), I endeavoured to ensure participants left in the same frame of mind as when they entered, by setting aside time at the end of the interview to discuss the research purpose, plans for dissemination, and answer questions. Participants were encouraged to only discuss experiences they felt comfortable sharing and were urged to seek support from the clinical psychologist available within the units if they experienced distress as a consequence of participation. One clinical psychologist available within the service agreed to adopt clinical responsibility for this purpose. The contact details of the independent Patient Advice and Liaison service were included within the participant information sheet if participants wished to make a formal complaint.

It is argued that a sufficient balance of benefits must offset the potential for harm, or participant burden, within applied research (Munthe, Radovic, & Anckarsater, 2010). I was informed that within the examined service, the female secure units had the highest number of reported violent incidents of any units within the NHS trust. I anticipated this project would likely benefit the patient population through improved understanding of how witnessing or perpetrating violence may perpetuate difficulties within TRs, and maintain cycles of violence; informing effective interventions and support provision, benefiting the unit milieu and patient wellbeing. I believed these potential benefits balanced the risks imposed by the invasive nature of research interviews. None of the participants reported feelings of distress at the end of research interviews.

2.4.8 Financial remuneration. The ethical implications of paying research participants for their contributions are debated within academic discourse. Offering financial incentives may

exert undue influence over recruitment, obtaining informed consent, and data validity (Russell, Moralejo & Burgess, 2000). However, in line with national recommendations (National Institute for Health Research, 2009) I believed participants should be remunerated for the use of their time, appreciating the value of their contributions.

The Offender Health Research Network outlines how it should not be expected detained individuals “give their time for free”, and recommends adherence to the INVOLVE national guidelines for non-detained individuals; stating “people who use services should be paid for their time and expertise to a level consistent with other members of the research team” (INVOLVE & Department of Health, 2006, p5). While some patients may decline payment due to concerns about their entitlement to benefits, it is suggested payment should always be offered (ibid). Due to the nature of secure detention, I anticipated participants would be unable to make use of high-street vouchers, they were instead offered a one-off cash gift of £10 to thank them for their participation. Based upon recent guidance, participants were advised they were able to accept a one-off financial gift on one occasion within a financial year without their benefits being affected (Mental Health Research Network, 2013) but were advised to contact the Disability Benefits helpline to discuss any concerns regarding whether the financial gift may impact upon the benefits they received.

Following consultation with professionals within the units, it was agreed staff would be provided with a series of addressed envelopes for participants, containing their £10 financial gift and a brief thank-you note (Appendix K), which patients were able to access when required. One participant reported she did not require financial remuneration, and informed me she intended to give the money to charity.

2.4.9 Risk. It was deemed possible that I may experience vicarious traumatisation (McCann & Pearlman, 1990) resulting from exposure to participants' accounts. My emotional reactions were discussed and contained through discussions with research supervisors, and peer-researchers. To manage the potential risk of physical harm, I adhered to risk management procedures and sought guidance from ward management when meeting with patients, to make myself aware of potential risks. Additionally, due to my pregnancy coinciding with the data collection phase of the research process, I also met with a senior health and safety advisor and completed a supplemental 'pregnant worker risk assessment'. No potential participants were excluded from participation on the basis of risk, and no incidents occurred during recruitment or data collection.

2.5.1 Ethical review. Full NHS ethical review was sought, and obtained (Appendix L), with minor amendments required prior to final approval being granted on 21st January 2014 (Appendix M). The study was subsequently reviewed by the local NHS trust's Research Governance Group, and approved on 10th March 2014 (Appendix N) with the inclusion of a definition of 'violence' within the study protocol. It was negotiated and agreed with research supervisors that the Historical, Clinical, Risk Management-20 (HCR-20) operational definition of violence would be followed. The project was granted approval by the University of Essex Faculty Ethics Committee on 24th March 2014 (Appendix O).

2.6 Method

2.6.1 Research design. Exploratory, naturalistic, qualitative methodology was employed to describe, comprehend, and interpret patients' lived experiences and understandings of TRs, violence and aggression.

2.6.2 Study context. The examined services provide therapeutic mental health services to females with a mental health disorder, requiring high levels of procedural, physical or relational security; to manage risk of harm to themselves or others. All individuals within the examined services are detained under the Mental Health Act (1983; 2007) and characteristically exhibit complex mental health difficulties with co-morbid substance misuse and/or personality disorders (PDs) which may be associated with offending behaviours or seriously irresponsible behaviour (NHS England, 2013). Research interviews were held in private meeting rooms within the low and medium secure units which lowered disruptions and protected participants' confidentiality.

Most recent obtainable figures indicate 589 medium secure beds, 46 enhanced medium secure beds, and 990 low secure beds are commissioned for females nationally within secure FMH services (Hartya, Somers & Bartlett, 2012). Of these, 52% of medium secure beds, and 25% of low secure beds are managed within the NHS (Ibid). Due to the relatively low number of NHS commissioned beds, and providers of female low and medium security FMH care, specific information about the examined units is not presented to safeguard participants' anonymity.

2.6.3 Data collection. Data was collected from semi-structured interviews, using an interview schedule, developed for the purpose of the study. A guided interview approach was adopted in order to explore, probe, and elicit information related to study aims (Berry, 1999). Wenden (1982) advocated the guided interview approach, for allowing "in-depth probing while permitting the interviewer to keep the interview within the parameters traced out by the aim of the study" (p. 39).

The interview schedule was developed in consultation with professionals within the examined service, discussions with research supervisors, and principles for interview schedule

development (McNamara, 1999; Zorn, n.d.). The exploratory interview schedule (Appendix P) was designed to facilitate description of participants' experiences in relation to the primary research questions. It contained five key areas for exploration: the nature of TRs, development of TRs, experiences of violence and aggression within the unit(s), perceived impact of violence and aggression upon TRs, and participants' support or intervention requirements following acts of violence or aggression. Participants were encouraged to discuss any other aspects related to TRs or violence they wished to comment upon. Probes accompanied research questions, to elicit a rich and detailed understanding of participants' experiences and explore issues identified from my prior clinical experience, previous research, psychological theory, and FMH policy literature. Interview questions were designed to be open and neutral, and phrased using non-technical, simple language enabling participants to easily share experiences in their own words.

Prior to the application of the interview schedule, time was spent discussing participants' reasons for participation, personal journeys into the units, general experiences of the unit environment, and general chat, to build rapport and develop engagement (Dundon & Ryan, 2010). Participants were provided with a copy of the interview schedule to be aware of the experiences they would be asked to discuss. All interviews commenced with an exploration of area one, and the opening question "Can you tell me about your relationships with staff here?" The order of question prompts and other interview questions was guided by participants' responses to avoid rigidity and facilitate a smooth-flowing conversational approach whereby participants felt at ease. Questioning also developed iteratively in response to participants' responses; with my intervention designed to reflect upon participants' responses to clarify meaning, convey understanding, and encourage participants to elaborate on their responses. I clinically formulated that given the emotionally evocative nature of the issues discussed, and nature of the patient population, it would be necessary for me to deploy basic clinical skills such

as being genuine, offering positive regard, and empathetic understanding (Rogers, 1986), to encourage engagement, provide a ‘safe space’ for patients to share their experiences, and ‘contain’ traumatic emotional reactions (Bion, 1962; Winnicott, 1965). I felt that a person-centred approach to interviewing mirrored the philosophy of the study. Examples of reflective statements are included within Table 1.

Table 1

Examples of reflective statements used within the interview process to encourage elicitation of participants’ experiences

Example Reflective Statements	Purpose
“So you see it as them as kind of being there to give you support?”	Checking understanding
“And is there anything you think I’m not really fussed about, or anything that you think is really unimportant?”	Use of participant’s language to convey understanding
“And coming back to when you first came on here, you said you knew some staff but others you didn’t know I guess and at that time when you kind of came here and you were having to kind of build up those networks and those relationships is there anything the staff could have done that would have made that easier?”	Clarifying understanding
“That sounds really difficult. Do you think it has an effect on the unit as a whole?”	Conveying empathy
“Ok, so it’s almost like it makes everything else safe if you know that staff can be firm and protect everybody?”	Reflective questioning to clarify understanding
“you mentioned something about the staff getting in a bad mood, and that might affect you, I was wondering whether there was anything else, like there’s other ways in which the staff reacted to you, or something about how that might change, following an incident, or following something violent?”	Conveying understanding and probing further

2.6.4 Participants and recruitment. Within an interpretivist paradigm, purposive sampling is commonly employed (Creswell, 2003; Denzin and Lincoln, 2000). A purposive approach to sampling allows identification and pursuit of participants best positioned to answer areas of examined interest (Creswell, 2003). I aimed to undertake purposive homogenous sampling and recruit between 6 – 10 participants (Flick, 2008; Morse, 1994; Creswell, 1998). I anticipated selecting a homogenous sample of ‘typical’ patients, based upon uniform characteristics, would allow detailed analysis of psychological variability within the sample. Appropriate participant criteria was pre-specified (Miles & Huberman, 1994) through inclusion

and exclusion criteria. As inclusion and exclusion criteria were applied to the pool of potential participants, I relied upon convenience to recruit all patients who met criteria and were interested in participating. I did not anticipate large numbers of eligible patients would wish to take part in the study. All female patients within the low and medium secure services of one NHS Trust were invited to participate, and screened for eligibility after expressing initial interest.

Patients were eligible to participate provided they were: female, aged between 18 – 65 years old, detained within the low or medium secure units, and had witnessed – or perpetrated – violence within the unit they were currently detained in. Participants were required to possess a psychiatric diagnosis of Borderline Personality Disorder (BPD), as evidence suggests individuals who have attracted this diagnosis may experience pervasive interpersonal difficulties, experience professionals as unhelpful and hostile, have commonly experienced substantial developmental trauma and may experience re-traumatisation following exposure to violence (Nehls, 1999; Moloney, van den Bergh & Moller, 2009; Swift, 2009). Additionally, a BPD diagnosis was required in order to ensure initially that the sample was as uniform as possible, meaning that diagnosis would not be an issue when analysing and interpreting findings.

For practical and methodological reasons, certain exclusion criteria were applied. Individuals receiving one-to-one clinical observations at the time of recruitment were to be excluded as this would prevent meeting with them alone. Females experiencing acute psychosis were to be excluded due to anticipated difficulties with communication and expressing lucid experiences. Patients deemed by their clinical team to pose too serious a clinical risk for me to interview alone were to be excluded. Individuals for whom English was not their native language were to be excluded as this was believed to potentially inhibit a comprehensive and accurate

linguistic appreciation of their experiences, and the use of interpreters may have restricted information elicited from the research interviews (van Nes, Abma, Jonsson & Deeg, 2010).

Eight participants were recruited to the study from the low and medium secure units. All participants who expressed an interest in participating were recruited apart from one individual who did not possess a BPD diagnosis. No other individuals expressed an interest in participating and were therefore not suitable for recruitment. None of the recruited participants withdrew from the study.

The practical attainment of data saturation within qualitative research appears poorly demarcated, but the concept appears to ubiquitously correspond with an assessment of whether significant data has been obtained to support claims, and whether sufficient content validity may be demonstrated by data being gathered to the point whereby no new themes or insights may be observed (Tay, 2014; Francis, Johnston, Robertson, Glidewell, Entwistle, Eccles & Grimshaw, 2010). Mason (2010) argued data saturation should be used as a guiding principle for informing sample size in qualitative research. Data saturation has indeed recently become the ‘gold standard’ by which purposive sample sizes may be appropriately assessed (Guest, Bunce & Johnson, 2006). The generic concept and requirement to achieve data saturation is however problematic (O’Reilly & Parker, 2012) and may only be precisely determined within specific qualitative approaches, such as grounded theory (Charmaz, 2000; Guest, Bunce & Johnson, 2006). Within the present study, sample size was unable to be determined, or informed, by the concept of data saturation due to the low number of patients expressing an interest in participating. Consequently, no claims of achieving ‘data saturation’ are made. Within an interpretivist paradigm data is situated within a particular context, moment, situation, and time; therefore caution should be exercised in generalising to wider populations. Nonetheless, obtained

findings may reveal important insights regarding the lived experiences of recruited participants at that moment in time within the low and medium secure units. Furthermore, an adequate sample size was obtained to yield sufficient answers to the research questions (O'Reilly & Parker, 2012; Marshall, 1996).

2.6.5 Research negotiation. A brief summary of the study and its aims was circulated within the participating NHS trust's secure services management group for review. The research proposal was granted 'whole-hearted approval'. The project was perceived as valuable, and the management committee were pleased to support it within the units (Appendix Q).

2.6.6 Research procedure. The research procedure was refined following discussions with managers within the units, and recommendations following ethical review. The procedure comprised four discrete stages.

2.6.6.1 Stage one: research promotion and participant identification. Ward managers of the low and medium secure units were contacted via email to arrange my attendance at patients' community meetings to promote the study. The ward manager of the medium secure unit was initially more readily available, for practical reasons I concentrated promotion and recruitment within this unit before moving on and repeating the process within the low secure unit. I attended one community meeting within both the medium and low secure units, where all patients were in attendance. I briefly presented the research project verbally; describing the project aims and what would be required of participating individuals; emphasising my independence as a researcher, limits to confidentiality, emotional support available for participating participants. I advised that a financial gift of £10 would be offered. Every patient was provided with a copy of the research information sheet (Appendix J) and asked to contact me to express interest in participating.

Patients were informed that upon contacting me, a second individual meeting would be arranged to discuss the project in-depth, and additional time would be granted after this for them to decide if they wished to participate. I anticipated some patients present within the community meetings would not be eligible to participate, but believed promoting the project within this forum was ethically preferable compared to identifying potential participants through FMH staff, to alleviate undue pressure perceived by patients to take-part, and establish my independence from the service. Ward managers and University administrative staff informed me of potential participants' names via secure email; individuals' eligibility to participate was confirmed with a clinical psychologist within the service.

2.6.6.2 Stage two: recruitment. Convenient times were arranged with ward management via secure email to meet individually with potential participants to discuss the study in more detail. When initially meeting patients, the majority of them immediately expressed they had read the research information sheet, did not have any questions, and would like to participate. However, I explained opportunity would still need to be granted for me to discuss the project with them, and for them to discuss their decision to participate with others; which patients were happy to do. Counselling and information giving skills were employed to reiterate the study aims and procedures involved. I systematically summarised each point highlighted within the research information sheet, and asked patients if they had any questions about participating; emphasising this decision was entirely voluntary and their participation would not impact upon their treatment or legal status under the Mental Health Act (1983; 2007). Each information sharing meeting lasted approximately twenty minutes.

One patient raised a concern, related to issues of confidentiality. Specifically, whether if they said something derogatory about a member of staff I would inform that staff member. I

reiterated the limits of confidentiality, and safeguards to protect anonymity. Following the meetings, all eight patients across the two units remained happy to participate.

Patients were advised a period of two days would be left, following the information sharing meetings, before interviews took place ; to allow time for them to reflect upon their decision to participate and discuss their decision with others. Preliminary interview dates and times were agreed, accommodating prior commitments and activities within the units. Managers within the units were subsequently advised of these arrangements.

To satisfy insurance requirements, allowing me to be alone with patients, and carry a personal alarm, I undertook clinical security management training within the service in July 2013.

2.6.6.3 Stage three: data collection. When meeting with patients to conduct interviews, I assessed their capacity to consent in line with recommendations within the Mental Capacity Act (2005). I ensured the research information sheet was understood and retained, and participants were able to articulate their reasons for participating. This was achieved by asking participants the following questions: “Do you remember what this project will involve?”, “Do you have any questions about the research?”, “What are your reasons for taking part?”, and “Are you still happy to take part today?” Participants were asked to read the consent form (Appendix R), and were encouraged to ask questions to clarify information they were uncertain about. Participants were asked to sign three copies of the consent form: one for themselves, one for their medical files, and one for my records.

Interviews were anticipated to last between 40 – 60 minutes; however the duration was

expected to vary depending upon participants' level of engagement and willingness to discuss areas. All interviews were digitally recorded using a Dictaphone. Provision for a second follow-up interview was incorporated within the research protocol, but follow-up interviews were not deemed necessary for any of the participants, by myself or them. At the end of interviews, plans for the dissemination of findings were discussed along with participants' satisfaction with the information they provided. Participants were reminded that a clinical psychologist within the service was available for follow-up emotional support if required. All participants reported they were happy with the information provided. Members of staff were supplied with participants' one-off financial gift in a sealed envelope following the completion of each interview.

2.7 Data Analysis

2.7.1 Data preparation. Following each interview, I noted my initial impressions of the interview process, and of each participant, along with sources of bias; to provide myself with an aide memoire when transcribing and analysing data. This process helped to improve research quality by creating transparency within the research process (Denzin, 1994; Ortlipp, 2008). I include my reflective summaries (Appendix S), enabling the reader to judge the influence of my biases upon data collection and analysis.

Rather than being transparent, transcripts represent a series of choices made by researchers; reflecting diverse theoretical, political and practical conventions in the transformation of recorded sound to written text (Davidson, 2009). Transcripts of the same data can vary significantly depending upon the purpose for which they are to be used (ten Have, 2007). I chose to refer to a specific notation system, outlined by McLellan, Macqueen and Neidig (2003), to guide the transcription process (Maclean, Myer, & Estable, 2004), systematically organise the data sets, accommodate an iterative process of analysis, and preserve

the integrity of original data recordings (Mergenthaler & Stinson, 1992). Transcription conventions are summarised within Table 2.

Table 2

Transcription conventions for interview content, summarised from McLelland, Macqueen and Neidig (2003)

Content Issue	Convention
Non-verbal sounds.	Type non-verbal sounds in parentheses. For example: (laughter).
Mispronounced words.	Transcribe words as they are said. Do not 'clean up' transcript by removing slang, grammatical errors, foul language, or misuse of words or concepts. Type correct words in square parentheses followed and preceded by forward slashes. For example: "pacifically [/specifically/] I thought".
Filler words.	Transcribe filler words as they are spoken. For example: hm, huh, mm, mhm, uh huh, um, mkay, yeah, yuhuh, nah huh, ugh, whoa, uh oh, ah, and ahah.
Inaudible information.	If a segment of the interview recording is indecipherable for transcription, place the phrase "inaudible segment" in square parentheses within the transcription. For example: "I wasn't sure what she meant when she [inaudible segment] with him"
Overlapping speech.	Transcribe the phrase "cross talk" in square brackets immediately following the last speaker's identifiable text, and continue with next audible speaker. For example: "Um, I have no idea [cross talk] but yes I think that's probably the case".
Pauses.	Brief, two to five second pauses identified and transcribed through the use of three ellipses, for example: "The last time it happened...it was very difficult". Considerate speech delays identified and transcribed by using "long pause" in parentheses, for example: "I'm not sure what happened (long pause) it's difficult to remember".
Sensitive information.	Replace sensitive, identifiable information, such as participants' names with appropriate naming convention. Transcribe an equal sign immediately before and after other identifiable named information, such as other peoples' names, locations, organisations, and replace named information with appropriately disguised replacement. For example: "I was talking to = Alice = and she told me that she'd seen him do that to = Theresa = on = Springfield = ward".

It has been argued that verbatim transcripts can never be produced (Emerson, Fretz & Shaw, 1995), as transcripts represent "artificial constructions from oral to written mode of communication" (Ibid, p. 163). I chose to omit non-linguistic information, such as body language and facial expressions, along with intonations and emotions. I chose to include information

pertaining to context such as pauses, and all verbal information, such as laughter, sighs, coughs, and other utterances. I took time to ensure punctuation did not change the conveyed emphasis or intent of participants' accounts. Interviews were transcribed manually, using Microsoft Word and the Digital Voice Editor (Version 2) computer software (Sony Corporation, 2004). Digital audio recordings were transferred to a computer, and listened to and transcribed using the aforementioned computer software, with aid of a transcription pedal. Interviews were transcribed in the order with which they were conducted. I checked the accuracy of transcripts against digital interview recordings three times; and checked each transcript twice more to correct grammatical errors and protect participants' anonymity. This process allowed me to immerse myself within the data, and become "intimately familiar with the content" (Ellsberg & Heise, 2005, p.204); although I recognised that the process of immersion would continue until each interview had been fully examined and themes identified (Denzin & Lincoln, 1994). The accuracy of transcripts was additionally checked by my primary supervisor.

Each transcript was read line by line, and annotated with my initial thoughts, ideas, beliefs, sources of bias and personal reactions, before the process of analysis began (see Appendix U for example excerpt). This was undertaken to promote a sense of transparency within the analysis process (Moravcsik, 2014) and ensure I remained mindful of my own positioning in relation to participants' accounts when interpreting data.

2.7.2 Thematic analysis. Data was analysed by means of thematic analysis. To assist with this I attended a workshop facilitated by Virginia Braun and Victoria Clarke in July 2013 which included a mixture of theoretical presentations and workshops aimed at developing data analysis skills. I adopted different approaches to reading participants' interview transcripts, as outlined by Miller and Crabtree (1999) who apply the metaphor of dancing to the reading of

transcribed qualitative data, and the three ‘modes’ within which a researcher may read textual information. Firstly, a researcher may engage with the text at a literal content level, whereby the data leads the dance. Secondly, a researcher may engage reflectively with the text, paying attention to sources of bias, meaning the researcher leads the dance. Finally, a researcher may engage with the data interpretively whereby they attempt to construct their personal interpretation of meanings.

I adopted an inductive, ‘bottom-up’ approach to coding, to establish links between research objectives and raw data, and summarise extensive data within a concise format (Braun & Clarke, 2006; Thomas, 2003). Inductive coding is congruent within an interpretivist paradigm (Cohen, Manion & Morrison, 2007). I anticipated implementing a data-driven approach to coding would minimise the influence of my preconceptions within the depiction of participants’ experiences, while acknowledging “data are not coded in an epistemological vacuum” (Braun & Clarke, 2006, p12) and that data interpretation would be influenced by the research objectives and my experiences and assumptions about the raw data. I acknowledged the development of thematic categories, encompassing significant processes and themes within the data, were developed based upon my personal judgements; therefore another researcher may likely produce different findings (Thomas, 2003).

I constructed themes at a semantic, rather than latent, level, based upon participants’ explicit verbalised accounts rather than the implicit unspoken meanings behind their communication. While this approach may invariably confer a loss of some interpretative complexity within the process of analysis, I hoped a semantic level of analysis would foster resonant description of the raw data in-keeping with participants’ experiences. To avoid mere summarisation of semantic content, patterns within categorised themes along with their broader

significance, meanings and implications were interpreted in relation to psychological theories and previous literature (Braun & Clarke, 2006; Patton, 2002) (see Appendix V).

I adhered to the Braun and Clarke (2006) six phase process model for conducting thematic analysis, summarised within Appendix W. The process of analysis involved a constant “moving back and forward between the entire data set, the coded extracts of data that you are analysing, and the analysis of the data that you are producing” (Braun & Clarke, 2006, p.15). Data analysis was facilitated by use of MAXQDA qualitative data analysis software (VERBI Software Consult. Sozialforschung GmbH, 2012). See Appendix V for a coded excerpt.

2.7.3 Quality assurance. Distinctive methodological and philosophical positions exist for establishing the trustworthiness of qualitative data (Cutcliffe & McKenna, 1999). I adopted a position whereby the present study was appraised using criteria developed for, and fitting, the qualitative paradigm (Hammersley, 1992), namely Lincoln and Guba’s (1985) evaluative criteria for qualitative research. Techniques promoting credibility, transferability, dependability and confirmability were adopted throughout the research process to promote rigour, enhance reproducibility, minimise the impact of bias upon findings, and improve validity and reliability (Mays & Pope, 1995; Tuckett, 2005).

Promoting credibility involves adopting strategies to ensure reported findings denote a sincere interpretation of participants’ original data (Lincoln & Guba, 1985). I enhanced credibility by immersing myself within the data set, transcribing and listening to interview recordings multiple-times until I was able to locate specific data passages with ease. Other strategies to enhance credibility, such as prolonged engagement in the field, and member checks, were not adopted due to practical constraints and risk management procedures associated with my pregnancy. It is argued that credibility may be appraised by evaluating the ability and effort

of the researcher, as the researcher themselves are the instrument (Patton, 2002). Therefore, the credibility of presented findings may reasonably be appraised by the reader.

Transferability refers to the extent with which findings may be generalised to other contexts and situations. Qualitative data must be appreciated within the specific context it was obtained (Shenton, 2004). Within an interpretivist paradigm, it has been argued “the only way to generalise to a new setting...is for a theory to survive an empirical test in that setting” (Carcary, 2009, p.15). Transferring findings to other settings is dependent upon the degree of congruency between the context within which the study occurred and the context within which the findings are to be applied, namely ‘inferential generalisation’ (Lewis & Ritchie, 2003). The responsibility of assessing transferability lies with the person(s) wishing to transfer findings to other situations, contexts, or populations (Lincoln & Guba, 1985) so long as researchers provide sufficient descriptive information enabling comparisons and evaluations to be made. Therefore, to facilitate evaluations of transferability, the boundaries and context of the research is presented (Cole & Gardner, 1979; Marchionini & Teague, 1987; Shenton, 2004) along with thick descriptive accounts of the research process (Lincoln & Guba, 1985; Ryle, 1949).

Dependability relates to the extent with which reported findings are consistent. Within a positivist framework, high dependability translates as meaning if the same methods were repeated in the same context with the same participants, comparable findings would be obtained (Lincoln & Guba, 1985). Within an interpretivist paradigm, dependability, relates to whether researchers have accurately presented data, and taken sufficient care within data analysis and recording (Carcary, 2009). To permit evaluation of the dependability of findings, a dense and transparent description of the research design, and operational implementation, is presented. Data collection was carried out consistently, participants were granted ample opportunity to

share their experiences, and interpretations are accompanied by verbatim extracts (Lewis & Ritchie, 2003).

The concept of confirmability concerns whether reported findings reflect ideas and experiences within the data, or are unduly influenced by the preferences, characteristics, and biases of the researcher (Lincoln & Guba, 1985; Shenton, 2004). To monitor and reduce the impact of my preconceived ideas and biases upon data collection and analysis, I ensured time was taken to reflect upon my thoughts and feelings throughout each stage of the research process, within: the formulation of interview questions, data collection and analysis, and the interpretation of findings.

CHAPTER THREE: FINDINGS

3.1 Introduction to Chapter

Within this chapter, I present themes and subthemes derived from participants' data, encapsulating five domains. Themes and subthemes are accompanied by interview extracts to facilitate understanding of patients' lived experiences; illustrating my analytic interpretations, and permitting the reader to derive their own interpretation. To protect anonymity and confidentiality, demographic information, specific contextual information, and participant profiles are omitted.

3.1.1 Navigating the reader. In addition to transcription conventions described earlier, double asterisks were used to disguise individual participants' particular turns of phrase. Verbatim extracts are presented and accompanied by paragraph indicators, locating participants' quotes within their interview transcripts.

3.1.2 Interview order. Table 3 outlines the order research interviews were completed, with participants' accompanying pseudonyms.

Table 3

Research interview order and participants' allocated pseudonyms (N=8).

Interview Order	Allocated Pseudonym
1	Daphne
2	Cora
3	Alice
4	Brenda
5	Elsa
6	Fiona
7	Grace
8	Helen

3.2 Overview: Themes and Subthemes

Twenty themes and fifty-five accompanying subthemes were extracted. Table 4 provides an overview of constructed themes and sub-themes. The presence of subthemes across participants' data sets is presented within Appendix T.

Table 4

Constructed themes and sub-themes extracted from participants' data (N=8)

Domain	Theme	Sub-theme(s)
Nature of TRs	Changeable, conditional and restricted	They're either good, or bad Maybe I was wrong about you Am I good enough yet? If we're close, we're very close
	It's a marathon, not a sprint	Do you want a relationship? It's a struggle I'm not sure about you yet Time's a great healer Needing to be well enough
	What can you offer me?	Will you stick around? Knowing and doing
	Shaped by perceptions of care	Feeling like you really care Treating us badly Neither of us want this Not ready to let my guard down Treated with dignity
	Influence multiple outcomes	Helping us to get better Protecting ourselves and others
	We need to be compatible!	
	Shaped by the FMH system	Feeling grateful Feeling neglected Boundaries keep us safe Power and powerlessness Too many women and not enough space!
Reason for, and function of, violence and aggression	It's a product of the system	Comes with the territory Violence breeds violence
	We're to blame	Gets my needs met! It's what we're used to doing How else do I show you how I feel? It's my mental health Attack as a form of defence
	Staff are the aggressors!	
	We can't make sense of it	

Table 4 continued

Domain	Theme	Sub-theme(s)
Lived experiences of violence and aggression	It really affects us, emotionally, and practically	Affects our recovery and progress We become shielding and defensive Wanting to avoid reality Moralistically judging others Deeply emotionally affecting Gaining control as a way to cope
	Creates a negative ripple throughout the system	They punish and dismiss us all! They treat us all differently! Makes our behaviour worse Cutting the atmosphere with a knife
	Pervasive and diverse	Frequency is in the eye of the beholder It comes in any form Everyone does it We don't always mean to hurt you
Impact of violence and aggression upon TRs	It helps to strengthen them!	Our allegiance is to staff Produces unexpected benefits
	Damaged by changes in staff behaviour	Dismissal and retribution We're sensitive to staff mood Being absent and avoidant
	Lying compromises trust	
	There is no impact	
Management of violence and aggression	Staff try but struggle to get it right	Taking care of ourselves Staff trying to get it right They don't know what they're doing! Needing staff to be 'present'
	We need you to actually do something!	Getting away from it We're reliant on you Take these feelings away from me or help me make sense of them!

Note. TRs = Therapeutic Relationships.

Supplementary data representation is presented within Figure 1, visually highlighting patterns of coding for each constructed domain (adapted from Verdinelli & Scagnoli, 2013). The document portraits (Figure 1) demonstrate how much text has been coded for each domain, according to the colours assigned within the coding system; and the amount text which remained uncoded. Codes relating to the nature of TRs, and the lived experiences of violence and aggression most prevalently applied. Codes pertaining to the impact of violence and aggression upon TRs were least frequently applied.

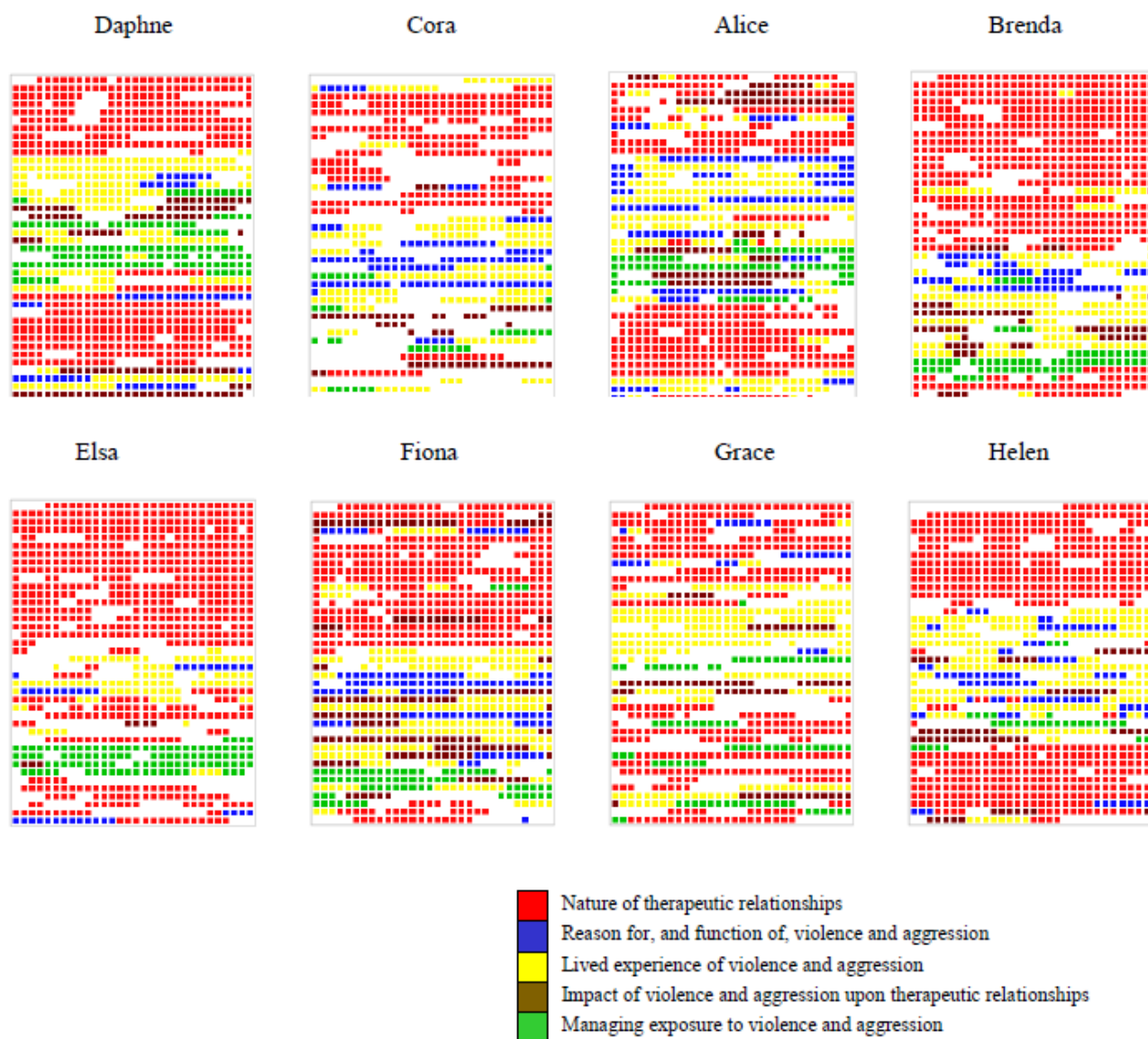


Figure 1. Document portraits for research interview transcripts, depicting the prevalence of coded segments associated with each overarching domain ($N=8$).

3.3 Domain One: The Nature of Therapeutic Relationships

Seven themes, and twenty three composite subthemes, were constructed summarising participants' perceptions of the nature of TRs.

3.3.1 Theme one: changeable, conditional and restricted. TRs are conceptualised as dynamic processes as opposed to static states; and categorised in dichotomous terms. Strong TRs are differentiated from working relationships with staff within the wider team.

3.3.1.1 *They're either good or bad.* Staff are perceived as 'good' or 'bad'; with varying degrees of strength for each categorisation. For example, Fiona reported "most of them I get on with but there's only a couple you think when they come on shift you're like oh it's just going to be a nightmare" (para. 23), and Helen observed "staff are really good, I mean if it wasn't for coming in to = this service = and having the treatment and support from staff which I've had, I wouldn't be here now today sitting and talking about it." (para.29)

3.3.1.2 *Maybe I was wrong about you.* First impressions of staff do not 'stick', and strong TRs may be forged and sustained despite negative first impressions. For example, Helen noted:

One particular staff nurse that I fell out with when I first come [/came/] into hospital, I used to hate her guts, now she comes on = here = and works and we get on really well, really close. I really get on with her... We've just sort of broke [/broken/] that barrier. (para. 83)

3.3.1.3 *Am I good enough yet?* TR quality, and staff readiness to meet patients in forming and sustaining relationships, is contingent upon the acceptability of patients' behaviour. For instance, Alice conveyed "well on the whole, [my relationships are] generally quite good, depending on [/upon/] my behaviour" (para. 31) and Brenda reported TRs were:

much better now 'cos [/because/] when I first come [/came/] I was very unwell, unsettled, and I'd attack staff so I didn't get on with staff at all, they they tried their best but they couldn't, just got tired in the end. (para. 5)

3.3.1.4 *If we're close, we're very close.* TRs tend to be strongest with an exclusive, number of staff. For example, Daphne reported "one or two, that...I wouldn't call them friends, but I would say, if I was on the outside...I'd like to have them as a friend because we've got similar personalities and get on well" (para. 144), and Grace conveyed "there is [/are/] two particular staff members that, um, I, I sort of like get on really really well." (para. 35)

Patients have ‘favourite’ members of staff, and emphasise specific ‘good’ individuals within the staff team, for example: “everyone has their own staff who they think are favourite members of staff” (Fiona, para. 175), and “there's some that's [/who have/] been here like = Sarah = that's [/who has/] been doing it for years, who's straight-up.” (Elsa, para. 59)

TR quality appears influenced by the degree of familiarity and understanding staff have of patients, for example: “I tend to get on with like the MDT team, my doctors and stuff, and then I’ve got a key worker, co-worker and associate and get on with them fine” (Daphne, para. 11), and “only my key-worker and my, and the um ward manager know me.” (Helen, para. 269)

TRs are distinct from wider, less bonded, relationships with staff, for instance Daphne commented “most of the team seem fine as well...when they’re here” (para. 13), and Grace reflected “there's one member of staff who I like trust the most, um, and the rest...sort of.” (para. 15)

3.3.2 Theme two: it’s a marathon, not a sprint. The process of forming TRs is a long struggle, and influenced by a range of conditional elements.

3.3.2.1 Do you want a relationship? Difficulties exist in establishing TRs if staff are not open to forming genuine human connections; while demonstrations of care ease the process. For instance, Alice observed “[staff] could of [/have/] been more friendly and more supportive than what they were” (para. 94) and Cora reported “they only talk to you if you’re upset and you have to ask them, they don’t just come up to you and say “what’s the matter?”” (para. 22) whereas

Brenda noticed “staff were all smiley and happy to help me and that, laugh and jokes about the food being bad.” (para. 84)

3.3.2.2. *It's a struggle.* Challenges with transitioning into the service combined with long-standing interpersonal difficulties mean forming TRs can be a struggle. For example: “it was quite hard because I've always had, like, trust issues” (Daphne, para. 37). Cora reflected “I guess I built up relationships through restraints, not really a good way to build it but that's how I built 'em [/them/].” (para. 66)

3.3.2.3 *I'm not sure about you yet.* Sensitive towards the power and influence staff have over their lives, patients are fearful of approaching staff to form genuine trusting relationships.

For example, Grace commented:

When I first came here it was sort of like terrible, um, it sort of like unsettled me very very much, um, and I'd reluctantly speak to the staff, I was very angry (long pause) and I like didn't like really like sort of like trust or like the staff. It was a sort of process. (para. 21)

Elsa additionally observed “I've learnt it's the only way to move on in here is to be extra nice, you have to walk on eggshells [with staff].” (para. 25)

3.3.2.4 *Time's a great healer.* Forming TRs is a process requiring the passage of time to accomplish. For instance, Brenda commented “they never gave up on me, but then they kept, come [/came/] back to me every time and gave me another try and now they've got me through it, so really good, I respect staff a lot, I have a lot of respect for the staff.” (para. 5)

Opportunities to spend time with staff are vital when forming relationships, for instance Daphne observed:

they do make it quite easy for you, they sit and create some time and especially when you're on like, closer observations when you first get here, they seem to want to spend more time with you and develop those relationships. (para. 37)

Building trust and developing relationships is facilitated by staff demonstrating steady consistency and perseverance within attempts to engage patients, for instance Brenda recalled:

I would probably end [/have ended/] up = never moving on = if staff had given, if staff had given up on me I'd be on = another ward = now. Because I.I..I've hurt a lot of staff and I've done some bad stuff but um, staff never gave up on me here, they've never gone "no we're not having you", "I don't care" and locked me away for ages. That's what places, places normally do sometimes, just lock you away until, 'till [/until/] the problem goes away. (para. 31)

Fiona commented that trusting a member of staff "just happened [inaudible segment] over many years = Identifiable Information Removed = I don't know, just not giving up on me really, really just persevering." (para. 61)

Long-lasting attachments are regarded highly, and emphasised as beneficial. For example: "I knew some of them from = elsewhere = because I've lived here = for a long time =, so it was nice to know them from = there =" (Daphne, para. 37), and Alice additionally mentioned "yeah. I love her to bits, she's such a lovely lady, I've known = Tracey = years." (para. 262)

3.3.2.5 Needing to be well enough. The ability to form TRs is contingent upon the stability of patients' mental health. Feeling unsettled and emotionally uncontained inhibits TR development. For example, Helen conveyed:

I've had moments when I was very unwell where I hated all the staff, I felt [/as though/] I just didn't get on with any of them at all. All they were trying to do was help me. I took that as a negative, and felt that everyone was against me. (para. 33)

3.3.3 Theme three: what can you offer me? Staff are expected to bring consistency, along with something ‘useful’, to TRs. What staff are able to offer as currency within TRs is invariably influenced by the nature of their roles.

3.3.3.1 Will you stick around? The regularity, and permanence, of relationships corresponds with patients’ perceptions of staff commitment and dedication to providing adequate nurturing. For instance, with regard to bank staff, Daphne reported:

Their heart doesn’t seem to be in it as much, they, quite a lot of them usually count down how many hours they’ve got left, saying “ooh, so many hours until I can go home” and it’s a bit off-putting because it’s like well we can’t go home for a long time, I know it’s our fault but...it’s sort of rubbing your face in it a bit and they don’t seem to want to get involved as much. (para. 9)

3.3.3.2 Knowing and doing. Merely spending time in the presence of staff is not sufficient for sustaining relationships. Patients expect their needs to be met within the context of TRs. Staff who have little to offer in terms of formal professional knowledge are devalued, for instance:

The support workers they could be like anybody, do you know what I mean? As long as they’ve got like, they can restrain and they just, anyone could become a support worker so to me I don’t think they’ve got the knowledge or the understanding sometimes to cope with us in a way that we feel it’s helped us but with the qualifieds [/qualified staff/] they’re much more professional. (Helen, para. 257)

3.3.4 Theme four: shaped by perceptions of care. Evaluation of TR quality is determined by how attuned and responsive staff are perceived as being towards patients’ needs.

3.3.4.1 Feeling like you really care. TR quality is affected by the presence of staff attributes and personality characteristics perceived as indicating they are nurturing towards patients. Staff demeanour affects relationships, and patients’ mental wellbeing. For instance, Fiona observed:

I really get on with = Jane = she's amazing, she's absolutely amazing, she's...I don't know, she's just, you can have a, a lot of them basically you can have a real laugh with, and um, and, sometimes it doesn't feel like a hospital. (para. 15)

Grace also emphasised the importance of “them not to be like angry, and um stuff like that, to actually care about you.” (para. 205)

Evidence of staff vocational passion, and genuine desire to be ‘present’ is valued, but inconsistently experienced. For example: “...some staff are quite...don’t want to talk to you, like just come in and do their job, most staff here, um, wanna [/want to/] help you and do anything they can for you” (Brenda, para. 11). Daphne further noted “it’s just nice to know they’re observant enough to see how you’re feeling and direct their time [inaudible segment] if it’s a negative then they just want to do something about it.” (para. 43)

Patients value indicators of affection from staff; and show a preference for relationships with staff who demonstrate consideration, sensitivity, warmth and kindness. Relationships with staff who are unable to demonstrate these qualities are experienced as challenging. For example: “like, when they like, talk to you as if you’re human, instead of talking to you as if you’re a robot” (Cora, para. 34), Brenda also observed:

and it’s not, it's not really a no, they don’t really say no here, instead of saying “no” it’s like, it’s not “we’ll see”, it’s more like, “um, we’ll try our best”, and they always do try their best to get everything you need. (para. 15).

Brenda further elaborated:

Some staff just don’t want to do, um, anything, like, you ask them and they're like “I’m busy”, and they're the ones that sit in the office and do nothing, but most of [/the/] staff, like the ward manager and everyone is really good. (para. 19)

Interpersonal consistency offers patients a sense of safety and security, and is valued highly. Daphne commented “I had someone really really good who was my key worker for = a long time = and would see me religiously, every week, for an hour, and that was so much better”

(para. 126). Brenda emphasised the importance of consistency and stability through boundary enforcement:

Well say someone, someone's quite shy and doesn't know what to do and staff are like really strict and that and the people are like muscle in like run around the ward like they do 'cos [/because/] staff can't, haven't got the authority to say "no you can't do that", they're too scared to say "don't do that", or 'cos [/because/] you're thinking they'll have a go at me, and hit me, and they won't say anything. (para. 66)

3.3.4.2 *Treating us badly.* Being in the presence of staff whom patients perceive as abusive, dehumanising, autocratic and inadequate, is challenging, and invariably inhibits TR formation and maintenance. For example:

= they'll = sit and say to me "oh, how long do you think this one will last?" like, patient, "before they go back on obs [/observations/]"; it's like, that's just off, and I sit and put up with it and I've reported it in the past, and other patients have reported = them = in the past, and nothing comes of it. So you don't bother anymore, you just put up with it. (Daphne, para. 134)

Inconsistencies in care provision is perceived as damaging for relationships. For instance, Elsa conveyed "= Hannah's = pretty good but then again she has favourites as well I'm afraid. They do invest a lot of time in the younger ones instead of getting the older ones through quicker and out" (para. 69), Alice further elaborated:

when I'm struggling I'll always go to a member of staff, certain member of staff for a cuddle they'll say "oh no I've been told off for cuddling people", but yet last night she cuddled a patient because they were crying, exactly what I was doing and she said "no I'm not giving you a cuddle", but they play us off against each other sometimes, night staff do. (para. 274)

3.3.4.3 *Neither of us want this.* Mutual interpersonal dismissal and avoidance exists between patients and staff. Patients perceive lack of care as a consequence of such dismissal, and that not all staff are 'available' to forge relationships with. For example: "they spend all their time in the office, you know, maybe they have to, they've got so much work to do that they hardly get to know anyone, maybe they need to get to know people really" (Elsa, para. 171), and

“I get very sensitive towards new staff, um, uh...it's like sometimes I like say like “morning” or “hello” to, um, to the staff, sometimes they don't say it back.” (Grace, para. 7)

3.3.4.4 *Not ready to let my guard down.* Anxiety experienced when interacting with staff, combined with staff failing to put patients at ease, inhibits TR formation. For example, Grace commented “I feel like scared to talk to staff, or I feel nervous to talk to staff, or I feel like I can't talk to staff.” (para. 225)

3.3.4.5 *Treated with dignity.* Staff who demonstrate patients are worthy of their respect, trust, and honour are regarded highly, for instance: “there's a lady on here called = Sarah = she's so sweet, she's got so much respect for me and trust in me.” (Alice, para. 260)

3.3.5 Theme five: influence multiple outcomes. TRs serve functions other than the experience of a positive attachment relationship, and have the power to influence recovery and perceived safety.

3.3.5.1 *Helping us to get better.* TRs influence patients' progress through the system. TRs provide the forum within which to develop interpersonal skills and emotional self-regulation strategies, which prevent incidents of violence. For example: “I find it really difficult to trust people, but, through building relationships with people [inaudible segment] eventually you learn to trust 'em [/them/], well eventually, and then you can talk to them and then you feel safe.” (Fiona, para. 25). Cora highlighted “need people around you to be able to, start building social skills” (para. 46), Daphne additionally emphasised “you're just gonna [/going to/] end up being violent, or having incidences [/incidents/] which set you back and 'cos [/because/] you can't be honest, you can't share your feelings.” (para. 25)

TRs offer companionship, which bestows a motivating sense of encouragement. For instance, “I like to know when staff are on again so you know if I’m having a bad day, oh yeah they’re on tomorrow it’s good; and it’s just seeing a friendly face type thing” (Brenda, para. 41). Helen further emphasised:

they're trying to help you and if you're like rejecting their help, or decline their help, what else can they do? Can't physically make you get better, they can encourage you, engage you with things and, I think it's really important that you do have good relationships with staff. (para. 87)

TRs offer attachment security, and provide opportunities to obtain containment. Grace commented for example “= Lucie = like I, uh, I feel quite attached, attached to her as well. Because she's sort of like been there when I was really really ill [cross talk] yeah then I was really ** ill but now um = we've got a good relationship =” (para. 43). Fiona reported “think the good thing with staff is they're really normal, be [/they're/] able to have a laugh a little bit but keeping [/keep/] to their professional boundaries.” (para. 67)

3.3.5.2 *Protecting ourselves and others.* TRs serve to buffer patients against disadvantages associated with living within the units. For instance, Elsa conveyed:

they [staff] have this power over you and it, it's not like in prison, you have a date when you're going to get out in prison, you can be your own person, in here they, I'm afraid they have absolute power, and so you have to be nice, even if they're unpleasant to you, you have to be nice because they write down everything you say and do, and some things aren't true, it's their interpretation. (para. 7)

Alice additionally commented:

Yeah, they try and talk to me and say right what's wrong, why are you self-harming I say well you know, this ward's hard, and people self-harming makes me wanna [/want to/] do it they help me find a way of not self-harming. (para. 290)

3.3.6 Theme six: we need to be compatible! Patients find it difficult to form TRs and live harmoniously with staff due to perceived characterological incompatibility. It is unrealistic to expect TRs can be formed between all individuals. For instance, Helen observed:

It's like in any, any work or job or anything that you do, I mean you don't get on with everybody, you know it's a real world out there and people have people that you do dislike and there'll probably be people in my care plan that I dislike but you know, I can't like everybody. And there's obviously been nurses and staff on the ward that I've just clashed [/with/], or we don't get on, you know 'cos [/because/] they don't understand me, you know, but some of my behaviours were very childish (para. 75)

3.3.7 Theme seven: shaped by the FMH system. TRs are influenced by aspects of the forensic system, and system norms.

3.3.7.1 Feeling grateful. Patients journey through the forensic system before the importance of TRs is realised. For example: “now I look back I can see how it's helped me along the way. It's been really positive, the consultants are fantastic” (Helen, para. 33). Material comforts do not influence patients' perceptions of care or TR quality, for instance Brenda expressed “I think NHS is better than private sometimes, 'cos [/because/] private you, they, they've got the money but they haven't got the care” (para. 37) and further “some of the stuff is basic, right, it's not all designer stuff, and like a swimming pool and stuff, but at the end of it the quality of care is much better” (Brenda, para. 39).

3.3.7.2 Feeling neglected. The forensic system overlooks and deprioritises patients' basic needs. Elsa, for example, voiced concerns about a lack of attention towards physical wellbeing:

get some healthy eating, stop people having seconds, ** get some, there's a gym, we get over there = Identifiable Information Removed = I don't like all that stuff, but there's people here who need it desperately, even the youngsters like = Kimberly = she's got a huge gut from all the meds [/medication/] they've pumped into her, and that must affect her self-esteem. (para. 261)

Whereas Brenda referenced lack of support with managing administrative matters:

they overwhelmed me a bit with all the paperwork, they were like “fill this form, fill this form, fill” and they wasn't [/did not/] explaining [/explain them/] to me ‘cos [/because/] I was signing forms 'cos [/because/] = it wasn't explained that well = I was just signing forms. (para. 84)

3.3.7.3 Boundaries keep us safe. Allowing patients to see the ‘human’ side of staff was experienced as motivating and beneficial for TRs. For instance, Cora felt that “say if they’ve self-harmed in the past sort of thing, yeah just sharing, saying how they got through it [inaudible segment] to help us get through it.” (para. 76) Fiona elaborated:

knowing they've [staff have] got a seven year old daughter or twelve, fifteen year old son or whatever kind of is nice but you don't wanna [/want to/] know their names, school, you know, but it's nice that lets, lets them in a tiny bit without breaking professional boundaries, say look I'm human, I have a life too (para. 69)

Boundaries related to unit routine provide a welcome sense of physical containment.

For instance:

the structure of the ward is quite good, I mean we've got our own individual timetables now so we know what we're doing, which is a good thing because this ward didn't have much structure before and now it's got quite a lot to do on here and a lot more activity wise, like we do groups in the morning, afternoon then late afternoon and then have supper, at weekends as well, as takeaways so it's quite good. (Alice, para. 98)

3.3.7.4 Power and powerlessness. Navigating interpersonal power dynamics, as recipients of care within a coercive environment, impacts detrimentally upon mental wellbeing.

For instance, Elsa commented:

shouldn't be this power thing, and no one knows when they're getting out, there's no hope in these places, 'cos [/because/] even when you're getting out you can be waiting for ages. Maybe if there's more hope, because like = Mandy = is getting out soon and when she found out she was getting out she stopped self-harming. (para. 241)

TRs are influenced by staff failing to empathise with patients’ lack of self-determination, for example by “understanding what it's like to be totally powerless with, you can't even plan your future.” (Elsa, para. 245)

3.3.7.5 *Too many women and not enough space!* Emotional wellbeing is affected by unit physicality. Mental wellbeing is influenced by inadequate resources and maladjusted care provision, for instance:

I know we're mental health patients but do we really need to be doing arts and crafts and board games? Do you know what I mean, I feel like there's, our teacher, a qualified teacher, I'm sitting here doing board games and arts and crafts, where do they get that that helps our mental health? When I'm sitting there and I'm thinking all this time, just offer me half an hour or something, fifteen minutes, with somebody, just so I can explain how I'm feeling. (Helen, para. 277)

Fiona also highlighted:

there's nowhere where you can just sit and write and there's not, there's like, there's all television and you know what I mean, the television's always on and there isn't really anywhere you can escape from that bit, only certain times. We have = another area but that's shut off at certain times = and this room's shut = then too = we're all bunged just in that area. (para. 33)

Physical space is welcomed for offering mental and emotional respite. For example,

Brenda conveyed:

we're not = Identifiable Information Removed = on top of each other all day 'cos [/because/] you're all stuck in = one space = together, on here, if you, if you have a row or something, you can go to your room for a little while and come back out when you want. (para. 78)

Whereas Cora expressed “the layout. It's not really, like I wouldn't say it's very open as well, I think confined in one space you can often row with people.” (para. 62)

Gender dynamics precipitate relational aggression, for instance Helen commented “you don't put = many = women all together, too much bitching.” (para. 209) Single sex units are perceived as paternalistic and restrictive, for example:

I think single sex wards are a very bad idea, even if people have suffered sexual abuse in here, you're getting them ready to go into the real world, men are there! Let's be realistic, these people are saying I don't want to be around men, well it's not reality. (Elsa, para. 277)

3.4 Domain Two: Reason For, and Function of, Violence and Aggression.

Four themes, and six subthemes, were constructed summarising participants' perceptions of the reason for and function of violence and aggression.

3.4.1 Theme one: it's a product of the system. Violence is a normal by-product of the female units, due to the inherent nature of the client population. The system cannot handle violence, particularly with regard to the 'snowballing' effect of incidents amongst patients.

3.4.1.1 Comes with the territory. Relational aggression causes violence, owing to hostility and competition between patients. Alice, for example, recalled "there's always verbal, against each other on this ward, 'cos [/because/] it's a female ward you're gonna [/going to/] get that and one of the patients on here called me a fat cow" (para. 128).

Institutionalisation increases violence, time spent within units correlates with the likelihood patients perceive violence as reflecting acceptable behaviour. For example, Elsa felt patients committed acts of violence "because they can, because that's what they're used to doing. It's what they do, a lot of them have been in these places years, or in and out of hospitals for years, it's what they do." (para. 141)

Punitive repercussions for acts of violence are effective. Cora felt patients committed acts of violence "just because they can" (para. 114). Fiona elaborated:

if a patient attacks a member of staff then I think the staff give in too easily, it doesn't, doesn't show ... consequences 'cos [/because/] they have to keep that professional boundary and not hold grudges and you should hold grudges ... it makes people learn. I remember I was verbal to a member of staff and I kept being verbal to that particular member of staff and then she just ignored me and I think that made me really learn not to do it again, and I haven't. (para. 123)

3.4.1.2 Violence breeds violence. Violence is attributable to a ‘snowballing’ effect within the units. For instance, Alice outlined the need for ‘evening the score’:

I said to staff “can I hit her back?”, they said “no because three seconds has gone so you can't hit her back = and you've got your progress to think of =” I said “listen she's just hit me, I'm not gonna [/going to/] let her get away with it.” (para. 124)

Patients perceive attack as the best form of defence, for example: “they can say I'm settled but one slight thing, someone attacked me I'd attack her back.” (Helen, para. 175)

The re-traumatising effects of witnessing incidents, combined with difficulties containing and regulating strong negative emotions further triggers violence. For example: “[incidents] used to make me really unsettled and if someone else had an incident I used to have an incident but it doesn't really make me that unsettled anymore, I think you just get used to it” (Cora, para. 118).

Brenda further expressed:

everyone gets a bit...uh...like a rush kind of a thing, because the alarm's going, staff running around, then when they go some people get [inaudible segment] and stuff like that but with me I, it makes me think, I wanna [/want to/] get restrained, I wanna [/want to/] get restrained now. (para. 174)

The instrumental use of violence may develop through observational learning. For instance, “I should say 99.9% of it is for attention and I think, and others copy others” (Elsa, para. 125). Fiona also observed “because patients have been violent, been here for a brief stay and try and copy it really.” (para. 131)

3.4.2 Theme two: we're to blame. Patients make an unambiguous choice to use violence, and do so instrumentally to communicate, and seek fulfilment of their needs. Violence is also used as a means of defence.

3.4.2.1 Gets my needs met! Violence is deployed instrumentally for interpersonal gain.

For example “I guess I built up relationships through restraints, not really a good way to build it but that’s how I built ‘em [/them/]” (Cora, para. 66). Daphne further elaborated “so it’s finding somebody to actually listen to you when you are struggling and not ending up having to use violence or self-harm as a way of getting that support.” (para. 120)

The primary aim of perpetrating violence is to achieve physical and emotional containment. Brenda explained observations made her feel:

cared for kind of thing, 'cos [/because/] someone’s with you the whole time, like near enough someone's with you the whole time, and if you've got someone with you then you feel cared for, don't ya [/you/]. (para. 152)

when I was growing up I used to get restrained = often = and then when I come [/came/] here I used to get restrained all the time, then staff said to me you know you’re very dangerous doing this because you can hurt people, and I’d never thought of it like that, and then she like, and then staff helped me look around it that it was maybe not a good thing to hurt people. (para. 158)

Daphne additionally remarked “I think they’ve made room for me at like seven o’clock this evening and I’ve been asking since yesterday...so it’s finding somebody to actually listen to you when you are struggling and not ending up having to use violence” (para. 120).

3.4.2.2 It’s what we’re used to doing. Violence represents the manifestation of historical trauma and abuse. Grace speculated acts of violence “could be because of their past backgrounds” (para. 125) although Fiona commented “I know a lot of people [/who/] have had violence in their life can be really violent but I’d never want to be one of those people” (para. 111).

Violence is caused by the inherent ‘badness’ of some patients. For example: “but most of the time the people obviously aren't unwell and they're just being horrible” (Fiona, para. 109).

3.4.2.3 How else do I show you how I feel? Violence is a substitute for verbalising complex negative emotions. Patients need staff to experience their pain to achieve genuine validation and empathy. Brenda, for instance, explained how violence represented: “frustration, like, anger, I don’t know, I don't know, frustration that builds up to anger and then I suppose...hurt feelings inside, really” (para. 150).

3.4.2.4 It’s my mental health. Violence and aggression occurs as a result of poor mental health. Patients’ mental state is sufficient reason for understanding the prevalence of violence. As an example, Grace reported:

when I first came here I, I wasn't trusting staff at all, I was really really ill and um, uh back then I can't really remember because I was ill, but um I was quite, apparently I was quite violent towards new staff. (para. 21)

Patients’ mental states are volatile, and therefore aggression may surface unpredictably, for instance:

The staff don't come into work here to get abused, or beaten up by patients, you know, you think you can trust people but they put their lives on the line every day when they come in here, 'cos [/because/] you don't know what people are thinking, and you know with like the slightest little trigger. (Helen, para. 157)

3.4.2.5 Attack as a form of defence. Staff manage violence unsuccessfully. Patients therefore take matters of safety into their own hands. For instance “I used to want to defend staff, or defend patients” (Cora, para. 120). Alice recalled an incident wherein:

one of the staff in particular who doesn't like ligatures, it scares her um she found one of the patients [inaudible segment] tying a ligature around her neck and then about two hours after again with another one and that member of staff had to go down and cut it off her and she was traumatised for weeks and then that patient's running around her to say sorry and I thought she was gonna [/going to/] hit her so I stood in the way of the patient and said “if you're gonna [/going to/] hit anyone hit me.” (para. 280)

3.4.3 Theme three: staff are the aggressors. Staff cause violence through poor emotional regulation, and abuse routine system procedures to express hostility. For instance,

Fiona highlighted “= they = used old like restraint techniques, and = Identifiable Information Removed = people on the ground, threw her on the floor, she banged her head” (para. 11). Helen remarked:

they've got this power over you, um and sometimes that power goes straight to their head. And, you know, I, I can't condemn [/condone/] what they've done, I mean you know when I was thrown to the floor in a restraint, um, it was an unprofessional person that did it. (para. 189)

3.4.4 Theme four: we can't make sense of it. Violence appears superficially senseless to observers. Acts of violence appear random and unpredictable. For instance, “well maybe there's a reason for the individual person but they don't show that reason, they don't share a reason when they bring it up in community meeting, or...anything like that” (Cora, para. 112).

Alice commented:

I got off the phone from my mate who's left this hospital now, on Tuesday night and she asked one of the patients here to ring her back at 9 and I said “yeah will do” then I put the phone down turned around and got = assaulted = (para. 120)

Elsa reflected “I don't understand it, I don't want to understand it, I don't want to be here, I don't want to be around it, it's all, it's all pointless violence” (para. 123).

3.5. Domain Three: Lived Experiences of Violence and Aggression

Three themes, and fourteen subthemes, were constructed summarising participants' experiences of violence and aggression.

3.5.1 Theme one: it really affects us, emotionally, and practically. Violence evokes an intensely negative psychological and emotional impact. Patients demonstrate fraught efforts to distance themselves from violent ‘others’.

3.5.1.1 Affects our recovery and progress. Witnessing violence and aggression

detrimentally impacts upon patients' recovery and progress. For example, Grace expressed "well one it like sets you back, and erm, it just makes it being on the ward more and more difficult" (para. 117). Alice reported "it annoys me because I'm trying to move on in my progress and you've got like this dragging me down...so I'm trying not to retaliate to anything, just keep me [/my/] head down more...stuff like that" (para. 134).

3.5.1.2 *We become shielding and defensive.* When confronted with violence, patients seek to distance themselves from the role of passive 'victim', adopting a protective position towards staff, with whom they identify and sympathise. For instance "...these are staff who I do really like care about and um, and um you know you sort of like worry about them you know. You sort of like care about them, you're thinking "you alright" and yeah" (Grace, para. 77). Alice pointed out "well, I know I've hurt staff but when the staff get hurt I'm generally the first one to stand up to staff and say right, look, don't do that" (para. 64).

3.5.1.3 *Wanting to avoid reality.* Physical and psychological avoidance are common defences against the lived experiences of violence. Avoidance is achieved through suppression of feelings and reactions, distancing, and escape. For instance:

she used to want to talk to me about her self-harm and what she'd done and I was like "no I don't wanna [/want to/] know" you know what I mean? I have my own problems, just wanna [/want to/] get out, deal with my = family when I get out =, you know, just be there for family = Identifiable Information Removed = but this ward is just ridiculous for self-harm. (Alice, para. 284)

Daphne further reported "it depends what stage I'm at in my progress because at the moment I'm doing quite well and I've got = access to rooms = so I can just get away from it" (para. 74). Elsa echoed the sentiment of needing to escape "I don't want to be here. Don't want to be around people like that, I'm not like that, you know, I've never been like that, so why have they put me here?" (para. 135).

3.5.1.4 Moralistically judging others. Perpetrators of violence are ostracised by other patients who take the moral ‘high ground’. For example, Daphne expressed “I just used to sit and watch and think oh you idiot” (para. 98). Fiona additionally conveyed:

if a patient like [inaudible segment] a patient attacks a patient then the staff has a duty of care, they have to remove that patient from the ward and to like a secure environment [inaudible segment] but if a patient attacks a [/member of/] staff 'cos [/because/] they're not as important they have to take it, and that's not right, I don't like that at all. (para. 117)

3.5.1.5 Deeply emotionally affecting. Patients defend against the emotional impact of violence through emotional disengagement and psychological ‘numbing’. For instance, Cora explained “Yeah...I’m used to it [violence] though. I’ve been in institutions a long time” (para. 130). Helen further commented:

she's very unsettled, she's having two staff, it's not her fault, she's unwell, but they should accommodate for extra staff because you know like I'm in this situation now and I think what do I do? But I'll be alright, I'll get through it. I always do. (para. 291)

Violence elicits a spectrum of powerful negative emotions, including: anger, panic, desire for retribution, and experiences of feeling re-traumatised. For instance: “I just want to get away from it, because it’s quite upsetting to see someone struggling, whether you think there’s a reason behind it or not, or whether they just want a bit of attention” (Daphne, para. 98). Helen reported:

just a few days ago a patient attacked another patient, started kicking the shit out of her, and then everybody else got involved and started hitting in to this other girl, the other girl's = been moved now = where they're managing her = there = because they couldn't manage her = here = but you get, you know, you just gotta [/got to/] keep your, keep your eyes peeled all the time, because you never know what's, what's, you know what someone's thinking. (para. 129)

Effective management of violence serves to reduce the negative emotional impact patients experience. For instance, Fiona communicated:

(laughs) it would scare someone if I'm honest, coming in to here [inaudible segment] = I'm familiar with incidents so I sort of know = but [inaudible segment] I'd just reassure them that staff do their jobs properly but mainly you are safe here, you know if you do get attacked you're not gonna [/going to/] get beat-on for like 5 or 10 minutes, you'll get beat-on 'till [/until/] a member of staff runs to you to get them off. (para. 163).

3.5.1.6 Gaining control as a way to cope. Violence creates uncertainty and the urge to regain control to manage anxiety. For example, Alice recalled an incident wherein:

she went down the corridor and done [/did/] it again then I said “you'd better just leave her, just let her get on with it 'cos [/because/] she ain't [/isn't/] gonna [/going to/] get very far [inaudible segment] outside anyway”, and then they left her and then I got her keyworker to go down (sniffs) and then her keyworker sorted her out and said “right you need to stop this stupid childish behaviour 'cos [/because/] you're not gonna [/going to/] get anywhere.” (para. 280)

Patients adopt positions of martyrdom, and subjugate their own needs to manage anxieties towards ‘powerful’ staff, and their own helplessness within the unit environment. For instance, Brenda expressed “(long pause) it's quite daunting at first, because you don't know anyone, but, um, everyone's here for themselves” (para. 302). Elsa commented “= they're a very scary person = you've got to patronise = them = all the time. Really have to” (para. 147).

3.5.2 Theme two: creates a negative ripple throughout system. Violence does not occur in isolation of the wider FMH system, and effects changes within other aspects of unit life. Incidents impact upon individuals' behaviour, and the ward atmosphere. Punishment for violence is collectively received by patients.

3.5.2.1 They punish and dismiss us all! Patients experience a sense of collective ‘punishment’ and deprivation of privileges as a consequence of the reprimands enforced upon perpetrators. Daphne observed that “drinks get missed and dinner becomes later and things like that, so we miss out quite a bit” (para. 88). Grace further articulated:

if there's [/there are/] incidents happening they um do patient obs [/observations/] so then like = your = leave could then like be cancelled and things like that, or [inaudible segment] so a lot of things changes when staff are on obs [/observations/] or when you know things have kicked off. (para. 175)

3.5.2.2 *They treat us all differently!* Violent incidents alienate patients from staff due to staff struggling to contain their emotional reactions. Staff take out their feelings on patients by acting unprofessionally. For instance, Daphne observed:

it can bring everybody down, it can really piss the staff off and put them in a bad mood, which, not purposefully I feel, but then end up with them being in a bad mood with the patients who haven't done anything wrong, just because they're having a bad day 'cos [/because/] certain patients are kicking off all the time then ending up getting hurt or tired from having to hold people down for hours on end. (para. 80)

3.5.2.3 *Makes our behaviour worse.* Witnessing incidents of violence evokes a sense of hypervigilance resulting in aggressive and confrontational behaviours. For example “it just makes everyone tense up, wonder if they're gonna [/going to/] get attacked” (Cora, para. 128).

Helen further expressed:

If there's a, a [/an/] um incident on the ward, that affects everybody um because you get really angry you know for instance there was an incident yesterday where a member of staff = was assaulted by a patient = that impacts on everybody, because they're all very angry with this person, started saying like “how dare you do that”...everyone's really angry, you know, but you get loads of violence in a hospital, this environment, there's loads of violence. (para. 113)

Violence evokes distancing behaviours, and damages relationships between patients. For instance, Alice observed “it's horrible. Absolutely horrible. You've got people ignoring each other, people calling each other names, saying things under their breath, and, it's just not nice on this ward at all, it's horrible” (para. 144).

Violence induces a tendency for patients to break unspoken rules of trust and integrity.

Elsa reported:

well you also get, I mean, it's like the one on Saturday, you get people gang together as well, and exaggerate the violence that's been done to them. Lie a lot, also I can understand, that, I've known people, I've known patients lie and accuse staff of doing things, specifically male staff, that they haven't done, I've had to go to one side and tell the staff "look that wasn't real, that didn't happen", you know, that, that's disturbing that they will lie and make things up, people you think you know, will do that. (para. 139)

3.5.2.4 Cutting the atmosphere with a knife. Incidents create a tense, volatile and uneasy atmosphere, impacting upon emotional wellbeing, precipitating further acts of violence, and inhibiting a sense of stability. For instance, "it sets off a major atmosphere, at the moment there's an atmosphere on the ward caused by certain patients, you could literally cut the atmosphere with a knife it's that bad." (Alice, para. 142) Fiona further commented:

the mood changes and everything, it all, it, it, makes other incidents happen like...I don't know, I can't think, little incidences [/incidents/] [inaudible segment] like = here = there was an incident and then that night, it was on the night shift, another person had an incident 'cos [/because/] of the stress of that, the alarms and, they're punching the wall and the alarms go off, another one kicks off and has to be taken to the quiet room, there's like five people kicking off and there's not enough staff. (para. 103)

3.5.3 Theme three: pervasive and diverse. Universal consensus does not exist regarding the definition, or frequency with which violence occurs. Frequency differs dependent upon perceptions of what constitutes 'violence'. Violence transcends patient and staff roles; and intent to harm is variable.

3.5.3.1 Frequency is in the eye of the beholder. Subjective perceptions of what constitutes violence invariably influences assessments of incident frequency. For example, incidents were assessed as occurring: "weekly" (Grace, para. 113), "monthly" (Helen, para. 165), "near enough everyday" (Alice, para. 132). Daphne conveyed that frequency "all depends, we can go three or four days without anything and then we can have two or three incidences [/incidents/] a day" (para. 70), and Cora further observed "more serious is like once every two

days, once every three days, or it'll be settled for like a week, then kick off in like over a week and a half.” (para. 104)

3.5.3.2 It comes in any form. Patients' conceptualisation of violence is broad and inclusive. Verbal violence includes shouting, screaming, swearing, arguments and abusive comments. For instance, Elsa reported witnessing “swearing and screeching, and attacking other staff, and...patients” (para. 105). Daphne expressed “the only thing that is kind of disturbing is seeing any like screaming.” (para. 74)

Intimidation constitutes violence. For example, “you do get bullying, the = unattractive one = is a terrible bully, you know” (Elsa, para. 193). Additionally, property destruction, and use of property to intimidate or break ‘rules’ represents violence, for instance: “loads of things quite sort of like stand out, um, when once someone locked themselves in = a room and they couldn't get in for a long time = that was really really disturbing” (Grace, para. 111).

Internalised anger was conceptualised as commonly experienced violence, for example Cora witnessed “other serious things happen, like people tying lesions [/ligatures/], people swallowing stuff” (para. 124). Helen recalled “I've seen a girl = cut herself badly = not a sharp knife, just a like dinner knife, but she still marked = herself = it was worrying and frightening” (para. 115).

Incidents where control and restraint techniques are deployed provide opportunities for both patients and staff to commit violence. For example, Daphne noted “the majority of patient to staff is in restraint where a patient's gone to self-harm and staff have done their job and tried

to stop them and people have kicked out, or punched out” (para. 51). Helen recollected “when I was thrown to the floor in a restraint, um, it was an unprofessional person that did it” (para. 185).

3.5.3.3 *Everyone does it.* Victims and perpetrators transcend ‘roles’, with both staff and patient groups occupying both positions. Violence directed by patients towards staff, and patients’ violence directed towards other patients constitutes the majority of incidents. However, staff-on-patient, and staff-on-staff violence was also observed. For instance, Helen reflected:

I've seen patients attack patients. I was attacked by a patient, um, before, as well, on = the other ward = I was attacked by one of the patients on = the other ward = um I've seen patients be attacked and beaten up by other patients. (para. 121)

Daphne expressed “the only thing I can think of really, is that there is, or there has [have/] been a few incidences [incidents/] where staff have hit patients” (para. 150), and Elsa reported “I've seen = a member of staff = make staff cry as well” (para. 141).

3.5.3.4. *We don't always mean to hurt you.* Violence is committed with the intention of inflicting harm and involves premeditative consideration of suitable ‘victims’. For example: “so you can do it ‘cos [because/] they’ll be like “oh what can they do back” whereas someone mentions “oh don’t got for that patient, that patient’s gonna [going to/] hit me back”” (Cora, para. 90). Conversely, harm is sometimes an unintended consequence of patients’ actions. For instance, Brenda acknowledged:

staff said to me you know you’re very dangerous doing this because you can hurt people, and I’d never thought of it like that, and then she like, and then staff helped me look around it that it was maybe not a good thing to hurt people. (para. 158)

3.6 Domain Four: Impact of Violence and Aggression upon Therapeutic Relationships

Four themes, and five subthemes, were constructed summarising participants’ perceptions regarding the impact of violence and aggression upon TRs.

3.6.1 Theme one: it helps to strengthen them! Witnessing violence strengthens TRs by increasing patients' empathy with the risks staff face. Violence increases feelings within patients of being protected.

3.6.1.1 *Our allegiance is to staff.* Authoritative staff management of violence is supported. For example:

I've seen staff affected by it but they always had to carry on whether they like it or not but, erm if a patient attacks a member of staff then I think the staff give in too easily, it doesn't, doesn't show how [inaudible segment] consequences (Fiona, para. 123).

Experiencing staff as 'under threat' induces fear and anxiety, for instance:

Uh, with like some staff, um, we sort of like really like worry about them and we say "are you alright", um, "are you, are you still coming back" and things like that. Um, plus I've seen like sort of like staff um being upset, and it's quite like upsetting for us because we, we don't want them to be upset. (Fiona, para. 169)

3.6.1.2 *Produces unexpected benefits.* Effective violence management bestows feelings of safety and trustworthiness. For example, Fiona reported "it happened once to me, = Identifiable Information Removed = which they've been um been very professional about, they've dealt with the situation, dealt with that member of staff, and I respect that, that's fine" (para. 185).

Being 'good' and 'helpful' by adopting a staff-like role, and distancing from the role of patient, strengthens TRs. Daphne commented:

I know that like when I'm doing better it improves things, 'cos [/because/] they see like I'm trying to move patients away from what's going on and I'm trying to distract them or I'll hold the door open for the rest of the team from the other like wards to come along if they have a restraint. (para. 82)

3.6.2 Theme two: damaged by changes in staff behaviour. Incidents induce damaging changes in staff attitudes and behaviours, negatively affecting TRs.

3.6.2.1 Dismissal and retribution. Patients experience a sense of rejection and disdain from staff following incidents. TRs are a commodity, bought through the currency of ‘good’ behaviour. Alice, for example, commented:

depending on what you've done and who you've hurt, like if you [/you have/] hurt one of their colleagues then they're not gonna [/going to/] be like “oh yeah I'll talk to you now, you've just hurt my colleague it's fine” [inaudible segment] 'cos [/because/] it's not like that. When it's more they just ignore you, and stuff. (para. 196)

She elaborated “if you haven't had an incident for 48 hours then they'll talk to you but some staff say if you're incident free for a week we'll talk to you, so it's like blackmail really, it's bribery” (Alice, para. 210).

Staff mirror patients' emotional dysregulation in behaving unprofessionally and abusively, including towards individuals not involved in incidents. Brenda observed “the other day staff was slagging a patient off, when talking to a patient, yeah.” (para. 226), that “they'll tell the patient to their face too” (Brenda, para. 228), and “...It was horrible, 'cos [/because/] the person who they were talking about was my friend” (Brenda, para. 230). Daphne additionally relayed:

when I was on = another ward there was a member of staff who assaulted = me twice = Identifiable Information Removed =, and I've seen a couple of other, well, I've seen and heard of a couple of other incidences [/incidents/] since, where, staff have been suspended or, um, (long pause) apparently staff have been caught on camera in the intensive care suite where they've pulled someone about a bit too roughly and things like that, just because they're causing hassle, but it doesn't happen very often. It's just a bit worrying (para. 152).

3.6.2.2 We're sensitive to staff mood. Negative emotional states induced in staff by incidents affect patients, who receive incongruous messages about staff wellbeing. This reduces perceived genuineness within TRs. For example:

I mean, like yesterday, patient, staff was attacked but they normally like just walk off and go home, they get sent home. Like if you're saying to the staff member “are you alright?”

she said “yeah I'm alright”, but she went home, she was crying, she was sent home. She's due back in = soon = I think, but whether she comes or not is another thing (Helen, para. 155).

Conversely, witnessing staff negative emotions enables a sense of genuine connection.

Oh god yeah. [cross talk] some are alright, I don't think there's anyone in this place who doesn't let their mood affect their day because they're humans, so there's a fine line [inaudible segment] but in a way it's human 'cos [/because/] they can't be the people otherwise (Fiona, para. 63).

3.6.2.3 Being absent and avoidant. Violence and aggression causes under-staffing, which creates a sense within patients of being abandoned and neglected. Helen, for example, outlined her frustrations at being unable to receive staff input:

They just tell you no. Can't talk to you at the moment, we're under-staffed. So, I, not much you can do, you know, go to the top, you know, deputy sister on the ward, I went to = them = before I come [/came/] in here, said “I really need to talk to you” and = they = said “well I've got two staff changed, I can't talk to you”, I mean how's that helping me? It's not helping me at all. (para, 285)

Daphne further expressed:

where the majority of staff are focused on one patient that's [/who is/] kicking off they have no time for you. But even when someone's not kicking off the majority of the support goes into people on higher observations because they all need it. (para, 51)

3.6.3 Theme three: lying compromises trust. False allegations induces wariness in staff, detaching them from relationships with patients. For example: “they also know to keep their distance from anyone else in case they get another allegation, and ooh they've got history now or something else will happen, and I think it's really unfair” (Daphne, para. 158).

3.6.4 Theme four: there is no impact. Patients are oblivious to ruptures within TRs caused by violence. TRs may be robust enough to weather the effects of incidents. Brenda, for instance, commented:

like, the ones that always come in the next day after we've had a row or something, and still talk to ya [/you/], and still say "are you alright", or they're always gonna [/going to/] talk to ya [/you/] no matter what you've done. (para. 112)

Elsa, also, reported "Well I've never been violent towards them so I wouldn't, I couldn't really say." (para. 177)

3.7 Domain Five: Management of Violence and Aggression

Two themes, and seven subthemes, were constructed summarising participants' lived experiences regarding the effectiveness of staff attempts to manage violence, along with the support perceived as beneficial following exposure to violence.

3.7.1 Theme one: staff try but struggle to get it right. Patients empathised with staff trying their best with managing violence. Through lack of awareness, staff inadvertently make things worse resulting in patients feeling ignored and discarded. Patients compensate for ineffective support through self-containment.

3.7.1.1 Taking care of ourselves. Exposure to violence creates the need for stoicism. Emotional numbing helps patients to manage the effects of incidents. Cora, for example, commented "used to make me really unsettled and if someone else had an incident I used to have an incident but it doesn't really make me that unsettled anymore, I think you just get used to it" (para. 118). Helen additionally expressed:

you have incidents on the ward, you know, you've got = lots of = other girls, women on this ward, you can't get on with all of 'em [/them/]. You know, some of their behaviours are not really acceptable either, so it's, you just take each day. (para. 199)

3.7.1.2 Staff trying to get it right. Patients value, and are tolerant of, efforts by staff to support them following incidents of violence; experiencing staff as well-intentioned despite their

ineffectiveness. For instance, Helen expressed “they do their best, they do do their best” (para. 250) and Fiona conveyed:

I think most of them do it really well and it's, it's just [inaudible segment] mainly they do deal with it really well and I'd just say...actually, keep on doing what you're doing. 'cos [/because/] like you know to say they do literally check and it's just = one incident = which shouldn't be reflective of the service it was one incident, so...they do do their best here, they really do, it's difficult for them as well because they shouldn't, they shouldn't get attacked. (para. 155)

3.7.1.3 *They don't know what they're doing!* Patients are dissatisfied with what they perceive as sub-optimal input from staff. Staff are perceived as ignorant of the support patients require. Elsa recalled how “they didn't even report the injuries this other girl's got = Identifiable Information Removed = it could have been dealt with so much better” (para. 225). Alice expressed “they're trying to talk to them and they just want to be left to calm down and chill-out really then staff are just pushing us to talk to them” (para. 188).

3.7.1.4 *Needing staff to be 'present'.* Staff are unable to support patients with managing exposure to violence due to failures within the system to provide sufficient resources. Staff unavailability evokes the experience of feeling deprioritised and neglected. For example, Alice reflected:

when someone kicks off everyone's left on their own and some patients are unpredictable, more than others, they can kick off at any point, or pull your hair or throw a cup of tea in your face or, so you need staff on the floor all the time to manage that, and if someone's down the corridor kicking off, and there's no staff here they can't be doing everything (para. 178).

Lack of staff ‘presence’ is also experienced in terms of insensitivity. For example, Grace commented:

it's like when someone like self-harms or does something really really stupid it makes, it gives, it's big impact on erm the um like uh clients here and also staff, but clients more, it can unsettle them. = Identifiable Information Removed = so it's very very difficult when staff say like “can you come to my office and can I talk to you” because mostly since I've been in hospital or homes, where there's like people killing themselves and it's really, it makes a massive massive impact on like you, yeah (para. 299).

3.7.2 Theme two: we need you to actually do something! Effective management of violence requires active processes, with a focus on ‘doing’ something to distract from and counteract intensely negative feelings. Successful management of incidents balances patients’ opposing desires for supportive emotional containment versus mental and physical avoidance.

3.7.2.1 *Getting away from it.* Physical and psychological avoidance are fundamentally important when managing the emotional impact of exposure to violence. For example:

I think, because they have quite a few members of staff from other wards, they could leave like one member of staff just to deal with the people who aren’t kicking off, like getting them in the = lounge = to get away from it, or signing them out to go on ground leave. (Daphne, para. 98)

Fiona emphasised the importance of physical removal and distraction techniques:

most staff will...if there's an incident, will take you, if there's a place, take you somewhere else like there isn't a day here, patients in the dining room and they'll give us drinks or get out some board games, they are really good and they are here, yeah. (para. 137)

It can be harder for patients to ‘escape’ the effects of violence at times when avoidance is most needed, exacerbating further deterioration in mental wellbeing:

when you’re on like = observations = you can’t go and have your freedom as much because you’re stuck with a member of staff all the time so it’s really [inaudible segment] so you see the majority of what goes on, and...that’s difficult and disturbing especially seeing as you’re already in a difficult place hence the reason you’re on = observations = so it makes it ten times worse (Daphne, para. 74).

3.7.2.2 *We’re reliant on you.* Patients depend upon the physical presence of staff for managing exposure to incidents. For example, Alice outlined reliance on staff to physically escape and discharge physical energy “...take us in the garden (laughs) for a run around [cross talk] play basketball and stuff” (para. 226).

Staff authority is welcomed for facilitating formal discussions following incidents, however gender dynamics prevent helpful exploration of patients' emotional reactions. Fiona, for instance, recalled "...we did after the incident = I mentioned earlier = we did have debriefing, like with DBT and stuff, I think that should be done more often" (para. 141). Daphne conveyed:

...we have like a business meeting on a weekday morning and some people do air their feelings, like just saying like, "oh so and so kicked off the other day and it was really off-putting, and we didn't get this, we didn't get that", but it certainly doesn't seem to have changed anything (para. 108).

Brenda expressed "...I think it'd turn into a bitch match, "I remember one day I didn't like it when she did this [inaudible segment]" then we'll get upset because they're friends and stuff like that"(para. 266).

3.7.2.3 Take these feelings away from me or help me make sense of them! Witnessing violence is extremely unsettling. To manage a range of negative emotions evoked by such incidents, patients feel compelled to voice their feelings to make sense of and process their experiences. For example, Elsa emphasised the importance of talking: "after that, yeah, to sit down and actively, openly talk to people about their feelings, what happened, you know, there and then, and then for a manager soon as they've got time, later on, come and do it again" (para. 215). Grace elaborated, highlighting the need to feel understood:

offer them like a one-to-one, and um sort of like, try and sort of like talk to 'em [/them/], um (long pause) try, yeah try and like talk to 'em [/them/] (long pause) offer talking but if talking doesn't help offer PRN. Um, (long pause) for staff to speak to the patients to understand more, um, about their like self-harm or something like that, um...because when you like talk to patients, um, when the patients talk to the staff like, you know what I'm trying to say is that it's good if the staff can understand what is going on with the um like patients. Sometimes instead of reading their notes (para. 253).

Containment is achieved in the aftermath of violence by maintaining consistency in ward routines, and meeting patients' care needs, for example: "because things are going on, drinks get

missed and dinner becomes later and things like that, so we miss out quite a bit” (Daphne, para. 88).

CHAPTER FOUR: DISCUSSION

4.1 Introduction to Chapter

Within the final chapter, I summarise findings in relation to psychological theory and previous research, critically appraise the current study, and present key limitations and strengths. I offer the reader recommendations in relation to: clinical practice, forensic mental health (FMH) policy, psychological theory, and further research, and conclude the chapter with a personal reflective summary.

4.2 Summary of Findings

Twenty themes and fifty-five accompanying subthemes were extracted from participants' data, reflecting five key research aims. Findings for each of the research aims are presented and discussed.

4.2.1 How do patients develop therapeutic relationships with FMH staff?

Participants appeared to possess high expectations regarding FMH staff behaviours and attitudes, and expect staff to demonstrate 'caring' behaviours in line with personal beliefs about what constitutes 'care'. Failures by staff to demonstrate care in accordance with expectations appeared to be experienced as a rejection, and an unwillingness by staff to form therapeutic relationships (TR). Such expectations may reflect a general wariness for connecting interpersonally with staff, perhaps fearing that they may be taken advantage of (Bender, 2005; Haskell, 2004); in essence scrutinising staff behaviour to gauge the safety of forming TRs. Patients may be hypervigilant, and anticipate staff may treat them badly, reflecting previous experiences of harmful help-seeking. Wariness and high-expectations may therefore serve a self-protective function.

When forming TRs, participants' wariness appeared to require the passage of time to diminish, and opportunities to spend quality time with staff for trust to develop. Relationships appear constructed as a process, wherein patients require opportunity to experience consistency and perseverance from staff team members. Other than staff needing to demonstrate their trustworthiness, participants' accounts suggested the passage of time and process of forming TRs was influenced by patients' mental states; namely TRs improved with time due to patients feeling more emotionally contained. Time may be significant for the process of TRs, owing to experiences of inconsistent and unavailable parenting, typical of the patient population. Observing FMH staff surviving painful interactions, and remaining sufficiently consistent, may allow patients to trust, heal, and grow (Lord, 2007).

Mirroring previous findings, and theoretical discourse, participants' accounts suggested the process of forming TRs was one of characteristic intensity and struggle (Lord, 2007). Participants acknowledged widely recognised difficulties with progressively establishing trust, and exhibited sensitivity to staff 'power' (Morrison, Burnard & Phillips, 1996; Schafer & Peternej-Taylor, 2003). Similarly, participants perceived the need to learn institutional and relational 'rules' in order to progress within the FMH system (Horberg, Sjogren & Dahlberg, 2012; Schafer & Peternej-Taylor, 2003).

Widely acknowledged and characteristic abandonment fears appear present within participants' accounts. The perceived permanency and duration of TRs seemingly corresponds with TR satisfaction and quality evaluations. As previously reported, participants appeared critical of 'bank staff' (Clarkson et al, 2009; Fortune et al, 2010); whom some patients experienced as disinterested, and as being in the job 'for the money'. Notwithstanding unprofessional behaviour, participants' accounts offer original insight in hinting that the stability

and permanency of TRs may influence patients' perceptions and general evaluations of staff intentions, behaviours, and attitudes.

Reflecting previous findings, participants' accounts suggest that what may be characterised as strongly-bonded TRs, are qualitatively different from wider relationships within FMH units (Aiyegbusi, 2011). TRs appear to possess an exclusive quality, with participants citing 'favourite' members of staff. There is a sense within participants' accounts, of needing to be 'known' and 'understood' by staff as a prerequisite for strong TR development. The desperation to be 'seen' for who patients are, is mirrored by previous findings (for example: Clarkson et al, 2009); and may reflect the patient populations' "pull for a very real interaction and a certain genuine intimacy" (Lord, 2007, p.208).

4.2.2 How do patients experience TRs with FMH staff? Participants reported that TRs are shaped by a multitude of individual, organisational, and situational factors. Reflecting previous findings, participants articulated a clear preference for TRs with staff perceived as genuinely caring, and who demonstrate care through 'being human' and showing respect, trust, compassion, and dignity (Aiyegbusi, 2011; Barnao, Ward & Casey, 2014; Clarkson et al, 2009; Fortune et al, 2010; Horberg, Sjorgren, & Dahlberg, 2012; Maguire, Daffern & Martin, 2014; Willmot, & McMurrin, 2013). Participants echoed sentiments expressed by Sweeney et al (2014): "What people overwhelmingly want is to be treated in a warm, caring, respectful way irrespective of the circumstances in which they come into contact with services. In other words, all of us would like to be treated with humanity" (p. 3).

Some participants expressed new insight in relating that relational compatibility largely determined TR strength. It is unclear how compatibility – of a lack of - may impact upon the

experience of TRs, although previous research suggests perceived compatibility may influence therapeutic outcomes (Malloy, 1981).

Some participants described anxiety and reticence for developing TRs, as previously reported (Aiyegbusi, 2009; Barnao, Ward & Casey, 2014). Such barriers may represent patients' dependency fears, and an inability to tolerate interpersonal vulnerability, stemming from histories of abuse or insecure-anxious attachment representations (Fonagy, 1999).

Avoidance and dismissal was experienced by some participants as the primary form of interaction, patients and staff being perceived as mutually unwilling to engage, representing fresh insight. Some FMH relationships may therefore serve functional purposes, but lack true interpersonal connection characteristic of TRs. Some patients may therefore connect to the custodial as opposed to therapeutic nature of FMH professionals' dual-roles. Interpersonal avoidance by staff may represent an inability to tolerate intense and challenging transference or countertransference (Hughes & Kerr, 2000). Alternatively, denial and avoidance may functionally protect FMH staff from the painful realities of patients' situations. Equally, patients may perceive - or act as if - staff are unwilling to engage, as a means of self-protection to avoid rejection (Catlett, 2009).

Some participants conveyed a need for greater interpersonal consistency across TRs, and appeared sensitive towards staff displaying signs of favouritism. The importance of boundaries was further emphasised in relation to staff self-disclosure, and unit routine. Participants' expressed need for interpersonal and physical boundaries appears to largely contradict academic and clinical discourse regarding the 'boundary pushing' nature of the patient population (Linehan, 1993). Within the often chaotic unit environments, a sense of predictability,

consistency of staff approach, and routine, may help to ‘contain’ patients’ distress and reduce feelings of anxiety. Participants’ use of professional jargon regarding ‘professional boundaries’ and the need for adherence to these, may alternatively represent internalisation of FMH discourse, and expectations placed upon them from the FMH system. Conversely, patients may seek to establish and demand adherence to self-imposed ‘boundaries’ as a means of regaining power within the coercive FMH environment (Schaffer & Peterneji-Taylor, 2003).

Contrary to previous findings, participants’ preference for close TRs with a small group of staff did not appear to promote engagement with wider FMH team members (Willmot & McMurrin, 2014); which may be accounted for through gender differences. Participants’ accounts therefore contradict findings from high secure FMH services, and uniquely suggest FMH TRs may be more representative of TRs within traditional therapeutic contexts.

Mirroring best practice guidance and previous research within other contexts, many participants reported experiencing TRs as inherently valuable for facilitating their recovery (Castonguay & Beutler, 2006; Gilbert, Rose & Slade, 2008; McGuire-Snieckus, McCabe, Catty, Hansson & Priebe, 2008; National Institute for Mental Health, 2003; Priebe & McCabe, 2008). Participants emphasised the importance of strong TRs for offering self-protection, developing interpersonal skills and emotional self-regulation strategies (Aiyegbusi, 2009). TRs were also experienced as beneficial for patients’ recovery owing to the companionship, sense of connection, and motivation such relationships provide (Barnao, Ward & Casey, 2014; Horberg, Sjogren & Dahlberg, 2012). TRs also serve to buffer patients against disadvantages associated with living within the units (Bressington, Steward, Beer & MacInnes, 2011).

Offering new insight, participants' accounts suggested that perceptions of TR quality, and the significance of TRs, appear influenced by patients' stages of recovery. One participant expressed how hindsight allowed her to fully appreciate the importance of TRs. Patients may therefore perceive, and require different things from, TRs at each stage of their recovery. Patients may not appreciate, or wish to acknowledge, the significance of close TRs at times when they may be most needed. Retrospectively acknowledging the importance of TRs may be accounted for within patients by: improved emotional regulation, restructured relational patterns, and decreased feelings of attachment vulnerability or anxiety.

Mirroring previous findings, participants experienced negative effects associated with power imbalances within TRs (Horberg, Sjorgren, & Dahlberg, 2012). While participants did not reference the coercive nature of FMH care previously cited as impactful upon TRs (for example: Livingston & Nijdam-Jones, 2013); some participants indicated lack of information and opportunity to collaborate within their recovery detrimentally affected wellbeing. Furthermore, that failures by staff to empathise with patients' lack of self-determination may alienate patients. This suggests, in corroboration of previous findings, while the coercive FMH environment itself may not necessarily inhibit TR formation, the transparency with which staff address power imbalances, and manner with which staff engage patients, affects TR perceptions (Sorgaard, 2007; Sweeney et al, 2014).

4.2.3 How do patients experience incidents of violence and aggression within secure FMH services? Commensurate with previous research, participants perpetrated and witnessed a spectrum of violent behaviours (Gudjonsson, Rabe-Hesketh & Wilson, 2000). Violence was, to a certain degree, perceived as 'normal' and to be expected within the service context. Such a

‘culture of violence’ has additionally been reported within acute inpatient services (Hinsby & Baker, 2004).

While violence was often perceived as pervasive, definitions of violence appeared subjective; suggesting patients may conceptualise violence differently, and have different thresholds for tolerating such behaviours. Violence was experienced as perpetrated by patients and staff alike, as previously reported (Bonner et al, 2002; Duxbury & Whittington, 2004); within and between groups, and against property. Routine FMH practices, such as physical restraints, were perceived as staff-perpetrated violence. In contrast to professionals’ definitions of violence, self-harm was perceived as the most commonly expressed form of violence. It would appear as though anyone or anything may be the target of staff and patients’ hostility, aggression and anger. Psychoanalytically, staff and patient behaviours may reflect the ‘acting out’ of transferential and countertransferential feelings between and within groups. Interfamilial stress theory may help to explain how diminished time and resources, beliefs about the acceptability of – or lack of repercussions for exhibiting – violence may interact to increase the likelihood of staff and patients interacting in violent and aggressive ways (Crouch & Behl, 2001).

Participants relayed a ‘madness versus badness’ dichotomous explanation for the causes of patient-perpetrated violence, echoing findings reported within acute inpatient services (Hinsby & Baker, 2004; Janicki, 2009). Reflecting previous findings and theoretical hypotheses, participants conceptualised violence as the re-enactment of violence within individuals’ personal histories (Bessel & van der Kolk, 1989; Glasser, 2001). Participants additionally appeared to have internalised a discourse of violence occurring due to patients’ general ill mental health as sufficient explanation in and of itself. This may reflect internalisation of public, professional and

policy discourses of blame, linking poor mental health with violent and unpredictable behaviour (Benson, Secker, Balfe, Lipsedge, Robinson & Walker, 2003).

Reflecting previous findings, participants reported deploying violence instrumentally to achieve superordinate goals (Bonner, Lowe, Rawcliffe, & Wellman, 2002); predominantly eliciting care. Violence may serve to redress power imbalances within the FMH system, with patients perpetrating incidents in order to obtain greater power status.

Commensurate with reports of staff miscommunication and provocation precipitating violence (Cooper, Brown, McLean, & King, 1983; Mellesdal, 2003) participants occasionally externalised the causes of violence to staff behaviour and attitudes. Staff exhibiting poor emotional regulation, and abuse of routine procedures as a way of expressing hostility, appear to precipitate incidents, echoing previous findings (Wynn, 2004).

Some participants experienced violence as a perpetuating vicious cycle, wherein one incident provokes other patients to aggression; thereby creating a 'snowballing' effect within units. Such snowballing may be conceptualised as stemming from a need to use violence instrumentally to 'even the score' between patients. Such 'dysfunction' or violence within patient-patient interactions may serve to affirm the custodian role of FMH staff, indicating violence may possess functionality (Dallos & Draper, 2010). The snowballing effect of violence may also reflect patients' compromised emotional regulation skills. An inability to tolerate vulnerability, combined with compromised self-containment skills, and low distress tolerance may interact in causing individuals to attack as a means to self-defend. Violence as a means of communicating distress and complex feelings is echoed by participants' reported experiences of

substituting verbal communication for aggressive behaviours, which has been previously reported within acute psychiatric services (Parkes & Freshwater, 2012).

Offering new insight, some participants' accounts suggested that the process of behaving in violent ways may serve a primary function, whereas the causing of harm to others may be accidental, or an unintended consequence of violent expressions. The outpouring of overwhelming feelings in aggressive or violent ways may therefore represent a failure to deploy adaptive emotion regulation processes. However, a lack of desire to control or dominate others, or to cause harm, may differentiate this form of violence from typical conceptualisations.

Corroborating previous findings, participants experienced violence as bestowing negative changes within TRs. Such changes in staff behaviour were experienced as affecting all patients, not just interactions between affected staff and violence-perpetrators, as has been previously observed (Wright, Gray, Parkes & Gournay, 2002). Participants' accounts suggested they perceived collective punishment and dismissal from the staff team if their basic care needs, unit routine, and privileges were disrupted. Furthermore, incidents appear to alienate patients from staff due to staff failing to contain their own emotional reactions, taking their feelings out on patients in unprofessional ways, and adopting confrontive ways of coping wherein aggression is deployed to change patients' behaviours (Whittington & Whykes, 1994b). The reactions of staff may be conceptualised as signifying transference and countertransference 'blindness', leading to the 'acting out' of roles projected onto FMH staff.

Substantiating findings within acute inpatient services, witnessing or perpetrating violence confers a range of profoundly negative, intense, complex and distressing emotional reactions (Bonner, Lowe, Rawcliffe & Wellman, 2002; Janicki, 2009). Similarly, patients appear

prone to re-traumatisation after witnessing incidents as has been found with prison populations (Hochstetler, Murphy & Simons, 2004). As has been noted within other contexts, witnessing violence detrimentally impacts upon patients' recovery (Janicki, 2009). This appears due in part to destructive changes within unit milieu and atmosphere, suggesting changes affected within the FMH system directly impact upon individual patients' progress, in line with systems theory (Gehart, 2013). These findings therefore emphasise the significance of FMH unit milieu upon patients' recovery and wellbeing.

4.2.4 How do patients experience TRs following incidents of violence? Mirroring previous findings, some participants reported violence may serve to improve and strengthen TRs; by affirming patients' allegiance to staff (Schaffer & Peterneji-Taylor, 2003). Originally, some participants conveyed that incidents afforded them the opportunity to be 'helpful'; which was perceived as strengthening for TRs. Perhaps adopting a staff-type role may serve to improve TRs by reducing in-group/out-group differences between staff and patients. Reciprocity within support provision, may further be understood within an attachment framework; whereby patients' efforts to support staff may serve a superordinate self-protective function, guarding the safety of their attachment figures (Crittenden, 2005).

Therapeutic alliance rupture-repair processes have been consistently found to improve therapeutic outcomes, and perceptions of TR quality, by individuals diagnosed with Borderline Personality Disorder (Muran et al, 2009; Safran & Muran, 2011). Consequently, perpetrators, or witnesses, of violence may experience improvements within TRs following incidents owing to efforts by staff to repair and improve such ruptures.

From a systemic perspective, a change in patient 'role' within the system, from that of receiver to provider of support, through the 'help' patients offer staff, may be understood as an attempt to maintain 'homeostasis' within the FMH system. Transient transitions in role from help-receiver to help-provider may enable a certain degree of conflict to remain present in the units (through other patients' violent behaviours), without conflict escalating to a point whereby the equilibrium within units is dangerously threatened (Dallos & Draper, 2010).

Some participants reported that the witnessing, or perpetrating, of violence had no impact upon TRs. However, given that violence was frequently experienced by others as impactful upon TRs, it is possible that such a refutation represents efforts by some individuals to block painful events from memory. Perhaps the defence of denial serves to ensure patients are protected from experiencing previously cited negative emotional reactions from professionals (Hamera & O'Connell, 1981; Smith & Hart, 1994). Alternatively, denial may allow patients to avoid acknowledgement that staff were – in some capacity - unable to protect them from emotional or physical harm (Stenhouse, 2012). In this sense, denial may serve to preserve attachment relationships. Systemically, participants' experiences contradict open systems theory (Dallos & Draper, 2010) by suggesting that TRs are formed and maintained irrespective of events within the wider FMH system, and that events within the FMH system are not mutually-affecting.

Mirroring findings within acute inpatient services, the majority of participants conveyed that witnessing or perpetrating violence detrimentally impacted upon TR quality (Janicki, 2009). Most participants expressed that this stemmed from negative changes in staff behaviour. However, offering new insight, a minority of participants acknowledged that changes in patients' behaviour, such as making false allegations, compromised TRs.

Emulating findings from research with FMH professionals, some participants reported wide-ranging negative changes in staff behaviour, after an incident, which impacts upon patients other than the perpetrator (Wright, Gray, Parkes & Gournay, 2002). Participants' experiences of negative changes in staff behaviour are corroborated by previous research, in suggesting that following – or during – incidents, staff may act in withholding, aggressive, abusive or controlling ways (Duxbury, 2002; Horberg, Sjorgren, & Dahlberg, 2012; Meehan, McIntosh, & Bergen, 2006; Wynn, 2004). This suggests that following incidents, staff may exhibit behaviours consistent with emotional dysregulation, which carry the potential to impact upon TRs with all patients. Such behaviours exhibited by staff may represent projective identification with feelings evoked by patients, drawing staff into various forms of 'acting out' (Waska, 1999). Staff behaviour may also reflect an enactment of patients' early, often abusive or inconsistent, attachment relationships.

The unavailability of staff to meet patients' needs, following incidents, was perceived by some participants as rejection and abandonment. Such perceptions of feeling ignored, or abandoned, by staff are commonly cited (Duxbury, 2002; Parkes & Freshwater, 2012). Notwithstanding the practical ramifications of low staffing numbers post-incidents, such perceptions may stem from patients' attachment representations, sensitivity towards real or perceived rejection, and the requirement for extensive reassurance and validation in the face of potential or actual rejection. Moreover, potentially compromised mentalisation capacities within the client group (Fonagy, 1999) may mean patients conceptualise staff absence as directly reflective of TR quality, or of negative staff attitudes; and struggle to conceive other possible explanations.

Mirroring previous findings, participants reported that TR quality and engagement largely depended upon compliance with staff expectations regarding their behaviour (Schafer, & Peterneji-Taylor, 2003). Participants expressed that being 'good', or well-behaved, was necessary to sustain staff engagement. Uniquely, this hints that within FMH services, TRs may be contingent upon patients 'playing by the rules' and modifying their own behaviours, rather than FMH staff accepting or 'joining' patients as they are. Besides from restructuring relational patterns, within the FMH system such expectations may protect existing power structures against the threat of disintegration, by using the giving or receiving of care and attention to control patients' future actions.

Participants appeared hypervigilant towards staff mood, particularly following incidents. Hypervigilance towards the mood and intentions of others is characteristic of the patient population (Sieswerda, Arntz, Mertens & Vertommen, 2007). However, participants intimated it was the messages received from staff regarding their welfare which may impact upon TRs, rather than staff wellbeing itself, offering new insight. Perhaps reflecting a need for honesty and trust within TRs (Fortune et al, 2010; Livingston & Nijdam-Jones, 2013), participants appeared tolerant of staff imperfections and absences, if staff conveyed truthful and genuine explanations. Consequently, perceived genuineness within TRs may serve to ameliorate the impact of staff absence, or potential relational ruptures.

4.2.5 What support do patients require following exposure to incidents of violence within secure FMH services? Themes encompassing participants' perceptions of needing staff to be present and available, feeling reliant upon staff, and needing staff to 'take away' negative feelings evoked by violent incidents, may reflect difficulties with self-soothing in times of distress (Firestone, 2009) and compromised emotion regulation capacities (Schore, 1996).

Some patients seemed to adopt passive post-incident roles, and look to their primary carers, or staff with whom they have strong TRs, to protect them and alleviate negative psychological and emotional consequences. The authority of staff was further emphasised as significant for facilitating post-incident support. Previous findings suggest consistent and firmly enforced boundaries, and imposed limits upon patients' behaviour, facilitates a containing sense of control and structure (Maguire, Daffern & Martin, 2014; Schafer & Peterneji-Taylor, 2003). Within the present study, post-incident containment also appeared contingent upon consistent unit routines and the reliable provision of care. Dependable staff presence was further experienced as facilitating containment. Patients' post-incident passive support-seeking behaviours may serve to maintain existing power structures, and homeostasis, within the FMH units, wherein FMH staff are depended upon to regain control, and 'power' is transferred from incident-perpetrators to FMH professionals (Dallos & Draper, 2010). Alternatively, patients' desire for sanctuary from stressful situations through the external imposition of control may represent a manifested need for a strong 'holding environment', as a means of alleviating responsibility for self-control (Gunderson, 2009; Winnicott, 1965).

Many participants emphasised the importance of verbally communicating the emotional impact of incidents to FMH staff, to make sense of events, and clear negative atmospheres; mirroring previous findings (Clarkson, Murphy, Coldwell & Dawson, 2009). Participants' strong desire for supplementary support, attention, validation and involvement from FMH staff, through the provision of additional one-to-one and group discussion time, may indicate deficits within self-care abilities, maladaptive or insecure interpersonal relationships, and lack of self-control (Gunderson, 2009). As patients journey through the FMH system, and internalise control, 'talking' may serve the function of a 'holding environment' (Gunderson, 2009; Winnicott, 1965)

before individuals are capable of intrapsychically sustaining a 'holding' function themselves.

While some participants recognised staff often try their best to support them post-incident, and acknowledged the difficulties involved in FMH staff roles, some patients reported FMH staff were ignorant of patients' needs, lacked empathy, and were perceived as insensitive and uncaring. Dissatisfaction with the support provided by FMH staff may reflect difficulties patients experience in being soothed by others, owing to internalised attachment representations and adverse experiences from early caregivers (Mikulincer & Shaver, 2007). Alternatively, patients may be dismissive and critical of the support provided by FMH staff as a means of achieving relational distance and control within TRs, due to anxiety and fears evoked by interpersonal closeness (Ibid). It would appear therefore, based upon participants' accounts, that patients may experience a degree of ambivalence between wanting staff to be present, available and supportive versus fearing such intimacy and denigrating attempts by staff to provide such care.

The need for self-care by taking care of themselves, or stoicism, reported by some participants, may represent a disconnectedness from feelings in relation to incidents, stemming from re-traumatisation (Duckworth & Follette, 2012). Equally, improved capacities for self-care may indicate improved affect regulation skills and distress tolerance, resulting from effective treatment (Gunderson, 2009).

4.3 Critique

Mirroring critical review processes adopted for reviewing previous literature, the current study was appraised using two recognised critical appraisal tools (CASP, 2010; Kmet, Lee &

Cook, 2004). The results of this appraisal are viewable within Appendix X. Key methodological and theoretical limitations, and strengths of the present study are outlined.

4.3.1 Limitations. Presented findings represent amalgamated data obtained across both low and medium secure FMH units. Females within both services undoubtedly vary significantly in terms of their level of risk and overall mental health. As participants intimated ‘illness’ severity affects TRs, females within the medium secure unit may experience greater relational challenges compared to low secure females, and experience TRs subjectively differently. On reflection it would have been valuable to have compared findings obtained between different services, or to have focused recruitment exclusively upon one service. Focusing recruitment exclusively upon one service would have reduced heterogeneity between participants, allowing for a more robust analysis of psychological variability. However, practical limitations meant it was not possible to recruit a sufficient sample size from either unit alone. While the current study provides novel insight regarding female FMH patients’ lived experiences, integrating data from across both services means the unique experiences, and challenges, faced by both patient groups remains unclear.

Within an interpretivist paradigm, no assumptions are made regarding the generalizability of findings obtained through qualitative research. However, the recruitment strategy employed may have failed to capture arguably more typical experiences within female secure services. Recruited participants were all relatively stable within their mental health and the units they resided in, they posed minimal risk to me as a researcher, and were sufficiently engaged with staff in order to approach them and express an interest in participating. While the experiences presented within the current study are unquestionably informative, it could be argued that it would have been more valuable – from a clinical perspective – to understand the lived

experiences of females who find it harder to engage interpersonally with others, and who may have struggled to approach staff and express an interest in participating. Recruitment may have been more successful, particularly with regard to engaging patients who may experience greater relational challenges, by meeting individually with all patients on the units to introduce the research, answer questions, and establish rapport. Nonetheless, practical and time constraints meant this was not possible.

The obtained sample size was within normal parameters, the suggested range being 6 – 10 participants (Flick, 2008; Morse, 1994; Creswell, 1998) and 8 participants having been recruited. Nonetheless, proportionately few patients – in relation to the total number of patients within the services - volunteered to participate; therefore there remains scope for recruitment improvement. I formulated that the relatively low response rate may have reflected perceptions of the research as lacking in meaning, value, and relevance to patients' lives. Arguably, the focus of the current study is borne out of professionals' interests in better facilitating the provision of care and management of risk through the medium of TRs, rather than understanding and addressing the needs of FMH patients, or issues they consider important. The patient involvement movement is gaining momentum within secure services (National Survivor User Network, 2011) and FMH research (Faulkner, 2006), however time and practical constraints resulted in a lack of meaningful patient involvement within the current study. An increased sense of 'ownership' within the research process, and relevance of issues explored to patients' lives may have yielded positive recruitment benefits, particularly with individuals who are less relationally engaged. If I were to conduct this research again, with greater time, I would aim to conduct a focus group at the design stage of the process, exploring issues patients perceive as important. Information and ideas expressed within such a forum may have beneficially informed

all stages of the research process, as is evident within other studies (for example: Kuyken et al, 2015).

While I tried to hold my assumptions and sources of bias in mind, an underlying assumption that patients would experience their interactions with FMH staff as constituting a 'relationship' remained present. Further, I assumed that such relationships would be characterised as inherently therapeutic in nature, as opposed to custodial, or alternative conceptualisations. Such assumptions have invariably influenced the study design, data collection and data analysis processes, and may have unduly shaped the accounts participants offered about their experiences. Nonetheless, as Norris (1997) pragmatically notes: "All research has to start somewhere. Researchers have to take some things for granted; to act they must accept much of the world as given" (p. 173). The present study offers a tentative exploratory account of the nature of interactions between receivers and providers of secure FMH care. However it may be valuable for future researchers to specifically explore and construct the nature of 'relationships' between FMH patients and staff, from patient perspectives.

Staff team members were not differentiated in terms of their role within the service. Participants were free to describe their subjective experiences of TRs in relation to any members of staff they perceived as having a TR with. It was clear from participants' accounts however that the positions staff occupied varied significantly, with patients describing experiences in relation to: ward managers, MDT members, nursing staff and psychologists. On reflection, given the diversity of power, contact time, and input type, different professionals have; it may arguably have been useful to have narrowed the focus of the present study in order to make sense of patients' subjective experiences in relation to one group of staff, such as the nursing team. This would have permitted more in-depth analysis of patients' experiences, and improved the

contextual basis of presented findings, particularly as TRs with nurses may be constructed wholly differently compared to those with psychologists, or ward managers.

4.3.2 Theoretical limitations. Systemic theory was conceived as potentially useful for understanding the relational determinants and factors influencing both TRs and the occurrence of violence, between patients and others within closed and complex FMH systems. However, there has been a marked lack of interest in the application of systemic theory, or theory development, in relation to secure FMH services. I tentatively reflected the absence of systemic understandings within secure FMH services may reflect a vested interest in propagating individualistic determinants of violence and TR difficulties, within a notoriously challenging, stigmatised, and often feared, clinical population. The effect of privileging individualistically based theories over relational conceptualisations may serve to justify often coercive, punitive and retributive FMH practices, theoretically ‘scapegoating’ FMH patients in order to maintain homeostasis and existing power structures within the FMH system, and wider society. While participants identified relational factors within their accounts in the current study, I am conscious that patients appear to have internalised dominant individualistic narratives, and therefore the findings of the present study may inadvertently perpetuate stigmatising attitudes associated with secure FMH services, and the ‘mad’ or ‘bad’ individuals who use them. I have attempted to relate findings to key principles and theories within systemic literature, nevertheless there is arguably a clear need for substantial theory development in order to make sense of the complex relational FMH world, and offer an alternative narrative.

The psychodynamic approach, and application of psychodynamic theories within applied research, has received considerable criticism owing to a lack of empirical support for concepts and ideas, and the perception that psychodynamic theories are often unfalsifiable (McLeod,

2007). By their very nature, unconscious drives, impulses and conflicts are not easily measured or applied. Consequently, interpreting participants' accounts within a psychodynamic framework entailed considerable surmising, the results of which may not be replicated by another researcher. However, within an interpretivist paradigm 'truth' is inherently subjective. Furthermore, while psychodynamic theories may not be easily validated that is not to say that they do not possess strong explanatory power (Kline, 1989). Limitations therefore exist regarding my interpretation of whether participants' accounts potentially reflect unconscious processes, early childhood experiences, or defence mechanisms. It can however be argued that the pragmatically and tentatively applied psychodynamic theories and concepts offer an alternative and valuable means of making sense of participants' lived experiences.

Arguably, it may have been valuable to have explored patients' experiences within the framework of social psychology, which is concerned with understanding group processes, and how individuals' thoughts, feelings and behaviours may be influenced by the presence of others (Hogg & Vaughan, 2013). This may have been beneficial for making sense of patients' experiences and behaviours in terms of the interactions between their psychological states and immediate social situations within the FMH units. Furthermore, it may have been useful to have considered the application of Close Relationships Theory as an alternative to Attachment Theory for making sense of patients' TRs (Harvey & Pauwels, 1999). This may have helped to understand staff-patient closeness, interdependence within their feelings and behaviours, and the myriad of ways their lives intertwine; without imposing the assumption that such relationships are 'therapeutic' or unduly shaped by patients' negative early life experiences.

4.3.3 Strengths. Few qualitative studies have explored the experiences of females within low and medium secure FMH services. It is a strength of the current study that the subjugated

knowledge and experiences of this clinical population have been given ‘voice’ and means of expression (Smart, 2010). I consider this significant in terms of actively involving the clinical population within research processes, making efforts to ‘hear’ their experiences, and offering a means of understanding TRs and violence, as an alternative to the dominant discourse of FMH professionals.

The present study offers novel insight regarding patients’ perceptions of TRs and the experience of witnessing, or perpetrating, violence within low and medium secure FMH units. Arguably the research, to a certain degree, lacks specificity and considerable depth. However, a breadth of experiences and perceptions are presented, and the current study has been successful in addressing the primary goals of exploratory, or descriptive, research: helping to define and formulate problems, clarify concepts, suggest hypotheses, and describing characteristics (Shields & Rangarjan, 2013). The novel insight obtained beneficially offers a tentative understanding of female FMH patients’ experiences, helps to develop current conceptualisations of FMH TRs and violence, and suggests avenues for future research.

The research methods adopted were most appropriate to addressing the research aims, and were applied in a robust, systematic and transparent manner. Furthermore, the current study is methodologically, theoretically, epistemologically and ontologically congruent with the research aims. Measures were adopted throughout the research process to enhance the credibility, transferability, confirmability and dependability of reported findings, such as: inquiry audits, thick descriptive accounts, and reflective accounts throughout the data collection and analysis processes (Lincoln & Guba, 1985). Such descriptive accounts allow the reader opportunity to evaluate the credibility of myself as the research ‘instrument’ in addition to the credibility of presented findings (Patton, 2002). Arguably it would have been preferable to have

presented the results to participants themselves in order to confirm developed themes, and enhance credibility (Leininger, 1994). However, notwithstanding time and practical restraints, within an interpretivist paradigm ‘truth’ is subjective and dynamic, and it has been argued that member checks represent participants’ responses to a researcher’s interpretations rather than original data (Sandelowski, 2002).

The present study benefited from my ability to engage patients within the research process, and quickly establish a rapport conducive to discussing emotive and challenging experiences, particularly within the context of the relational nature of mental health difficulties such women typically experience. While researchers must take care to ensure clear differentiation between their roles as clinicians and researchers (Yanos & Ziedonis, 2006), deploying clinical engagement skills beneficially helped participants to explore challenging experiences while potentially high levels of affect were contained, adhering to professional ethical requirements (The British Psychological Society, 2014). As I was not working within the examined service, I did not perceive a role-conflict in deploying basic therapeutic skills within my role as a researcher (Yanos & Ziedonis, 2006).

4.4 Implications and Recommendations

Notwithstanding theoretical and methodological limitations, implications and recommendations are presented in relation to clinical practice, FMH policy, psychological theory and suggested further research.

4.4.1 Clinical practice. In order to promote the development of strong TRs, it may be beneficial for staff particularly within medium secure services to focus initial relationship building efforts upon establishing and demonstrating trust with, and respect towards, patients.

Patients within the study demonstrated a preference for FMH professionals who are emotionally available, sensitive, attuned and open in their approach to working alongside them. They valued attempts by staff to demonstrate humanity, dignity, compassion and humour; striving to embody such values may serve to improve patient engagement and TR quality. Consequently, this may carry implications for a values-based means of recruiting new FMH staff in order to enhance patient-staff TRs and clinical outcomes.

Patients may not be capable of talking to, or receiving emotional support from, just any member of staff. Findings suggest that patients are discerning within their TRs, and TRs tend to be established with a small and select number of individuals. The current 'key worker' system wherein patients are able to spend time regularly with one or two staff they feel particularly close to therefore appears to fit well with patients' needs. There is some evidence to suggest patients prefer time with professionally qualified members of staff, for the specialist knowledge and support they are able to provide, therefore support should be offered by both qualified and unqualified staff members.

To promote FMH professionals' responsiveness to patients' needs, particularly following violent incidents; it may be beneficial to provide additional clinical supervision. Providing professionals with increased opportunities for emotional containment by senior management may help with 'containing the container' (Toasland, 2007), and potentially bestow increased emotional capacity within staff to help regulate and contain patients' affect. Additionally, by ensuring staff receive ample clinical supervision to reflect upon the personal impact of witnessing, or being involved in, violent incidents, this may increase awareness of transference

and countertransference issues, and prevent staff from ‘acting out’ in aggressive ways towards patients or other staff.

Findings tentatively support the idea that FMH professionals need to demonstrate continued efforts to de-normalise violent and aggressive behaviour within the FMH population. This may be achieved through positive interpersonal role-modelling with patients and fellow staff members, avoiding the tendency to ‘act out’ in aggressive ways towards others.

Patients’ exposure to violence may be better supported through efforts by FMH staff to explore and understand individuals’ past experiences of violence, and how these may impact upon their reactions to the occurrence of violence within the FMH units. Formulating, and remaining minded of, individuals’ experiences and coping strategies, may allow staff to offer person-centred responsiveness and better contain patients’ reactions. This may potentially serve to curb the ‘snowballing’ effect of violence within the FMH units, stemming from affective dysregulation in response to incidents.

To further contain patients’ reactions following incidents, it may be useful to provide regular informal, and formal, opportunities for patient debriefing meetings. These could take the form of facilitated reflective discussion spaces. It is likely this would best be facilitated by a member of staff with moderate levels of power and influence within the units, such as ward managers.

It may be helpful to consider formulating and formalising a standard operational policy for the removal, or ‘zoning’ of patients away from areas where and when incidents occur, to an alternative place of safety; to avoid re-traumatisation, and contain patients’ emotional reactions.

Furthermore, allocating specific members of staff to remain with uninvolved patients when incidents occur, will ensure their basic needs continue to be met; and potentially limit subsequent reactive violence.

4.4.2 FMH policy. It is recognised within best practice guidance for the client population, that the withdrawal and ending of treatments and services should be carefully discussed and managed (National Institute for Health and Care Excellence, 2009). The importance of strong TRs within FMH services, in particular for women, is acknowledged (Department of Health, 2007, 2007b, 2010; National Institute for Mental Health, 2003). Further, it is accepted that there is a need to: “build a trusting relationship, work in an open, engaging and non-judgemental manner, and be consistent and reliable” (Ibid, p. 6). However, no mention is made regarding the stability of FMH patients’ attachment relationships, or how relational endings are managed. Findings from the present study tentatively suggest there is a need for relational endings to be managed commensurate with treatment endings. Further, that considerable thought should be given to the provision of stable attachment relationships for patients throughout their FMH service journeys.

The management of risk by means of relational security is emphasised within best practice guidance (Department of Health, 2007, 2010). However such guidance fails to emphasise the significance of patients’ past experiences of violence, or consider how that may impact upon their behaviour(s) following incidents perpetrated by others within the FMH environment. Findings from the present study suggest that overall risk within FMH units may be more effectively managed by clinicians formulating, and responding to, individual patients’ needs, in accordance with their specific ‘triggers’ and past experiences. This may help to curb

violence ‘snowballing’ in the aftermath of incidents, through the provision of person-centred support.

The importance of clinical supervision for FMH staff is emphasised within policy literature. For example, it is suggested FMH services know they are getting it ‘right’ when “Uptake of supervision is high, staff report that it is of value to them and we engage in reflective practice” (Department of Health, 2010, p. 14). Specifications for medium-secure services additionally outline “a programme of clinical supervision, continuing professional development and personal development plans for all staff” (Department of Health, 2007b) as a required quality principle. Additionally, reflective practice and clinical supervision are considered crucial for effectively managing risk within FMH environments (Department of Health, 2007), acknowledging “All staff should receive supervision – regardless of their skills, competency or experience.” (Ibid, p.26). However, unlike for other professional groups (The British Psychological Society, 2010), the amount and nature of supervision FMH professionals receive is not formally specified within policy literature. The Royal College of Psychiatry’s quality network for forensic mental health services sought to review the ways in which supervision was provided and received by frontline staff (King, n.d.). From this audit, it was identified that of the units sampled, only 60% were found to be fully compliant with a suggested one hour supervision per member of staff per month. Furthermore, it was highlighted that there are often no consequences for lack of supervision attendance, supervisees often lacked choice regarding supervisors, supervision is often deprioritised in favour of everyday tasks, supervision quality is variable, and resource constraints inhibit supervision provision. Results from the current study would suggest a need for standardisation of supervision requirements within FMH policy literature. Findings indicate that it may be beneficial for FMH professionals to receive considerably more clinical supervision and opportunities to engage in reflective practice

activities than is currently recommended. Supervision appears of fundamental importance for clinicians to reflect upon transference and countertransference and prevent ‘acting out’ in aggressive or inappropriate ways towards patients and other staff. Increased opportunities to reflect upon difficulties within TRs with the patient population, and emotional reactions towards incidents, may allow FMH professionals to better ‘contain’ patients’ distress and lower violence, reduce burnout, stress and sickness levels, thereby contributing to greater consistency within unit environments (Ashburner, Aleyer, Cotter, Youog & Ansell, 2004; Gonge & Buus, 2011). Clinical supervision should be provided by individuals with appropriate transference based skills and training in order to address underlying modes with which patients and staff relate (Jacob & MacAllister, 2010).

4.4.3 Psychological theory. There is a lack of psychological theory development regarding the experiences of female FMH patients. It may be useful in terms of further research, and clinical decision making, for theoretical development in the areas of: patient constructions of TRs within FMH services, the relational nature of FMH services from patient perspectives, and systemic conceptualisations of the relational FMH world from patient perspectives. It may be helpful to understand female FMH patients’ experiences with regard to TRs and violence through a social psychological lens. In particular, focusing on the roles FMH patients may adopt (Miller, 2004), and the application of Close Relationships Theory. Aspects of Feminist Theory have been implicitly touched upon throughout the current study. It may be useful for further research to explore the application of Feminist Theory more explicitly and robustly with the patient population, for example drawing upon the work of David Karp in considering what it means to be a woman struggling with mental illness, particularly when struggling with what may be perceived as too many emotions in a society which devalues emotional experience (Karp, 1997).

4.4.4 Further research. Based upon the findings from, and limitations with, the current study, it may be beneficial for future research to focus upon: exploring patients' experiences of TRs between low, medium and high secure FMH services. It may be beneficial to adopt an alternative individually-based recruitment strategy in order to engage with and explore the experiences of patients with greater relational difficulties and lower levels of engagement with FMH staff. It would be valuable to explore patients' TR experiences in relation to different FMH professional groups. It may also be useful to explore patients' lived experiences in relation to specified and differentiated forms of violence, for example attacks on staff, patients, or property, verbal aggression, or self-directed violence, in order to gain a more comprehensive and in-depth understanding of their experiences.

The plausibility and value of engaging female FMH patients within applied research has been demonstrated within the current study. In order to involve patients in a more meaningful way within research processes in the future, it would be valuable to conduct focus groups to identify areas of research patients deem important, and use such information to guide future research activities.

4.5 Personal Reflections

Mirroring the sentiments expressed by Lord (2007); I perceive myself as a constantly evolving clinician, open to influence from a multiplicity of perspectives and voices, all of which dynamically shape who I am, and how I engage with patients (Anderson & Gehart, 2007). I am, and have invariably been, shaped by patients I have worked with in the past, colleagues, supervisors, family and friends. Mindful of the sample size for the current study, I am cautious about drawing gross generalisations; however undoubtedly participants' accounts have left their

imprints upon me, and have affected the way I now engage with patients, and other staff. Before commencing this study, I was moved by the tragedy permeating patients' lives and personal histories, and the long-lasting impact that often bestows. I was surprised, and saddened, to later recognise such tragedy reflected within many other aspects of the FMH system, FMH staff, and interactions between individuals within the system. I feel far greater compassion for secure FMH staff, and the enormous complexities and challenges they face in working with the patient population, within the wider context of oppressive and restrictive FMH services. Similarly, I feel I have developed a far more nuanced appreciation of the difficulties the patient population may experience in forming TRs, theoretically anchored within both psychodynamic and systemic perspectives.

At a time in my training and career where I have sometimes felt overwhelmed by the different – often competing - voices of multiple therapeutic languages, skills, and techniques learnt; I have found the process of completing the current study reassuring. For keeping me grounded to the fundamental basics of human connection; and how at times of desperation and vulnerability, being 'human' and offering warmth, care and respect to patients appears more highly valued than any specific therapeutic technique.

Completing this study has made me ponder the unspoken expectations placed upon patients I work with, regarding what is considered 'appropriate' within professional TR interactions. I perceive that as a profession, psychologists seem to expect adherence to unspoken rules and 'norms'; and are often quick to label non-adherence as 'boundary pushing' or indicative of 'dysfunction'. This struck me as a way of maintaining professional 'power' structures, and relational distance. I reflected that adherence to such unspoken expectations seem not only unrealistic, but highly uncompassionate, given what is known about the typical

relational histories, difficulties, and attachment templates of individuals diagnosed with Borderline Personality Disorder. I have translated these reflections into greater transparency within TRs, which I feel is a necessary step towards genuinely addressing and working with power imbalances.

Within the socio-political context of evidence-based service delivery, and need for applied research within the National Health Service (NHS); I felt frustrated by the challenges and time required to gain ethical and governance approval for the study. While entirely necessary for the protection of vulnerable populations, I experienced current approaches to ethics and governance approval processes as a significant barrier for conducting future research within the NHS. I reflected that with increasing austerity cuts, and the drive for delivering increased services with fewer resources, delivering post-qualification applied research would likely be impossible without considerable whole-system sign-up and support. This challenged my pre-training expectations that the role of Clinical Psychologist would involve both research and clinical activities; and reinforced a dichotomous split between pursuing a research or clinically driven career.

I was heartened by recruited participants' enthusiasm and engagement in the research process. This has strongly motivated me towards wanting to engage patients more meaningfully in any future research activities.

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Appendix A

Systematic Review One: FMH Inpatients' Experiences of Therapeutic Relationships

Table A1

Systematic review one search strategy: forensic mental health inpatients' experiences of TRs

Search Number	Search Terms	MEDLINE Search run: 28/09/2015 All years (Results)	CINAHL Complete Search run: 28/09/2015 All years (Results)	PsycINFO Search run: 28/09/2015 All years (Results)	PsycARTICLES Search run: 28/09/2015 All years (Results)
1	“Therapeutic relationship” OR “Working relationship” OR “Alliance”	61, 881	66, 338	28, 978	11, 140
2	“Attitude*” OR “Experience*”	1, 555, 277	804, 545	803, 399	91, 406
3	#1 OR #2	1, 580, 142	171, 762	822, 504	92, 387
4	“Forensic” OR “Secure psych*” OR “Secure mental health”	86, 555	23, 733	33, 449	5, 094
5	“Inpatient” OR “Offend*” OR “Acute”	1, 431, 091	437, 361	178, 341	24, 110
6	#4 OR #5	1, 472, 261	389, 975	175, 330	26, 517
7	“Qualitative*”	286, 423	159, 810	200, 514	18, 088
8	#3 AND #6 AND #7	34, 636	33, 853	3, 677	3, 986

Combined results (duplicates removed) = 14, 690

Search Limiters and Expanders	Justification
1. English language	1. Translation unavailable
2. Journal articles	2. Accessible empirical evidence sought
3. Apply related words	3. Broaden search terms
4. Search within full-text	4. Identify full-range of available research.

Inclusion Criteria	Justification
1. Focus on service-user experiences	1. Focus of review
2. Qualitative methodology	2. Obtain rich accounts of lived experiences
3. Inpatient context	3. Focus of review
4. Adult population (aged 18 years and older).	4. Research suggests therapeutic relationships with children or adolescents differ from adult relationships ¹
5. Focus on therapeutic relationships	5. Focus of review
6. Empirical research (interview or focus groups)	6. First hand accounts sought.
7. Forensic mental health services	7. Focus of review

¹ Hawes (2005).

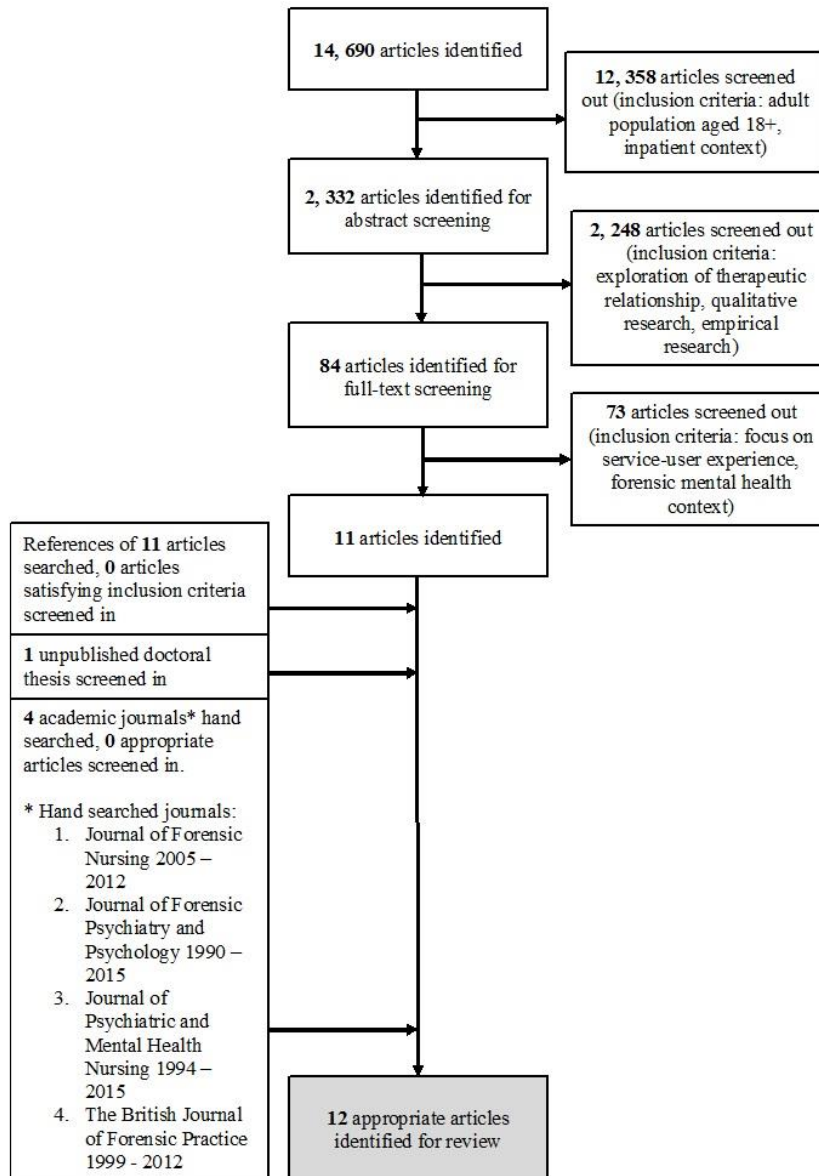


Figure A1. Flowchart of Included Studies for Systematic Review One: Experiences of TRs

Appendix B

Systematic Review Two: Inpatients' experiences of Violence and Aggression within Acute
Mental Health Services

Table B1

Systematic review two search strategy: inpatients' experiences of violence and aggression

Search Number	Search Terms	MEDLINE Search run: 30/09/2015 All years (Results)	CINAHL Search run: 30/09/2015 All years (Results)	PsycINFO Search run: 30/09/2015 All years (Results)	PsycARTICLES Search run: 30/09/2015 All years (Results)
1	“Aggress*” OR “Violen*” OR “Incident*”	558, 900	219, 926	152, 072	36, 659
2	“Experience*” OR “Impact” OR “Effect*”	8, 281, 041	1, 672, 377	1, 520, 052	127, 572
3	“Forensic” OR “Secure psych*” OR “Secure mental health”	86, 603	23, 733	33, 521	5, 234
4	“Qualitative”	272, 409	159, 810	193, 930	18, 126
5	#1 AND #2 AND #3 AND #4	1, 426	1, 659	123	530

Combined results (duplicates removed) = 3, 750

Search Limiters and Expanders	Justification
5. English language	5. Translation unavailable
6. Journal articles	6. Accessible empirical evidence sought
7. Apply related words	7. Broaden search terms
8. Search within full-text	8. Identify full-range of available research.

Inclusion Criteria	Justification
8. Focus on patient experiences	8. Focus of review
9. Qualitative methodology	9. Obtain rich accounts of lived experiences
10. Inpatient context	10. Focus of review
11. Adult population (aged 18 years and older).	11. Research suggests therapeutic relationships with children or adolescents differ from adult relationships ¹
12. Focus on experience of aggression within the units	12. Focus of review
13. Empirical research (interview or focus groups)	13. First hand accounts sought.

¹ Hawes (2005).

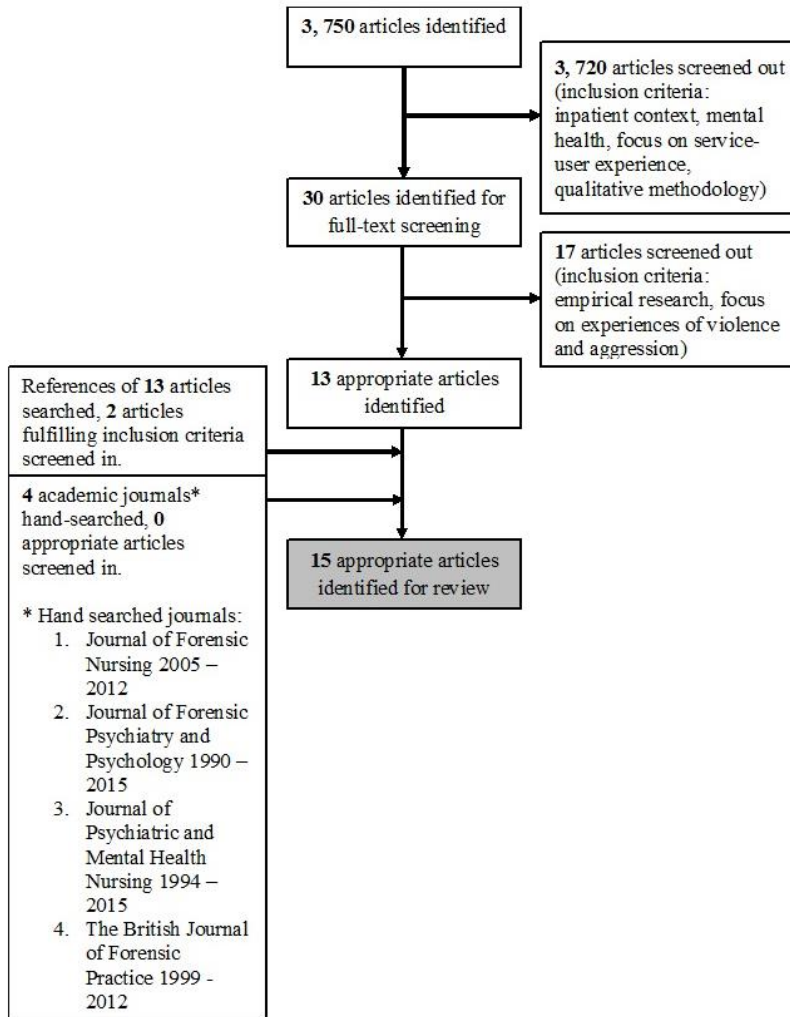


Figure B1. Flowchart of Included Studies for Systematic Review 2: Experiences of Violence and Aggression

Appendix C

Methodological Quality Appraisal: Systematic Review One, Forensic Mental Health Inpatients' Experiences of Therapeutic Relationships

Table C1

QualSyst quality appraisal of reviewed articles regarding Forensic Mental Health patients' experiences of Therapeutic Relationships (N = 12), adapted from Wassenaar, Schouten & Schoonhoven (2013).

Reviewed Article	Quality Appraisal Criteria										Summary Score
	1. Question / Objective	2. Study Design	3. Context	4. Theoretical Framework	5. Sampling Strategy	6. Data Collection	7. Data Analysis	8. Verification Procedure	9. Conclusion	10. Reflexivity	
Aiyegbusi (2011)	2	2	2	2	2	2	2	0	2	2	18/20 = 0.9
Barnao, Ward & Casey (2014)	2	2	2	2	2	2	2	2	2	2	20/20 = 1.0
Clarkson, Murphy, Coldwell & Dawson (2009)	2	2	2	2	2	2	2	2	2	1	19/20 = 0.95
Fortune et al (2010)	2	2	1	2	1	2	2	1	2	0	15/20 = 0.75
Horberg, Sjogren & Dahlberg (2012).	2	2	2	1	1	1	2	2	2	0	15/20 = 0.75
Livingston & Nijdam-Jones (2013)	2	2	2	2	1	2	2	2	2	1	18/20 = 0.9
Maguire, Daffern & Martin (2014).	2	2	2	2	2	2	2	0	2	0	16/20 = 0.8
Mezey, Kavuma, Turton, Demetriou & Wright (2010).	2	2	1	2	1	2	2	2	2	1	17/20 = 0.85
Olsson, Strand & Kristiansen (2014)	2	2	2	2	2	2	2	2	2	0	18/20 = 0.9
Schafer & Peterneji-Taylor (2003)	2	2	2	2	2	2	2	2	2	2	20/20 = 1.0
Tapp, Warren, Fife-Schaw, Perkins & Moore (2013)	2	2	2	2	2	2	2	1	2	1	18/20 = 0.9
Willmot & McMurrin (2013)	2	2	1	2	2	2	2	1	2	1	17/20 = 0.85

Note. 2 = yes; 1 = partial; 0 = no

Table C2

CASP quality appraisal of reviewed articles regarding inpatients' experiences of therapeutic relationships (N = 12).

Reviewed Article	Quality Appraisal Criteria									
	Clear statement of aims?	Qualitative methodology appropriate?	Appropriate research design?	Appropriate recruitment strategy?	Appropriate data collection?	Relationship – participant relationship considered?	Consideration of ethical issues?	Rigorous data analysis?	Clear statement of findings?	How valuable is the Finresearch?*
Aiyegbusi (2011)	2	2	2	2	2	1	2	2	2	Findings related to previous theory, research, policy and practice. Further research identified. Limitations and implications presented.
Barnao, Ward & Casey (2014)	2	2	2	2	2	2	2	2	2	Implications for clinical practice are not discussed thoroughly.
Clarkson, Murphy, Coldwell & Dawson (2009)	2	2	2	2	2	1	2	2	2	Findings related to previous theory, research, policy and practice. Further research identified. Limitations and implications presented.
Fortune et al (2010)	2	2	2	1	2	0	2	2	2	Methodological limitations not discussed fully. Findings are not related to wide body of previous research, policy or theory.
Horberg, Sjogren & Dahlberg (2012).	2	2	2	1	1	0	2	2	2	Limitations, limits to transferability and areas for further research are not discussed.
Livingston & Nijdam-Jones (2013)	2	2	2	1	2	0	2	2	2	Findings are not discussed in relation to previous research, theory or policy.
Maguire, Daffern & Martin (2014).	2	2	2	2	2	0	2	2	2	Findings are discussed in relation to existing research and policy. Implications and areas for further research are presented. Limitations to transferability are outlined.
Mezey, Kavuma, Turton, Demetriou & Wright (2010).	2	2	2	1	2	1	1	2	2	Findings related to limited previous research.
Olsson, Strand & Kristiansen (2014)	2	2	2	2	2	0	2	2	2	Comprehensive recommendations suggested for practice improvement.
Schafer & Peterneji-Taylor (2003)	2	2	2	2	2	2	2	2	2	Further research not indicated. Findings are not related to previous research, theory or policy.

Table C2 continued

Tapp, Warren, Fife-Schaw, Perkins & Moore (2013)	2	2	2	2	2	1	2	2	2	Does not offer suggestions for further research.
Willmot & McMurren (2013)	2	2	2	2	2	1	2	2	2	Thoroughly relates findings to previous research and practice, extensive discussion of limitations, implications and further research

Note. * contribution of the study to existing knowledge, consideration of findings in relation to current practice, policy, or literature base, areas identified for further research, transferability of findings discussed; 2 = yes; 1 = can't tell; 0 = no

Appendix D

Methodological Quality Appraisal: Systematic Review Two, Inpatients' Experiences of Violence and Aggression within Acute Services

Table D1

QualSyst quality appraisal of reviewed articles regarding inpatients' experiences of violence and aggression (N = 15), adapted from Wassenaar, Schouten & Schoonhoven (2013).

Reviewed Article	Quality Appraisal Criteria										Summary Score
	1. Question / Objective	2. Study Design	3. Context	4. Theoretical Framework	5. Sampling Strategy	6. Data Collection	7. Data Analysis	8. Verification Procedure	9. Conclusion	10. Reflexivity	
Bonner, Lowe, Rawcliffe, & Wellman (2002)	2	2	2	1	2	1	0	2	2	0	14/20 = 0.7
Duxbury & Whittington (2004)	1	2	2	2	1	2	1	0	2	0	13/20 = 0.65
Hinsby & Baker (2004)	2	2	2	2	2	2	2	1	2	0	17/20 = 0.85
Horberg, Sjogren & Dahlberg (2012)	2	2	2	1	1	1	2	2	2	0	15/20 = 0.75
Janicki (2009)	2	2	1	2	2	2	0	0	2	0	13/20 = 0.65
Kennedy & Fortune (2013)	2	2	2	2	2	2	2	2	2	1	19/20 = 0.95
Lilja & Hellzen (2008)	2	2	1	2	1	2	2	1	2	1	16/20 = 0.8
Lindgren, Aminoff & Graneheim (2015)	2	2	2	2	1	1	2	1	2	1	16/20 = 0.8
Maguire, Daffern & Martin (2014)	2	2	2	2	2	2	2	0	2	0	16/20 = 0.8
Meehan, McIntosh & Bergen (2006)	2	2	2	2	1	2	2	2	2	0	17/20 = 0.85
Mezey, Hassell, & Bartlett (2005)	2	1	2	2	1	1	1	2	2	0	14/20 = 0.7
Parkes & Freshwater (2012)	2	2	2	2	2	2	2	0	2	0	16/20 = 0.8
Stenhouse (2012)	2	2	2	2	2	2	2	2	2	0	18/20 = 0.9
Winship (2014)	2	2	2	2	0	2	1	0	2	0	13/20 = 0.65

Table D1 continued

Wynn (2004)	2	2	2	2	2	2	2	2	0	2	1	17/20 = 0.85
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Note. 2 = yes; 1 = partial; 0 = no

Table D2

CASP quality appraisal of reviewed articles regarding inpatients' experiences of violence and aggression (N = 15).

Reviewed Article	Quality Appraisal Criteria										How valuable is the research?*
	Clear statement of aims?	Qualitative methodology appropriate?	Appropriate research design?	Appropriate recruitment strategy?	Appropriate data collection?	Relationship – participant relationship considered?	Consideration of ethical issues?	Rigorous data analysis?	Clear statement of findings?		
Bonner, Lowe, Rawcliffe, & Wellman (2002)	2	2	2	2	2	0	2	1	2	Does not relate findings to policy. Limited discussions of transferability and study limitations.	
Duxbury & Whittington (2004)	2	1	2	1	2	0	2	1	2	Findings related to previous research and current practices. Identifies areas for further research, clinical implications, and discusses limitations.	
Hinsby & Baker (2004)	1	2	2	1	2	0	1	2	2	Findings are not related to previous research, policy or practice. No areas for further research are suggested, nor implications or limitations discussed.	
Horberg, Sjogren & Dahlberg (2012)	2	2	2	1	1	0	2	2	2	Limitations, limits to transferability and areas for further research are not discussed.	
Janicki (2009)	2	2	2	2	2	0	2	2	2	Does not relate findings to previous literature. Limitations are not discussed. Limited suggestions for further research are offered.	
Kennedy & Fortune (2013)	2	2	2	2	2	0	2	2	2	Findings related to previous research, limitations and implications discussed partially. Areas warranting further research are referenced.	
Lilja & Hellzen (2008)	2	2	2	2	2	1	2	2	2	Implications and limitations are discussed however no suggestions are presented regarding further research.	

Table D2 continued

Lindgren, Aminoff & Graneheim (2015)	2	2	2	1	2	0	2	2	2	Limitations and clinical implications are partially discussed. Limited suggestions for further research are offered.
Maguire, Daffern & Martin (2014)	2	2	2	2	2	0	2	2	2	Findings are discussed in relation to existing research and policy. Implications and areas for further research are presented. Limitations to transferability are outlined.
Meehan, McIntosh & Bergen (2006)	2	2	2	1	2	1	2	2	2	Results are not discussed in relation to areas for further research.
Mezey, Hassell, & Bartlett (2005)	2	2	2	1	1	0	0	2	2	Findings are not discussed in relation to existing research or policy. Areas for further research are not identified.
Parkes & Freshwater (2012)	2	2	2	2	2	0	2	1	2	Methodological limitations are not discussed, nor areas for further research.
Stenhouse (2012)	2	2	2	2	2	0	2	2	2	Further areas for research are not offered.
Winship (2014)	2	2	2	1	2	0	2	1	2	Further research is not suggested, findings are discussed in relation to a very limited amount of existing research.
Wynn (2004)	2	2	2	2	2	1	2	2	2	Findings are discussed in relation to extensive previous research, limitations, implications, and transferability limits are outlined.

Note. * contribution of the study to existing knowledge, consideration of findings in relation to current practice, policy, or literature base, areas identified for further research, transferability of findings discussed; 2 = yes; 1 = can't tell; 0 = no

Appendix E

Systematic Review One: Reviewed Articles

Table E

Characteristics of synthesised articles examining inpatients' experiences of therapeutic relationships (N = 12)

Article	Aims	Patient Sample	Data Collection	Analysis	Context
Aiyegbusi (2011)	Explore nurses' and personality-disordered patients' experiences of therapeutic relationships, interpersonal challenges, and establish practices both groups perceive as enabling for relationships. To develop nursing guidance for managing therapeutic relationships with personality-disordered patients.	11 patients	FG	FA	1 MSU, 1 DSPD service, 1 TC, British
Barnao, Ward & Casey (2014)	Explore patients' perspectives of rehabilitation.	17 male, 3 female patients	SSI	TA	2 MSU, 1 rehabilitation ward, New Zealand
Clarkson, Murphy, Coldwell & Dawson (2009)	To explore staff characteristics patients value within residential FMH service.	16 males, 5 females	SSI and FG	IPA	1 MSU, 1 LSU, 1 rehabilitation ward, British
Fortune et al (2010)	Examine staff and patients' experiences of receiving and delivering treatment within a forensic service for personality disordered offenders.	30 male patients	SSI	TA	4 MSU, 3 residential services, 1 community team, British
Horberg, Sjogren & Dahlberg (2012).	Explore patients' lived experiences of receiving care within FSUs.	6 male and 5 female patients.	SSI	PA	1 Swedish FSU
Livingston & Nijdam-Jones (2013)	To examine treatment planning from the perspectives of patients and service providers.	23 male, 6 female patients	SSI	TA	9 HSU, MSU and LSU within 1 Canadian FMH hospital
Maguire, Daffern & Martin (2014).	Explore the nature of limit setting within a FMH setting; gaining perspectives of staff and patients.	12 patients.	SSI	TA	Australian FSU
Mezey, Kavuma, Turton, Demetriou & Wright (2010).	To explore experiences, perceptions and definitions of 'recovery' in patients detained within MSUs.	8 male, 2 female patients.	SSI	TA and CA	4 British MSUs
Olsson, Strand & Kristiansen (2014)	Explore perceptions of 'recovery' within forensic patients at high risk of committing violence.	8 male, 2 female patients.	SSI	CA	8 Swedish HSUs
Schafer & Peterneji-Taylor (2003)	To explore experiences of patients enrolled in a treatment programme for violent offenders.	12 male patients	SSI	GT	1 Canadian FMHU
Tapp, Warren, Fife-Schaw, Perkins & Moore (2013)	To explore 'what works' in treatment for patients detained within HSUs.	12 male patients	SSI	TA	1 British HSU

Table E continued

Willmot & McMurran (2013)	Explore the process of change within therapeutic interventions for male FMH inpatients diagnosed with personality disorders.	12 male patients	SSI	TA	1 British HSU
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Note. CA = content analysis; DSPD = dangerous and severe personality disorder; FA = framework analysis; FG = focus group; FMH = forensic mental health; FSU = forensic secure unit; GT = grounded theory; HSU = high secure unit; LSU = low secure unit; MSU = medium secure unit; PA = phenomenological analysis; SSI = semi-structured interview; TA = thematic analysis; TC = therapeutic community

Appendix F

Systematic Review Two: Reviewed Articles

Table F

Characteristics of synthesised articles examining inpatients' experiences of violence (N = 15)

Article	Aims	Patient Sample	Data Collection	Analysis	Context
Bonner, Lowe, Rawcliffe, & Wellman. (2002).	Explore staff and patients' subjective experiences of restraint, and factors perceived as helpful or unhelpful during and following violent incidents.	Patients involved in violent incidents. (gender and sample size unknown).	SSI	TA	AIUs (number unknown)
Duxbury & Whittington (2004).	Explore staff and patient perspectives regarding the cause and management of patient aggression.	5 patients (gender unknown).	Mixed-methods, qualitative element: SSI	CA	3 British AIUs
Hinsby & Baker (2004).	To explore nurse and patient accounts of violent incidents, considering similarities and differences in their narratives.	4 male patients	SSI	GT	1 British MSU
Horberg, Sjogren & Dahlberg (2012).	Explore patients' lived experiences of receiving care within FSUs.	6 male and 5 female patients.	SSI	PA	1 Swedish FSU
Janicki (2009)	Explore staff and patient perceptions about the involvement of the CJS when responding to patient-perpetrated assaults within a MSU.	6 female patients.	Mixed-methods, qualitative element: SSI	Unknown	1 British MSU
Kennedy & Fortune (2013).	Identify factors influencing female service-users' occupational engagement within an AIU.	5 female patients.	SSI	PA	2 Australian AIUs
Lilja & Hellzen (2008).	Advance understanding of former inpatients' experiences regarding their admissions within an AIU.	3 male and 7 female patients.	SSI	CA	Swedish AIUs
Lindgren, Aminoff & Graneheim (2015).	Describe features of everyday life within AIUs for females who self-harm.	6 female patients.	Informal interviews.	CA	2 Swedish AIU
Maguire, Daffern & Martin (2014).	Explore the nature of limit setting within a FMH setting; gaining perspectives of staff and patients.	12 patients.	SSI	TA	Australian FSU
Meehan, McIntosh & Bergen (2006).	Explore patients' perceptions of aggression and violence within a HSU.	22 male and 5 female patients.	5 FGs	CA	Australian HSU
Mezey, Hassell, & Bartlett (2005)	Explore the impact of gender segregation upon the perceived safety of females within MSUs.	31 female patients.	SSI	CA	16 British MSUs

Table F continued

Parkes & Freshwater (2012).	Elicit and describe female patients' experiences of distress within secure FMH services, and understand their care and treatment needs.	11 female patients.	SSI	TA	1 British HSU and 1 British MSU
Stenhouse (2012).	Understand the experience of being a patient on an AIU.	6 male and 7 female patients.	Unstructured interviews	HA	1 British AIU
Winship (2014).	Identify nursing staff and patients' attitudes towards the management of violence and aggression within a HSU.	8 male patients	SSI	TA	1 British HSU
Wynn (2004).	Explore inpatient experiences of physical and pharmacological restraint.	9 male and 3 female patients.	SSI	GT	Norwegian AIUs

Note. AIU = acute inpatient unit; CA = content analysis; FG = focus group; FMH = forensic mental

health; FSU = forensic secure unit; GT = grounded theory; HA = holistic analysis; HSU = high secure unit; MSU = medium secure unit; PA = phenomenological

analysis; SSI = semi-structured interview; TA = thematic analysis

Appendix G

Systematic Review One: Themes and Subthemes Located Across Reviewed Articles

Table G

Presence of constructed themes and subthemes within reviewed articles regarding Forensic Mental Health patients' experiences of TRs (N=12)

Themes and <i>Subthemes</i>	Reviewed articles											
	1	2	3	4	5	6	7	8	9	10	11	12
Negotiating TRs within a confusing coercive environment		X			X	X				X		
<i>Unspoken expectations</i>		X			X					X		
<i>Learning the rules and finding out place</i>		X			X	X				X		
Tolerating vulnerability: a leap of faith	X	X	X		X	X				X		X
<i>Fear of attachment</i>	X	X	X		X	X				X		X
<i>Learning to trust again</i>			X		X	X				X		
<i>How am I doing?</i>	X					X						X
Managing uncertainty: the importance of boundaries	X		X		X		X			X		
Staff wanting, and knowing how to be, present	X		X	X						X		
<i>Emotional unavailability</i>	X		X	X						X		
<i>Do you know what you're doing?</i>	X		X	X						X		
Relationships of variable attachments	X	X	X	X	X	X	X	X	X	X		X
<i>Variable strength and quality</i>	X	X	X		X	X						
<i>Being treated like a human</i>	X	X	X		X	X	X	X		X		
<i>Testing the waters</i>				X						X		
<i>Recognising and responding to needs</i>	X	X	X				X		X	X		X
The significance of time	X	X	X	X	X	X				X	X	X
<i>Making time</i>	X					X				X		X
<i>Changing with time</i>			X							X		X
<i>Consistency over time</i>	X	X	X	X	X	X					X	X
A vehicle for connection, containment and change	X	X	X	X	X	X		X	X	X	X	X
<i>Honesty and trust</i>	X		X	X	X	X			X	X		X
<i>Protection</i>			X		X					X		X
<i>Emotional expression and containment</i>	X		X		X							
<i>Human connection and companionship</i>					X					X		
<i>Impact upon outcomes</i>	X	X	X	X				X	X	X	X	X
Connecting with staff who are only human	X	X	X	X	X	X	X	X		X		X
<i>Negative traits damage TRs</i>	X		X		X		X			X		
<i>Positive traits improve TRs</i>	X	X	X	X	X	X	X	X		X		X
<i>Staff as abusers</i>					X							

Note. 1 = Aiyegbusi (2011); 2 = Barnao, Ward & Casey (2014); 3 = Clarkson, Murphy, Coldwell & Dawson (2009); 4 = Fortune et al (2010); 5 = Horberg, Sjogren & Dahlberg (2012); 6 = Livingston & Nijdam-Jones (2013); 7 = Maguire, Daffern & Martin (2010); 8 = Mezey, Kayuma, Turton, Demetriou & Wright (2010); 9 = Olsson, Strand & Kristiansen (2014); 10 = Schafer & Peterneji-Taylor (2003); 11 = Tapp, Warren, Fife-Schaw, Perkins & Moore (2013); 12 = Willmot & McMurrin (2013).

Appendix H

Systematic Review Two: Themes and Subthemes Located Across Reviewed Articles

Table H

Presence of themes and subthemes within reviewed articles regarding inpatients' experiences of violence and aggression (N=15)

Domain	Theme and Subthemes	Reviewed Articles															
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	
Antecedent(s)	We're ill, violence is inevitable.	X		X		X				X	X	X	X	X	X	X	
	<i>Madness = badness</i>	X		X		X				X	X	X	X	X	X	X	
	<i>Feelings get the better of us</i>												X	X		X	
	<i>Attack or risk being attacked</i>									X			X			X	
	We get something from it	X						X			X		X		X		
	Staff bring it on themselves	X	X	X	X						X		X		X	X	
	<i>Staff are the aggressors</i>			X	X	X					X				X	X	
	<i>Reaction to malevolent and neglectful care</i>	X	X	X	X						X		X			X	
	Violence is the product of a broken system	X	X	X	X							X		X		X	X
	<i>Managing uncertainty and regaining control</i>				X							X		X		X	X
<i>Product of unit dynamics</i>	X	X	X	X							X						
Feelings and Experiences	Offers a chance for self-containment												X				
	Affects our relationships and our progress	X			X									X			
	We are sensitive to gender dynamics	X					X					X		X			
	Intensely negative emotional impact	X		X	X	X	X		X		X	X	X	X		X	
Managing the aftermath	We're ill, we need staff to make it better	X	X	X	X	X		X		X	X	X	X	X	X	X	
	<i>We're vulnerable and in need of protection</i>			X		X				X		X		X		X	
	<i>We need our feelings and experiences to be contained</i>	X	X		X			X			X		X				
	Prevention is better than cure			X		X				X	X		X		X	X	
	<i>Improve the system</i>									X		X		X		X	
	<i>If you can't prevent it, do something else quickly</i>			X		X					X		X			X	
	Help us to make sense of it	X									X	X			X		
Taking responsibility and facing the consequences		X	X		X						X	X		X			

Note. 1 = Bonner, Lowe, Rawcliffe, & Wellman. (2002); 2 = Duxbury & Whittington (2004); 3 = Hinsby & Baker (2004); 4 = Horberg, Sjogren & Dahlberg (2012); 5 = Janicki (2009); 6 = Kennedy & Fortune (2013); 7 = Lilja & Hellzen (2008); 8 = Lindgren, Aminoff & Graneheim (2015); 9 = Maguire, Daffern & Martin (2014); 10 = Meehan, McIntosh & Bergen (2006); 11 = Mezey, Hassell, & Bartlett (2005); 12 = Parkes & Freshwater (2012); 13 = Stenhouse (2012); 14 = Winship (2014); 15 = Wynn (2004).

Appendix I

Positivist Versus Interpretivist Paradigms

Table I

Key assumptions and differences in the research process between positivist and interpretivist paradigms, adapted from Neufeldt (2007).

Research Assumptions	Positivism	Interpretivism
Nature of reality	Reality is single, tangible and objectively given.	Realities are socially constructed, there can be multiple constructions and realities, they are accessed through shared meaning.
Relationship of knower to the known	Knower and known are independent (dualism)	Knower and known are interactive and inseparable
Generalisation	Generalisations are possible, and are time- and context-free	Only time- and context-bound working hypotheses are possible
Causal linkages	There are real causes, that precede or are simultaneous with their effects	All entities are in a state of mutual simultaneous shaping, so that it is impossible to distinguish causes from effects
Role of values	Inquiry is value-free	Inquiry is value-bound
Aim of knowledge	Increase predictive understandings of phenomena	Deep and insightful understanding of phenomena

Appendix J

Participant Information Sheet

RESEARCH INFORMATION SHEET

Title of Project: *The impact of violence upon therapeutic relationships in secure forensic mental health units: a qualitative study of female service-users' experiences.*

Name of Researcher: Katie Budge (Trainee Clinical Psychologist)

You are invited to participate in a research project

Before you decide whether to take part, it is important you understand the purpose of the research and what will be involved. Please take time to carefully read this information sheet. If you have any questions about the research please contact Katie, or ask a member of staff to arrange for Katie to come and talk with you. Katie will go through this information sheet with you if you would like to take part, and answer any questions you may have about the project.

Thank you for taking the time to read this information.

PART ONE: Essential information to help you decide if you would like to take part.**1. Why is this research being done?**

This project forms part of the requirements for the Essex University Doctorate in Clinical Psychology course, undertaken by Katie Budge. The study aims to explore female service-users' experiences of relationships with staff in secure forensic mental health settings, and examine any impact violence or aggression may have upon relationships. There has been very little research examining service-users' experiences of relationships with staff in forensic mental health services. Understanding service-users' views and experiences may allow forensic mental health services to consider the way in which services are provided, develop the ways staff support female service-users, and enhance relationships between staff and service-users..

2. Why have I been invited?

Katie is interested in hearing the views and experiences of female service-users who are currently detained within secure forensic mental health services, specifically at XXXXX. She hopes to carry out interviews with between 6 – 10 people. You have been invited to participate as you may be suitable for the research and may like to share your experiences.

3. Who can participate?

You may be eligible to participate if you are:

- Female
- Aged between 18 – 65 years old
- Have a psychiatric diagnosis of Borderline Personality Disorder
- Have witnessed or been involved in violence within XXXXX, in the unit you're currently in.

4. Do I have to take part?

No, you do not have to participate. Deciding to take part in the research project is completely up to you. If you do not wish to take part, this will not affect the treatment you receive, legal status under the Mental Health Act or your length of admission. If you are interested in participating, Katie will meet with you and describe the study, go through this information sheet and ask you to sign a consent form before taking part.

5. What will happen if I agree to participate?

If you are happy to participate, please inform a member of the staff team who will arrange for Katie to come and meet with you to talk about the research study in more detail and answer any questions you have. She will check you understand what is involved with taking part and that you are happy to participate. You will then be given some time (a minimum of 2 days) to think about taking part and have the chance to talk about this with other people. After this time, Katie will arrange to meet with you again, and will ask you to sign a consent form. Once you have signed the consent form, you will then take part in an interview with Katie lasting approximately one hour.

In the interview, Katie will ask you to share your experiences of relationships with staff. The interview will take place in a private room at XXXXX and will be recorded using a digital audio recorder. Katie will make sure at the end of the interview you are happy to still participate, she will ask you how you felt about the information you shared. If you are unhappy about something you have said being included in the findings this will be removed. If at the end of your interview, you and Katie feel that you have not discussed your experiences fully, you will be invited to meet again and take part in another interview, otherwise you will not need to meet with Katie again.

You are free to withdraw from the project at any time, without having to give a reason and without it affecting your treatment. Participating in this research will in no way affect the treatment you receive at XXXXX.

6. Will I get paid to participate?

If you take part in the research study, you will be provided with a once-off financial gift of £10 as a thank you. A member of the staff team at XXXXX will provide you with an envelope containing the gift and a letter of thanks once you have finished participating.

If you are in receipt of benefits, it is important to be aware that receiving a financial gift may affect these. According to recent guidance, you may receive a one-off gift of money, once in a financial year, without your benefits being affected, provided this does not take your personal savings over £6000. You are encouraged to discuss this with someone at the Disability Benefits Helpline before accepting the once-off financial gift (contact details are provided at the end of this information sheet).

7. What will I have to do?

As described in question 4, you will be asked to participate in one digitally audio recorded interview with Katie and talk about the relationships you have with staff at XXXXX. If you feel you need more time to fully discuss your experiences you may be invited to participate in a second interview.

8. Are there any risks or disadvantages of taking part?

For some people, talking about experiences can be upsetting. During the interview with Katie you do not have to talk about anything you do not want to talk about, and if you feel uncomfortable when talking about something let Katie know and you will not be asked to talk about it more. If you do feel upset about the things you discuss, please contact XXXXX or XXXXX who will be happy to talk to you about these.

As interviews will take place at XXXXX, members of staff and other service-users will be aware of who is taking part in the study. Neither the staff team, or other service-users, will be directly told about your specific personal experiences, and as far as possible the information you provide to Katie will be disguised so you cannot be directly linked with results; but as direct quotes of the things you talk about will be shared, there is a possibility you may be identifiable through the things that you say. XXXXX and XXXXX will be happy to talk to you after the study should you experience any distress as a result of taking part. Should you experience any negative effects of participating from a member of staff, you are encouraged to contact the independent Patient Advice and Liaison Service (contact details at the end of this information sheet), or talk to a member of staff if you are experiencing any negative effects from a service-

user due to taking part. Please also inform Katie or one of her supervisors if you experience any negative consequences of participating in the study.

9. Are there any benefits or advantages of taking part?

We cannot promise that the research project will directly help you, however you may find that talking about your experiences is valuable. We hope that the information we get from the project may benefit female service-users in secure forensic services, and XXXXX, by helping staff understand more about service-users' needs and ways they can meet them.

10. What will happen after the research finishes?

When the project has finished all participants who took part and staff will be given an overall summary of the findings, these findings will also be presented at XXXXX. Katie will ask you within your research interview whether you would like to be involved in presenting the findings to the staff and service-users within XXXXX. Specific information you have share which may identify you personally will be disguised, such as your name and the unit you are in, so you will not be obviously identifiable within findings, however direct quotes of the things you say will be presented, meaning that there is a risk you could be identified within results.

The project will be submitted to the University of Essex Clinical Psychology Doctorate Course. A summary of findings will be provided for policy makers, service-providers and academic researchers. Findings will also be written into an academic journal article, and presented at national conferences.

11. Will my taking part in the research be kept confidential?

Staff and other service-users at XXXXX will be aware that you are taking part in the project, as the interviews will take place within XXXXX. However, personal details related to the experiences you share in your interview(s) will be disguised so you will not be obviously identifiable, but you may still be identifiable through direct quotes of what you have spoken about. Katie will follow ethical and legal guidelines, and all information about you will be handled confidentiality, except where:

- There are serious concerns for your safety
- There are serious concerns for the safety of other people
- You have said something that might threaten the security of XXXXX.
- You have disclosed something which is illegal.

In these instances, where Katie believes this poses a potential future risk, she will share this information with the staff team at XXXXX but not the other experiences you have shared within your interview(s). This information may also be shared with authorities outside of XXXXX, such as the police or your GP. Katie will let you know before this information is shared. If, during your interview, you disclose information which suggests professional misconduct by a member of the staff team at XXXXX, Katie will have a duty to share this information with the appropriate authorities within and outside of XXXXX; she will notify you before this information is shared.

12. What will happen to the information I provide?

The interview will be digitally audio-recorded and only available to Katie and her supervisor to listen to. The audio-recorded interview will be written out and the recording will be destroyed once Katie's supervisor has made sure the written out account matches what was recorded. All personal information within the written account of your interview will be disguised, the file will be password protected, and stored securely. The written accounts may be looked at by Katie, her supervisors and one other Doctorate in Clinical Psychology student conducting a similar research study at XXXXX in order to make sure Katie is conducting the study properly.

No information will be stored on personal (home) computers. Every effort will be taken to make sure no written report includes personal information or details which may allow another person to easily identify you from your responses. The disguised written account of your interview(s) may be kept for up to 3 years by the University of Essex School of Health and

Human Sciences in order to allow articles to be written. If you have concerns about the quotes from your interview being used in the research write-up, you can talk about this with Katie.

If the information in Part 1 has interested you and you are considering taking part, please read the additional information in Part 2 before making any decision.

PART TWO: Further information about the research study.

1. What will happen if I don't want to carry on with the research?

If you decide to withdraw from the research project, either during the interview or afterwards, please ask one of the staff team to contact Katie for you. The information you have already provided will be kept and used within the study write-up but no further information will be collected from you.

2. What can I do if I am unhappy with some aspect of the project?

If you have concerns about the research, please contact Katie in the first instance. The staff at XXXXX are not involved in the research, and will support you in contacting Katie. If you remain unhappy and wish to complain formally, please ask a member of staff to support you with contacting the independent Patient Advice and Liaison Service (contact details are at the end of this information sheet).

3. What can I do if I am harmed by this research?

In the unlikely event that you are harmed during the research project, and this is due to someone's negligence then you may have grounds for a legal action for compensation against the University of Essex but you may have to pay your legal costs. The normal National Health Service complaints procedures will still be available to you (if appropriate).

4. How will the confidentiality of my data be managed?

- Your data will be collected from one (or more) digitally audio-recorded interviews. The digital audio-recording will be written out using Microsoft Word, and your personal details will be disguised so you cannot be obviously identified from your responses, for example, you will be given a 'fake name' and specific details that may identify you or other people will be changed; however direct quotes of the things you have said will be reported in findings. The written account of your interview (s) will be password protected and stored securely by Katie on a University of Essex computer.
- Once the recording of your interview has been written out, and the accuracy of this has been checked against the audio recording by Katie's supervisor, the recording will be securely and safely destroyed.
- The written account of your interview(s) will be stored for up to 3 years by Katie to be referred to when writing up academic journal articles.
- Only Katie will have access to view identifiable data you have provided.
- The data you provide will not be transferred outside of the United Kingdom.
- The data you provide will not be used for future research projects other than the study you have consented to take part in.
- Katie will adhere fully to the Data Protection Act (1998).

5. What will happen to the results of the study?

Findings will be written up into a research report submitted to the University of Essex Doctorate in Clinical Psychology programme by Katie Budge. Anonymous findings will also be presented:

- To forensic mental health service providers

- To forensic mental health policy makers (for example: Department of Health)
- To other academic researchers within the area of forensic and clinical mental health
- To an academic journal for publication
- At academic and clinical conferences in the form of a poster presentation
- To service-users who have participated in the research project, and staff within XXXXX and XXXXX NHS Foundation Trust.

6. Who is funding and organising the research?

This research is being done as part of the qualification for the Doctorate in Clinical Psychology, by Katie Budge. The research is sponsored by the University of Essex. The professionals involved in your clinical care are not being paid, or receiving any incentive, for you participating in the research project, they are in no way involved in this research study.

7. Who has reviewed the study?

All research conducted in the National Health Service is reviewed by an independent group of people, called a Research Ethics Committee, to protect your interests. This research project has been reviewed and given favourable opinion by NRES Committee East of England - Essex. The project has additionally been reviewed by the managerial team within XXXXX. If you decide to take part, you will be given a signed copy of your consent form and copy of this information sheet to keep.

FURTHER INFORMATION AND CONTACT DETAILS

<p>General information about research Information about mental health research can be found on the Mental Health Research Network website:</p> <ul style="list-style-type: none"> • Mental Health Research Network: www.mhrn.info 	<p>Advice as to whether you should participate Please feel free to discuss this research project with friends or family, staff, and other service-users, who may be able to help you decide whether you would like participate.</p>
<p>Further information about this research Please contact Katie Budge who will be happy to answer any questions you have about the project. You can contact Katie by approaching a member of the staff team; or calling the University of Essex Department of Health and Human Sciences, on: 01206 873 910 Alternatively, you may contact Katie's supervisors: Dr XXXXX: 01206 873 910 Or XXXXX</p>	<p>Who to approach if you are unhappy with the research study Please contact Katie or her supervisors in the first instance, via the telephone numbers provided, who will do their best to answer your concerns. If you would like to make a formal complaint, please contact the independent Patient Advice and Liaison Service: XXXXX (09:00 – 17:00 Monday - Friday, an answerphone service is available outside of these hours).</p>
<p>Financial Gift For advice about the potential impact of receiving the once-off financial gift of £10 for participation, upon your benefits, please contact: Disability Benefits Helpline: 08457 123 456</p>	

If you think you would like to participate in the research study, please ask a member of staff to contact Katie and arrange for her to visit you.

Appendix K
Participant Remuneration Letter

Dear Participant,

Thank you for your contribution to the research study “The Impact of Violence upon Therapeutic Relationships in Secure Forensic Mental Health Units: A Qualitative Study of Female Service-Users’ Experiences.”

Please accept this once-off £10 cash gift as a token of my appreciation for your time and effort in sharing with me the experiences you have had within the units, here at XXXXX.

If you have any further questions about the study, please talk to XXXXX or XXXXX, who will contact me.

Warm wishes,

Katie Budge

Trainee Clinical Psychologist

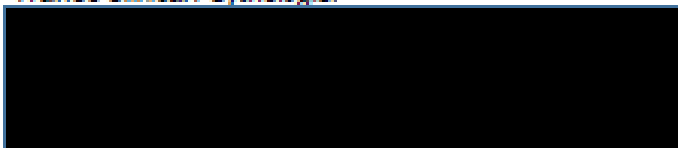
Appendix L

NHS Ethical Approval Confirmatory Letter


Health Research Authority
NRES Committee East of England - Essex

 London REC Office
 Health Research Authority
 Ground Floor, Skipton House
 50 London Road
 London
 SE1 6LH
 Telephone: 02079722580

21 January 2014


 Ms Katie Budge
 Trainee Clinical Psychologist


Dear Ms Budge

Study title:	The Impact of Violence upon Therapeutic Relationships in Secure Forensic Mental Health Units: A Qualitative Exploration of Female Service-Users' Experiences.
REC reference:	13/EE/0406
IRAS project ID:	133957

Thank you for your email of 10 January 2014, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

We plan to publish your research summary wording for the above study on the NRES website, together with your contact details, unless you expressly withhold permission to do so. Publication will be no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to withhold permission to publish, please contact the Co-ordinator, 

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS sites

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 8 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication rules).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non clinical trials this is not currently mandatory.

If a sponsor wishes to contest the need for registration they should contact Catherine Blewett (catherineblewett@nhs.net), the HRA does not, however, expect exceptions to be made. Guidance on where to register is provided within IRAS.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Evidence of Insurance or Indemnity		16 September 2013
Interview Schedules/Topic Guides	Research Interview Schedule V1	29 October 2013
Investigator CV	Student CV: Katie Budge V1	29 October 2013
Letter from Sponsor	Letter from	29 October 2013
Other: Academic Supervisor CV: [REDACTED]	1	29 October 2013
Other: CV: [REDACTED]	1	29 October 2013
Other: Participant Remuneration Letter	1	29 October 2013
Other: Management Approval Letter	1	22 May 2013
Other: Participant remuneration letter	2	29 December 2013
Other: GCP certificate - [REDACTED]		19 December 2013
Other: GCP certificate - [REDACTED]		08 January 2014
Other: GCP certificate - Katie Budge		28 December 2013
Participant Consent Form	1	29 October 2013
Participant Consent Form	2	29 December 2013
Participant Information Sheet	1	29 October 2013
Participant Information Sheet	2	29 December 2013
Protocol	1	29 October 2013
REC application	133567/3204 34/1/578	29 October 2013
Response to Request for Further Information	Letter to Essex REC from Katie Budge	10 January 2014

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

Further information is available at National Research Ethics Service website > After Review

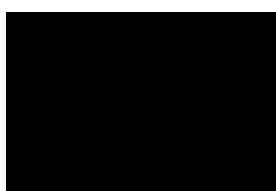
13/EE/0406

Please quote this number on all correspondence

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at <http://www.hra.nhs.uk/hra-training/>

With the Committee's best wishes for the success of this project.

Yours sincerely



Chair

Appendix M

NHS Ethical Approval: Provisional Decision Letter



Health Research Authority

NRES Committee East of England - Essex

London REC Office
Health Research Authority
Ground Floor, Stilton House
80 London Road
London SE1 6LH

Telephone: 020 7572 2554
Facsimile: 020 7572 2592

13 December 2013

Ms Katie Budge
Trainee Clinical Psychologist



Dear Ms Budge

Study Title: The Impact of Violence upon Therapeutic Relationships in Secure Forensic Mental Health Units: A Qualitative Exploration of Female Service-Users' Experiences.
REC reference: 13/EE/0405
IRAS project ID: 133957

The Research Ethics Committee reviewed the above application at the meeting held on 05 December 2013. Thank you for attending to discuss the application.

Documents reviewed

The documents reviewed at the meeting were:

Document	Version	Date
Evidence of Insurance or Indemnity	Gallagher Heath	16 September 2013
Interview Schedules/Topic Guides	Research Interview Schedule V1	29 October 2013
Investigator CV	Student CV: Katie Budge V1	29 October 2013
Letter from Sponsor	Letter from [REDACTED]	29 October 2013
Other: Academic supervisor CV: [REDACTED]	1	29 October 2013
Other: CV: [REDACTED]	1	29 October 2013
Other: Participant Remuneration Letter	1	29 October 2013
Other: Management Approval Letter	1	22 May 2013
Participant Consent Form	1	29 October 2013
Participant Information Sheet	1	29 October 2013
Protocol	1	29 October 2013
REC application	133957/520434/1/678	29 October 2013

Provisional opinion

In discussion, the Committee noted the following ethical issues.

Ethical issues raised, reserved or noted in preliminary discussion:

- The committee discussed the independent scientific review and commented it was lacking true independence, as [REDACTED] where the research is taking place and does not constitute an independent reviewer.
- It was not clear what was being studied from the "title" of the study.

Ethical issues raised by the committee in private discussion, together with responses given by the researcher when invited into the meeting.

You were invited to join the meeting. During your attendance the following discussion took place:

- A. It was asked and clarified the focus of the study was looking at the relationships service-users have with professionals. The committee suggested clarifying this research was looking at enhancement of relationship with staff in the Participant Information Sheet. This was agreed.
- B. The committee asked how the researcher knew that violence itself was the therapeutic care factor. It was responded the research was focusing specifically on violence as previous research has shown environment may have influence on relationship, which showed a gap in the field. The inference therefore was that violence itself was the impacting factor in relationship. It was clarified that as this was a qualitative study it may not provide the absolute truth.
- C. Would participants not be immune to violent incidents? It was clarified the effects of witnessing or perpetrating violence could be traumatising but could in turn help participants to overcome relationship ruptures both inside and outside the Unit.
- D. It was asked whether it would be practical to recruit only 10 participants to the study. It was responded the interviews would be done on a one-to-one basis and although the participants may know other participants on the study, the specific nature of violence experienced would not be known. It was further clarified that between six to ten participants was standard sample size for qualitative research, bearing in mind this study was being done as part of her PhD.
- E. The committee asked whether questions asked at the interview would be directive or open-ended and participants would be prompted in this process. It was responded there would be a possibility of a follow-up interview.
- F. The independent scientific review was discussed and the committee was assured that [REDACTED] had managerial responsibility of the Unit and was the researcher's [REDACTED]
- G. It was unclear why only non-native English speakers were excluded from the study. Clarification was given that similar studies done previously lacked common linguistic understanding. This study was therefore designed with this exclusion criterion, taking the impediment into consideration. The Chair asked the proportion of native English speakers in the Unit. It was confirmed currently everyone in the Unit spoke native English.
- H. The committee noted interviews would be transcribed and tapes would then be destroyed. It was unclear why verification of transcripts was not being done as part of the process. It was confirmed there was no verification process in place but agreed with the committee's suggestion of getting either the participant or Supervisor to verify the transcripts. It was agreed to add this to the information sheet.
- I. Clarification was given that as it was a closed Unit with fixed number of staff the researcher was

asking participants within research interviews if they would be happy to be involved in dissemination of results.

- J. The committee asked whether it would be hard or sufficient to avoid disclosure as quotes from the interviews would be hard to anonymise. It was responded identifiable data would be anonymised. The committee argued that due to the small sample size it would become obvious and anonymity could be broken.
- K. The committee further discussed issues around anonymity in the Participant Information sheet and consent form. The information sheet mentions anonymity would be preserved whereas the consent form has a clause which could make the participant personally identifiable. The committee suggested adding 'direct quotes would be used' to the information sheet to make the two documents consistent.
- L. The committee discussed the Participant Information sheet and suggested changes which were agreed.
- M. Discussion took place on how the researcher would draw a line and decide when disclosure may go to authorities beyond the FMH Unit. The committee was informed the researcher would take responsibility and follow appropriate procedures. The committee suggested adding a 'limits of confidentiality' clause to the information sheet. This would cover any professional 'misconduct' disclosed by staff in the institution. This was agreed.
- N. Clarification was given that transcription would be shared with another trainee psychologist in the researcher's cohort.
- O. The committee asked whether the researcher would still present the results if they were not as useful as hoped or even inconclusive. It was responded results would not be inconclusive; although it could be difficult to pick out a theme.

The committee discussed the responses given by the researcher and felt the supervisor's attendance at the REC meeting would have been beneficial. The committee noted there was no independent scientific review (someone independent to the research).

Further information or clarification required

The Committee is unable to give an ethical opinion on the basis of the information and documentation received so far. Before confirming its opinion, the Committee requests that you provide the further information set out below:

- Clarify that [REDACTED] have current GCP training.

Participant Information sheet

The committee requested the following amendments to the participant information sheet and consent form:

- Language generally to be simplified. Avoid using long words and putting meaning in brackets – use of simple words is adequate.
- Add that participants who have perpetrated violence in the Unit may also be included. This raises the concern whether participants would know who is taking part especially as one participant may have suffered violence at the hands of another inmate – add assurance on how this would be handled.
- Add that disclosure during the interview may go to authorities beyond the FMH unit.
- Add verification of transcripts before recordings are destroyed.
- Warning that £10 gift may affect benefits
- Clarify inclusion criteria to say that those that have been involved in violence are also within the inclusion criteria.

- Independent contact in the event of any complaints should be given at Part 2 section 2 and also at the end.
- Provide phone numbers for participants to approach Investigators if required.
- Clarify the process for any professional misconduct in the study.
- Consent form asks for consent to publication of responses that may identify participants – this should be corrected as it is inconsistent with the Information sheet and Protocol.

Authority to consider your response and to confirm the Committee's final opinion has been delegated to the Chair.

If you would find it helpful to discuss any of the matters raised above or seek further clarification from a member of the Committee, you are welcome to contact 

When submitting your response to the committee, please send revised documentation where appropriate underlining or otherwise highlighting the changes you have made and giving revised version numbers and dates.

If the committee has asked for clarification or changes to any answers given in the application form, please do not submit a revised copy of the application form; these can be addressed in a covering letter to the REC.

The Committee will confirm the final ethical opinion within a maximum of 60 days from the date of initial receipt of the application, excluding the time taken by you to respond fully to the above points. A response should be submitted by no later than 12 January 2014.

Membership of the committee

The members of the Committee who were present at the meeting are listed on the attached sheet.

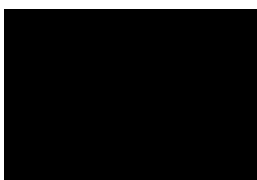
There were no declarations of interest.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

13/EE/0406:	Please quote this number on all correspondence
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Yours sincerely
PP



Chair

Email: NRESCommittee.EastofEngland-Essex@nhs.net

Enclosures: *List of names and professions of members who were present at the meeting and those who submitted written comments.*

Appendix N

Research Governance Group Approval Letter



10th March 2014

Research Department

Ms K Budge



Dear Kate

Letter of access for research

Research Study – The impact of violence upon therapeutic relationships in secure forensic mental health units: A qualitative exploration of female service-users' experiences.

This letter confirms your right of access to conduct research through XXXX Partnership University NHS Foundation Trust for the purpose and on the terms and conditions set out below. This right of access commences on the 10th March 2014 and ends on 10th March 2015 unless terminated earlier in accordance with the clauses below or extended by written agreement.

You have a right of access to conduct such research as confirmed in writing in the letter of permission for research from this NHS organisation.

The information supplied about your role in research at XXXX NHS Foundation Trust has been reviewed and you do not require an honorary research contract with this NHS organisation.

You are considered to be a legal visitor to XXXX NHS Foundation Trust premises. You are not entitled to any form of payment or access to other benefits provided by this NHS organisation to employees and this letter does not give rise to any other relationship between you and this NHS organisation, in particular that of an employee.

While undertaking research through XXXX NHS Foundation Trust, you will remain accountable to your employer XXXX NHS Foundation Trust and the University of Essex but you are required to follow the reasonable instructions of XXXX in this NHS organisation or those given on her behalf in relation to the terms of this right of access.



Where any third party claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by this NHS organisation in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings.

You must act in accordance with XXXX NHS Foundation Trust policies and procedures, which are available to you upon request, and the Research Governance Framework.

You are required to co-operate with XXXX NHS Foundation Trust in discharging its duties under the Health and Safety at Work etc Act 1974 and other health and safety legislation and to take reasonable care for the health and safety of yourself and others while on XXXX NHS Foundation Trust premises. You must observe the same standards of care and propriety in dealing with patients, staff, visitors, equipment and premises as is expected of any other contract holder and you must act appropriately, responsibly and professionally at all times.

If you have a physical or mental health condition or disability which may affect your research role and which might require special adjustments to your role, if you have not already done so, you must notify your employer and the Trust R&D department on XXXX prior to commencing your research role at the Trust.

You are required to ensure that all information regarding patients or staff remains secure and strictly confidential at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice (<http://www.dh.gov.uk/assetRoot/04/06/92/54/04069254.pdf>) and the Data Protection Act 1998. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

You should ensure that, where you are issued with an identity or security card, a bleep number, email or library account, keys or protective clothing, these are returned upon termination of this arrangement. Please also ensure that while on the premises you wear your ID badge at all times, or are able to prove your identity if challenged. Please note that this NHS organisation accepts no responsibility for damage to or loss of personal property.

We may terminate your right to attend at any time either by giving seven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you commit any act that we reasonably consider to amount to serious misconduct or to be disruptive and/or prejudicial to the interests and/or business of this NHS organisation or if you are convicted of any criminal offence. You must not undertake regulated activity if you are barred from such work. If you are barred from working with adults or children, this letter of access is immediately terminated. Your employer will immediately withdraw you from undertaking this or any other regulated activity. You MUST stop undertaking any regulated activity immediately.

Your substantive employer is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you.

XXXX NHS Foundation Trust will not indemnify you against any liability incurred as a result of any breach of confidentiality or breach of the Data Protection Act 1998. Any breach of the Data Protection Act 1998 may result in legal action against you and/or your substantive employer.

If your circumstances change in relation to your health, criminal record, professional registration or suitability to work with adults or children, or any other aspect that may impact on your suitability to conduct research or your current role or involvement in research changes, or any of the information provided in your Research Passport changes, you must

inform your employer through their normal procedures. You must also inform your nominated manager in this NHS organisation and the Chair of the Research Governance Approval Group.

Yours sincerely



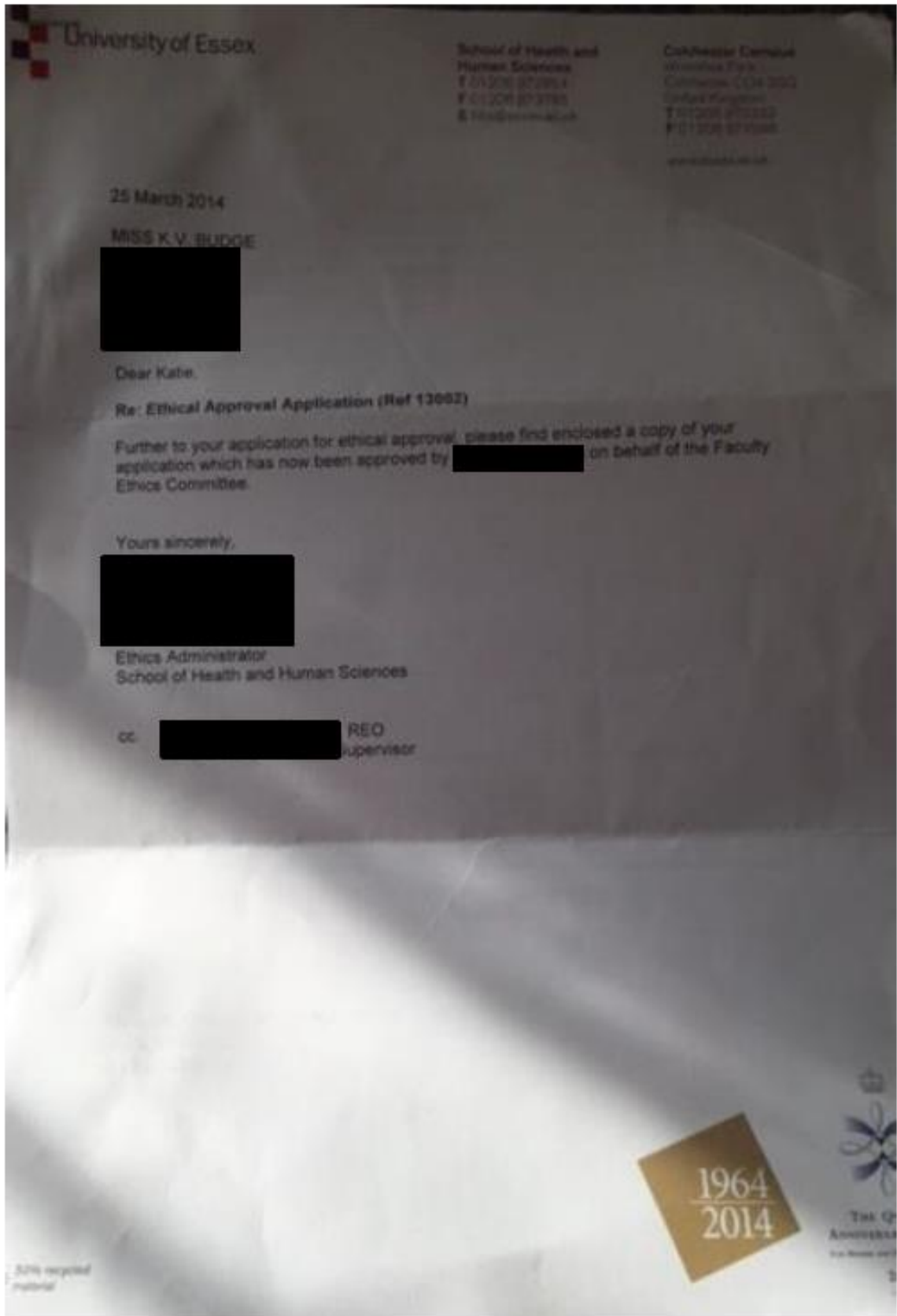
Head of Research



Cc: [Redacted]
Cc: [Redacted]
Cc: [Redacted]

Appendix O

University of Essex Ethical Approval Confirmation Letter



Appendix P

Research Interview Question Schedule

<p>1. Interview Introduction (following consent)</p> <ol style="list-style-type: none"> a. Outline purpose of the interview b. Describe how interview data will be stored and what it will be used for c. Inform service-user of how anonymity and confidentiality will be protected, but indicate that some responses may make them personally identifiable. d. Check that service-user is still happy to participate. If not, terminate interview.
<p>2. Service-user introduction</p> <ol style="list-style-type: none"> a. Background questions, gather info and 'warm up' develop rapport <ol style="list-style-type: none"> i. Reasons for participating ii. Length of time in unit iii. Journey into FMH unit / history iv. General experiences of being in the unit- good and bad.
<p>3. AREA 1: Therapeutic Relationships</p> <ol style="list-style-type: none"> a. E.g. "Can you tell me about your relationships with staff here?" <p>PROMPTS</p> <ul style="list-style-type: none"> • Experiences of relationships with staff team • Quality of relationships with team • Purpose of relationships • Things that are important / unimportant in relationships • Influence of the unit on relationships • Forming relationships
<p>4. AREA 2: Relationship Development</p> <ol style="list-style-type: none"> • E.g. "Is there anything you would like to change about relationships with the staff team here?" <p>PROMPTS</p> <ul style="list-style-type: none"> • Requirements • Improvements • Things that work well / appreciate
<p>5. AREA 2: Violence and Aggression</p> <ol style="list-style-type: none"> a. E.g. "Can you tell me about any violence or aggression you've seen here at the unit?" <p>PROMPTS</p> <ul style="list-style-type: none"> • Type of violence / aggression • Understanding of purpose / function / cause • Frequency • Psychological impact • Effect upon the unit
<p>6. AREA 3: Violence and Aggression- impact on relationships</p> <ol style="list-style-type: none"> • E.g. "Can you tell me how seeing violence and aggression in the unit affects your relationship with staff ?" <p>PROMPTS</p> <ul style="list-style-type: none"> • Personal impact – ability to get support, feelings associated with it. • Effect on the wider unit. • Reactions from staff team • Reactions from other service-users
<p>7. AREA 4: Support / Intervention</p> <ol style="list-style-type: none"> • E.g. "When violent things happen in the unit, is there anything you think the staff team could do that would help you?" <p>PROMPTS</p> <ul style="list-style-type: none"> • What's needed when violence occurs • Unit changes / relationship changes
<p>8. AREA 5: Service-user comments</p> <ol style="list-style-type: none"> • E.g. "Is there anything else I haven't asked you about that you feel is important about relationships with staff or seeing violence and aggression in the unit?"
<p>ENDING</p> <ul style="list-style-type: none"> • Check service-user is happy with information provided • Opportunity to ask questions about the research • Discuss dissemination plan and feeding back findings

Appendix Q

Forensic Mental Health Service Management Group Approval Letter

[Redacted]

22nd May 2013

Department of Forensic Inpatient Psychology

Katie Budge
Trainee Clinical Psychologist

[Redacted]

[Redacted]

[Redacted]

Dear Katie,

"The Impact of Violence and Aggression upon Therapeutic Relationships in Secure Forensic Mental Health Units"

I write in reference to the above study.

I am delighted to confirm that the study was discussed within the [Redacted] Secure Services Management Group (SSMG) March 2013 meeting and was given whole-hearted approval by the management committee. The management committee of [Redacted] felt that this was a very valuable piece of research and will be pleased to support it within the unit. We wish you all the best, and hope that you are able to communicate your findings to the management team after the research is completed.

There were some specific points that you wished me to confirm:

1. I can confirm that it will be possible for you to use a tape-recorder within the unit to record interviews, as required by the research design. You will need to ensure that you have specific patient consent to do this. We do have a standardised form for this purpose but if your consent form includes all the relevant information then this should suffice.
2. I can confirm that you will be able to use specific interview rooms on the ward for completion of research interviews.
3. If patients were upset or distressed by any of the material discussed then they can contact either of the ward psychologists – [Redacted] – who would be able to provide any support required. Alternatively, if there were problems that required managerial input then I would of course be happy to be contacted.

I trust the above is helpful, and wish you well with the study.

[Handwritten signature]

Lead Psychologist / Clinical Psychologist

[Redacted]

[Redacted]

Appendix R

Participant Consent Form

Participant Consent Form

Title of Project: The impact of violence upon therapeutic relationships in secure forensic mental health units: a qualitative study of female service-users' experiences.

Name of Researcher: Katie Budge (Trainee Clinical Psychologist)

Please initial

I confirm that I have read and understood the research information sheet dated [29/12/2013] (Version 2) for the above research project.

I have had the chance to ask questions about the above research project, and these have been answered satisfactorily.

I understand that I am free to withdraw from the research project at any time without needing to provide a reason without my treatment being affected; data already provided will be kept and used within the study write-up.

I understand that participating in this research project will not affect my mental health treatment or my legal status under the Mental Health Act.

I understand that I do not have to talk about any experiences I do not want to discuss.

I consent to my interview(s) being digitally audio-recorded, and for a disguised written-out account of my interview(s) to be stored for up to 3 years by the University of Essex.

I consent to direct quotes and extracts from my interview(s) being used within: academic reports, conference posters, research articles, and summaries for other researchers, policy makers and service-providers. I understand that personal details and information I provide will be disguised so I cannot be obviously identified, but there is a risk I could be identified in findings as direct quotes from my interviews will be presented.

I understand that the information I provide in my interview(s) will be treated confidentially except in instances where I or someone else is at risk, if the security of ██████████ is threatened, or if I disclose that a crime has been committed, and Katie believes this may pose a potential future risk, or if I share information suggesting professional misconduct by a member of staff.

I agree to participate in the above research project.

I understand that if the researcher suspects during the course of the interview that I no longer appear to have capacity to consent to participate in the study, the interview will be terminated but data already collected will be kept and used within the study write up.

Name of participant

Date

Signature

Name of person taking consent

Date

Signature

1 copy for participant; 1 copy for researcher file; 1 copy (original) to be kept in medical notes.

Appendix S

Reflective Diary

Interview One: “Daphne”

Felt apprehensive before my first interview, unsure about how the interview guide would ‘flow’ and anxious about how these questions would be received or what they might evoke in the women taking part; felt I absorbed some of the anxiety within the system about the potential risk posed to me, along with my own preconceived ideas about the potential risk posed within the unit, due to being pregnant and fearing for the safety of me and my unborn baby, think on reflection that I overcompensated within the interview by conveying empathy akin to that of a therapeutic session rather than a qualitative research interview, and therefore may have led her in her responses to me as a result of this. Experienced her as very keen to be liked, and helpful, and found myself questioning the way in which she wanted to be perceived within the interview and what she thought the implications of participating might be in terms of her progress within the service; i.e. painting staff in a positive light while acknowledging their shortcomings / her frustrations, however my perception may have been influenced by an expectation that patients would not speak favourably about staff. Perceived a weighty sense of ambivalence. Became aware that my own preconceived ideas i.e. that patients would hold certain negative views about the staff team, meant I felt quite disbelieving about the way in which she conveyed her experiences, and that I may have led her to describe more negative experiences than she may otherwise have experienced on balance. Feel that through my questioning style I was perhaps encouraging ‘extreme’ responses, e.g. “really really positive versus really negative” which may have encouraged her to embellish or provide only extreme examples of her feelings and experiences; resulting in a polarised view. Experienced myself as therapeutically oriented within the interview, and aware of my lack of research interviewing experience causing me to rely upon general clinical skills for eliciting information and encouraging her to continue talking. However on balance I believe this helped to develop rapport and encourage her to talk to me. Became aware of preconceived ideas I hadn’t consciously contemplated throughout the interview, e.g. my assumption there would be a greater bond between patients, that issues surrounding power and control of staff would be felt more viscerally, and that patients would attribute external blame regarding the causes of aggression / violence rather than ‘own’ their own role in incidents; all of which were challenged by her account. Feel that I developed my awareness of timings regarding the interview schedule within this interview, that it felt as though I rushed through it only to realise that we had lots of time left, and then revisited key points; and that I will be more aware of holding back from doing this in future interviews. Think I was unrealistic in my expectations about how much the women would have to say about the research area, and that 35mins felt more than adequate for exploring the key questions to the limit of her ability, and level of concentration. Felt a sense of awareness that I missed follow-ups on certain issues and responses from her I could have probed more deeply about; which may have limited the richness of the account she provided.

Interview Two: “Cora”

Felt more confident embarking on the second interview, less anxious about personal safety concerns, and had a clearer indication of how to manage the timings of different elements of the research schedule. I felt quite dismissed within the interviewing process. I experienced her as bored, fed-up, tired and highly medicated; and felt frustrated by her frequent yawning and monosyllabic answers to open questions from the schedule. Felt like I attempted a range of strategies to engage her within the interview process, but did not perceive these to be very effective in helping her to open up to me and expand on the points she made. This left me feeling

stuck and unsure whether the account she was providing would be adequate for analysis; interpreted this as indicative of reciprocal rejection with her rejecting me through her closed responding style, and me then rejecting what she offered in return. As a consequence of her style of responding I relied upon using many reflective and inquisitive prompts to gather more information, believe this may have had the potential to 'lead' her in what she then discussed, unsure about how authentic her account therefore is. I perceived her as angry and disaffected about being moved to the service, and 'stuck' in a state of ambivalence- of feeling emotionally and physically neglected and needing or relying upon staff to reassure, comfort and protect her, but of them failing to meet her standards and fall-short of being able to provide that. Wonder whether she may have been transferring hostile or defiant feelings towards significant members of staff or others towards me; as countertransferentially I experienced her as difficult to like, and oppositional. Due to the way in which she engaged in the research process (largely withholding), on re-listening to her interview I found myself questioning her motivation for participation, and whether she was drawn more to the offer of financial remuneration rather than wishing to convey her experiences. Conversely, I found myself surprised by her honesty and frankness about the way she used restraints as a way to get close to staff; recognised that this confirmed my pre-conceived idea that this form of physical holding may be sought for reasons other than for the necessity of risk and safety. Felt her account challenged my pre-conceived idea that witnessing violence may have a significant emotional impact upon patients, as she was largely blasé in her depiction of the impact of this although I found myself questioning whether that was genuine 'acclimatisation' to its effects, or was more reflective of how emotionally numbed and medicated she appeared to me to be. The pace of the interview felt more measured compared to the first interview.

Interview Three: “Alice”

After my experience in the second interview I was relieved that “Alice” appeared so forthcoming and open about her experience and perceptions and that her responses to the interview questions were lengthy and detailed without the need for persistent prompting. Experienced “Alice” as desperate to be liked / loved by me, and as though she was positioning herself as my friend and as though she was very familiar with me, rather than the relative strangers we were to one another. Interpreted what I perceived as her attempts to signal herself as non-threatening to me in the way she spoke of protecting pregnant staff as an attempt to gain affection. It was my impression that this was mirrored in the way she spoke about her relationships with members of staff, seemingly avoiding the inherent power imbalance, that she considered, or wanted to be considered, more as a peer and friend rather than as patient of a group of staff; for example in talking about informing new staff about the 'rules', and assisting at times of violent incidents. Wondered whether aligning herself in this way was as a means of self-protection, denial, or perhaps as a way of gaining control over her environment and relationships. Warmed to “Alice”, found her to be humorous, likeable and fully engaged within the research process; enjoyed the interview and consequently feel I need to appropriately weight what she offered relative to the other participants as there could be a tendency for me to pay more credence to what she offered. Found myself disbelieving of the 'love' she professed to feel towards staff, owing to my pre-conceived ideas about how patients may feel angry or resentful towards staff for denying them their freedoms. Perceived her as being quite critical of certain male members of staff, which I believe I may have over enthusiastically picked up upon; owing to my suspicion that gender may play a significant role within the service due to the frequent occurrence of sexual abuse within the females' personal histories. Due to what I perceived as her need to be liked, the open and frank way I believe she 'owned' her role in violent or aggressive incidents, and the way she almost seemed grateful to have the interview for the opportunity to have someone to talk to and share her experiences; I felt quite exploitative within my role as a

researcher, wondered whether she may elicit such feelings in the staff who support her. “Alice’s” portrayal of her relationships with staff seemed more balanced than the somewhat dichotomous good versus bad depictions from the first two interviews; think I felt reassured by the allowances she made for staff’s imperfections, almost as if this somehow made her account more believable; aware that I should hold this in mind as her experiences are no more or no less valid than the those from the other women. Her account challenged my view of how “violence” was conceptualised, aware that I assumed this would be predominantly the witnessing of externalised anger rather than self-directed harm being perceived as violent, aggressive, and traumatising.

Interview Four: “Brenda”

I experienced “Brenda” as very earnest, upfront and direct. I found what I perceived as her balanced and reflective account of her experiences refreshing, but I think that due to how she took full personal responsibility for the violent and aggressive incidents she had been previously involved in that perhaps left me with a tendency to view her account as more believable, identifying my bias that patients may generally externally rather than internally attribute the causes of violence. I also was not, on reflection, expecting any of the participants to appear so forthcoming and frank about their experiences, and was struck by the trust she seemingly placed in me discussing her experiences. I found myself wondering whether she placed me in the role of a sort of independent friend or confidante, due to what seemed to be her disinhibition and ease with which she opened up; or whether – given the context – she was just grateful for the opportunity to talk about what it was like in the service. I felt bombarded, as though she was flooding me with information in the pace at which she spoke and the amount of experiences she conveyed, as though she had so much to say and get out; the interview felt very intense and I was left with a sense of having received a great deal of valuable information I wasn’t quite sure where I would start with making sense of it, which may well have been a reflection of how she felt. I sensed that she gained a lot from the experience of being able to participate in the interview, which I viewed as a consequence of her perception as having been neglected within the ward (for example: no one being around to support or help due to being short-staffed); wondered whether if staff had been available for her to talk to that she would have shared as much as she did within the interview. Challenged through her account a bias I held that violence may be functional in describing it as a largely unintended consequence secondary to being restrained or getting her needs for containment met by staff; surprised that she seemed surprised to realise that she didn’t need to hurt people to get what she needed from them. Unlike some of the other participants, her understanding of relationships with staff seemed to rely on the premise that they would be very boundaried; she depicted the relationships as being traditionally conceptualised i.e. staff were there to provide a service and care, patients were there as recipients of that care; challenging widespread - and my own – conception (fear?) and discourse about “womens’ services” and what relationships within those may be like, or what patients want. One area she identified which I hadn’t considered was the impact of staff stress levels on patients’ abilities to have a relationship with them, and how systemic influences such as the need to complete paper-work may impact upon staff but that this is viscerally felt by patients too; on reflection it would have been valuable to have incorporated this within the interview schedule in a specific sense rather than enquiring about how certain staff qualities may impact upon relationships.

Interview Five: “Elsa”

Experienced myself as far more formal and less leading compared to the other interviews, I perceived her as giving the impression of being quite open and forthcoming with me, but detected a sense of passive hostility or confrontation which put me on edge. Unsure what it was about the dynamic between us but I felt very differently being around her than the other participants, the atmosphere was much colder and I felt uneasy and slightly apprehensive about

being in her presence. I found it very difficult to warm to her, and noted that I felt quite disapproving and considered some of her experiences objectionable, for example: what I perceived as her speaking very disparagingly and judgementally about other patients, and her dismissive attitude about the input received to date. Believe that her account and reported experiences identified my biases about the importance of therapeutic relationships, I interpreted her as indicating all relationships within the service are an 'act' or a game to be played; felt pulled into an almost dismissing / dismissive reciprocal role with her. Challenging my preconceived ideas about the importance (and need for) strong relationships tapped into insecurities I have about forming working relationships with certain client groups, and my own sense of inadequacy. As a consequence of this, and what I perceived as her being highly narcissistically defended (above the place, the staff, the patients), identified that I may be at risk of not 'hearing' her story with integrity, or dismissing the points she raised, also aware because of this that I should be aware of a desire to over-compensate within the analysis. "Elsa" discussed power issues in-depth, which resonated with my preconceived ideas about that being an area of difficulty, along with her anti-medication approach; again, aware that I should be careful not to over-emphasise or inflate the significance of this. Challenged by the notion that mixed-sex wards would be preferable; experienced a mild sense of alarm at the idea of this, this wasn't an area I had given any real contemplation to and I was not expecting this to be suggested (by other participants too); flies in the face of FMH policy and research literature supporting single-sex services. Made me question whether (asides from very real issues of risk management and safeguarding) structuring services in that way was more for the benefit of paternalistic policy makers rather than what might best serve the needs of patients. As a consequence of how talkative she was within the interview, I feel my style was less leading and she required fewer prompts to elaborate on points made, therefore her account may be generally less influenced by me than many of the other interviews.

Interview Six: "Fiona"

I perceived "Fiona" to position herself as somewhat of an "expert patient" within the interview process, in our discussions prior to and following the interview she seemed to be communicating that she was participating to do me a favour, and that she was just happy to help out; unsure how this may have impacted upon the account and experiences she described, whether she may have felt compelled to provide particularly extreme or grabbing instances of violence, or experiences, for her account to be valuable and interesting. In the way she described concealing her true feelings from people around her, I was unsure whether the account of her experiences she was portraying was congruent with her true feelings, or whether I was receiving the 'public persona' version of events, I felt I was positioned as an "equal" or as a "friend" and that by suggesting she was doing me a big favour by participating that somehow served to address the power imbalance between us. I was surprised by the way in which she described the need for punitive and more severe consequences from staff in the face of unacceptable or violent behaviour from other patients, and her conviction in the need for "tough love" in order for patients to "learn"; particularly within the context of her initially bemoaning the sense of power that staff had over patients within the service; seemed somewhat incongruently expressed to me and reflective of somewhat idiosyncratic needs and desires. "Fiona" also challenged my bias about how I suspected patients may wish staff to be with them as regards consistency in mood, that seeing staff being "normal" and experience "normal" variations and fluctuations in mood was welcomed as it somehow hints towards them being more "human" and therefore more able to trust. Felt to me as though she was very accommodating and caring towards staff and their perceived shortcomings, and it seemed that she felt a sense of loyalty towards them; this I believe led me to probe persistently to try and uncover, beneath the loyalty, what her feelings were about them not being available, or acting unprofessionally, which may have biased her

account. However, I acknowledged that this was my bias and that her sense of 'duty' or 'loyalty', at the cost of expressing any other feelings, was in and of itself very informative. Found that through her account my appreciation and understanding of what it might be like, for some people, building therapeutic relationships with people within the context of a tremendous power imbalance, and her empathy for her view that knowing some details about staff may facilitate a deeper level of trust, i.e. how exposing and difficult it may be to 'give everything' to a virtual stranger without any indication of them as a person; while recognising the need for professional boundaries and not encroaching upon these, how potentially one-sided and non-reciprocal issues such as trust and affection may be felt.

Interview Seven: “Grace”

My first impressions of “Grace” were of being quite helpless, desperately sad and having experienced a tremendous amount of loss, and extremely vulnerable; which pulled at the 'rescuer' tendencies in me and made me question the integrity of the research (and myself). It seemed obvious to me in what she said and how she struggled throughout that participating in the research was of huge significance for her, and given the extent of the traumas detailed, I felt pulled into almost an exploitative 'abuser' role merely by harvesting her tales of woe, despair and hardship with nothing to offer other than shallow platitudes and empathy in return. Found myself focusing on, and being mindful of, the context, resisting paternalistic urges to 'protect' her and recognising that she provided informed consent, with capacity, to take-part; and she knew what was and was not involved in the process. Felt as though she had put me on a pedestal almost as some kind of independent 'saviour' to listen to her while feeling totally dismissed and ignored by staff on the ward; found myself listening to, and paying greater attention to, what she was saying than perhaps I did in the other interviews. Wondered whether her perception, or the experiences she portrayed, regarding her interactions with staff indicated that she positioned herself within a “victim” role. Experienced her range of emotional expression as severely limited; which left me questioning how I may reasonably convey, analyse or articulate her experiences in a way that might resonate true to what she may have been trying to convey in her emphasis of “really really good” or “really really bad”, unsure I will be able to really. Identified with her frustration at feeling (as mentioned by another participant) that staff may bypass building relationships or getting to know patients sufficiently by relying on reading their case files and notes as a proxy for face-to-face communication and how dehumanising that seems to be experienced as. Sensed (accurately or not) considerable fear within her accounts of having a relationship with members of staff, of feeling ambivalent about approaching them for support, and frightened to show her vulnerability to them and engage; unaware I held biased perceptions about this until I perceived this in her account, given the discourse around working in such services, and my personal experiences, fear is usually spoken about in the context of staff fearing violent attacks, but her account suggested relationships existed within the context of mutual fear.

Interview Eight: “Helen”

I experienced “Helen” as having been someone who has “survived” the system, been through it all, seen and done it all, and conveyed her experiences with the sort of pragmatic reflection which may only be achieved with imminent discharge in sight. Her account therefore seemed different to me than many of the other participants, not at her stage of progress or recovery, which made me question how her recall and feelings about her experiences may have differed if she wasn't in the position she was. She seemed very “socialised” to the system, stating that “I have BPD” and talking in a way which to me seemed reflective of the language most likely used by professionals around her rather than perhaps her own beliefs and thoughts. While obviously she was aware that staff would not be able to identify – or have access to – her interview, I found myself doubting whether what she was portraying at times reflected her true

feelings, or whether this may have been an attempt to be “good” and highlight how ready she is to leave; compounded by how complimentary she was about her time in the service. My scepticism and doubt however may have been significantly biased by my beliefs and pre-conceived ideas that possessing overly positive feelings about relationships or that type of service would be present; and any such feelings may result out of submissive, acquiescing behaviour; because it would be impossible to feel genuine affection for people or systems which deprived the women of their freedoms and controlled practically every aspect of their lives, often against their will. I really enjoyed listening to “Helen's” account, I found her to be witty, sarcastic, and pragmatic; she described her experiences in very matter-of-fact terms, and as she seemed so well contained, emotionally, within herself the interview process felt easy and relaxed; while she conveyed a great deal of information, I did not experience the same sense of being 'overwhelmed' with her. However, because of this I felt to a certain extent that her account lacked the emotional depth or insight present within other interviews, and experienced her as quite distanced – at points – from the experiences she described, for example when talking about jealousy within the dynamics with the other patients it was as if she was impervious to this, rather than being a part of it. I felt that she positioned me as a peer, and spoke to me as if she was speaking to a colleague. “Helen's” perception of therapeutic relationships drew largely on her expectations of how relationships may be “in the real world”, i.e. that she could not expect to get on with everyone there so why would she expect to get on with everyone in the service she was in, she tended to ascribe relationship difficulties as resulting largely from internal factors i.e. personality clashes; which I interpreted as pragmatic, but ignored issues of power and context, and I wondered whether (perhaps as a means of self-protection) she engaged with staff as though they were not in that service. She raised a couple of pertinent issues I had not considered when designing the interview schedule, which in hindsight I wish I had incorporated, namely the distinction between relationships with qualified versus unqualified staff (with qualified staff being perceived as more worthy of trust and engagement); and how stage of progress impacts upon relationship perceptions. It may have been advantageous to have contrasted the experiences of the participants in the low versus medium secure settings. “Helen” like other participants gave the impression of caring deeply about staff, recognising that they “put their lives on the line every day when they come in here”; I therefore held the impression that she may have been “protecting” staff in her accounts, but again recognised that this was potentially due to my beliefs about what may, and may not, represent genuine feelings about relationships within that setting.

Appendix T

Presence of Constructed Subthemes across Participants' Data Sets

Table T1

Presence of developed subthemes relating to the nature of therapeutic relationships, across participants' datasets (N=8)

Subtheme	Daphne	Cora	Alice	Brenda	Elsa	Fiona	Grace	Helen
They're either good, or bad	X	X	X	X	X	X	X	X
Maybe I was wrong about you				X				X
Am I good enough yet?			X	X	X			X
If we're close, we're very close	X	X	X	X	X	X	X	X
Do you want a relationship?		X	X	X		X		X
It's a struggle	X	X	X	X	X	X		X
I'm not sure about you yet	X		X	X	X	X	X	X
Time's a great healer	X	X	X	X	X	X	X	X
Needing to be well enough				X	X	X	X	X
Will you stick around?	X							
Knowing and doing								X
Feeling like you really care	X	X	X	X	X	X	X	X
Treating us badly	X	X	X	X	X	X	X	X
Neither of us want this	X	X	X	X	X	X	X	X
Not ready to let my guard down					X		X	
Treated with dignity			X	X	X			
Helping us to get better	X	X	X	X	X	X	X	X
Protecting self and others	X	X	X	X	X	X	X	X
We need to be compatible!	X					X		X
Feeling grateful				X		X	X	X
Feeling neglected				X	X			
Boundaries keep us safe		X	X	X	X	X	X	
Power and powerlessness			X		X	X	X	X
Too many women and not enough space!	X	X		X	X	X		X

Table T2

Prevalence of developed subthemes highlighting the reason for, and function of, violence and aggression, across participants' datasets (N=8)

Subtheme	Daphne	Cora	Alice	Brenda	Elsa	Fiona	Grace	Helen
Comes with the territory		X	X		X	X		X
Violence breeds violence		X	X	X	X	X		X
Gets my needs met!	X	X	X	X	X	X		X
It's what we're used to doing			X			X	X	
How else do I show you how I feel?	X		X	X				X
It's my mental health		X	X	X		X	X	X
Attack as a form of defence		X	X					
Staff are the aggressors!	X					X	X	X
We can't make sense of it	X	X	X	X	X			X

Table T3

Prevalence of developed subthemes regarding the lived experiences of violence and aggression, across participants' datasets (N=8)

Subtheme	Daphne	Cora	Alice	Brenda	Elsa	Fiona	Grace	Helen
Affects recovery and progress	X		X				X	
We become shielding and defensive		X	X			X	X	X
Wanting to avoid reality	X		X	X	X	X		X
Moralistically judging others	X				X	X		X
Deeply emotionally affecting	X	X	X	X	X	X	X	X
Gaining control as a way to cope		X	X	X	X			X
They punish and dismiss us all!	X			X			X	
They treat us all differently!	X	X		X		X	X	X
Makes our behaviour worse	X	X	X	X	X			X
Cutting the atmosphere with a knife	X	X	X	X		X	X	X
Frequency is in the eye of the beholder	X	X	X	X			X	X
It comes in any form	X	X	X	X	X	X	X	X
Everyone does it	X	X	X	X	X	X	X	X
We don't always mean to hurt you	X	X	X	X				

Table T4

Prevalence of developed subthemes regarding the impact of violence and aggression upon therapeutic relationships, across participants' datasets (N=8)

Subtheme	Daphne	Cora	Alice	Brenda	Elsa	Fiona	Grace	Helen
Our allegiance is to staff						X	X	X
Produces unexpected benefits	X	X		X		X		
Dismissal and retribution	X	X	X	X	X	X		X
We're sensitive to staff mood	X	X	X	X		X		X
Being absent and avoidant	X	X	X	X		X	X	X
Lying compromises trust	X							
There is no impact	X			X	X			

Table T5

Prevalence of developed subthemes regarding perceptions and the management of violence and aggression, across participants' datasets (N=8)

Subtheme	Daphne	Cora	Alice	Brenda	Elsa	Fiona	Grace	Helen
Taking care of ourselves		X						X
Staff trying to get it right		X	X			X	X	X
They don't know what they're doing!	X		X		X	X	X	
Needing staff to be 'present'	X	X	X	X	X		X	
Getting away from it	X		X	X		X	X	
We're reliant on you	X		X	X		X		
Take these feelings away from me or help me make sense of them!	X		X	X	X	X	X	X

Appendix U

Example: Reflective Coding of Transcripts

INTERVIEW 1
"Daphne"
 [33:59]

















<p>K So, I wondered to start with whether you could kind of tell me a bit about what your relationship's like with the staff team here?</p>	
<p>D Um, yeah, <u>quite positive most of the time</u>, yeah, <u>get on with say 95% of the staff</u></p>	<p>Comment [Katie Bud1]: Quite positive as in sort of OK? Most of the time as in changeable, depending on what's going on- not constant.</p>
<p>K OK</p>	<p>Comment [Katie Bud2]: Small proportion do not get on with ever? Regardless of what's going on?</p>
<p>D <u>I mean regular staff, some of the bank staff are...not as...I don't know, there's nothing wrong with them, I don't think [inaudible segment] but yeah, they all seem alright</u></p>	<p>Comment [Katie Bud3]: Difference between regular versus bank relationships different, bank staff = worse relationships?</p>
<p>K OK, so can you tell me more about the reason why that's different?</p>	<p>Comment [Katie Bud4]: Perceiving less care / love?</p>
<p>D <u>Um, their heart doesn't seem to be in it as much</u>, they, <u>quite a lot of them usually count down how many hours they've got left, saying ooh, so many hours until I can go home and it's a bit off-putting because it's like well we can't go home for a long time</u>, <u>I know it's our fault but...it's sort of rubbing your face in it a bit and they don't seem to want to get involved as much</u></p>	<p>Comment [Katie Bud5]: Staff not wanting to build relationships? Only there to do a job rather than care? Staff do not want to know / build relationships? Lack of sensitivity to context.</p>
<p>K Ok. And, um, how would you, how would you describe, like, the quality of the relationships you have, would you say they're really really positive, or really negative or...</p>	<p>Comment [Katie Bud6]: Almost like 'we know we're bad, but care for us' Feeling uncared for / rejected?</p>
<p>D <u>I'd say quite positive</u>, um... <u>I tend to get on with like the MDT team, my doctors and stuff, and then I've got a key worker co-worker and associate and get on with them fine</u></p>	<p>Comment [Katie Bud7]: Quite as in not very much?</p>
<p>K OK</p>	<p>Comment [Katie Bud8]: Relationships with key team closer than other staff on the unit.</p>
<p>D mainly (laughter). <u>Most of the team seem fine as well...when they're here</u></p>	<p>Comment [Katie Bud9]: Seem fine, as in don't really know because r'ship not that close? Fine as in adequate?</p>
<p>K You said when they're here</p>	<p>Comment [Katie Bud10]: Unreliable? Absent? Inconsistency in staffing?</p>
<p>D <u>Yeah, it's, there's, there's quite a lot of sick leave</u>, but I think that's mainly due to the <u>structure of the ward...to be honest, there's obviously other things going on, but...</u></p>	<p>Comment [Katie Bud11]: Wonder what effect that has- staff not robust enough to cope?</p>
<p>K Yeah, OK. And..this may seem like a strange question (laughter), but what, what do you see is like the purpose of having a relationship with the staff team?</p>	<p>Comment [Katie Bud12]: Interpreted as 'effect' of ward rather than physical structure- effect of working with 'us'? i.e. we're a handful, staff can't cope</p>
<p>D <u>So you can be honest with them</u> and <u>tell them how you feel so they can help you</u></p>	<p>Comment [Katie Bud13]: Crucial factor in relationships and recovery? Being honest / genuine about what's happening? Facing reality?</p>
<p>K OK. Is there anything else?</p>	<p>Comment [Katie Bud14]: Giving something to staff for them to process and contain and do something with?</p>
<p>D Um (long pause) just for support</p>	<p>Comment [Katie Bud15]: Helping, fixing, doing something expectations</p>
<p>K OK</p>	<p>Comment [Katie Bud16]: Initially interpreted this as getting out i.e. ground leave, but believe this may have meant to get out of the service, without staff women otherwise lacking in motivation to want to get better?</p>
<p>D <u>To encourage you to get out really</u></p>	

Appendix V

Example: Transcript Coding

MAXQDA12

Document Browser: INTERVIEW 5- ELSA (RT)

<p>..Don't do anything </p> <p>..Writing letters </p> <p>..Talking </p> <p>.Staff / manager ii </p>	<p>213 E [cross talk] Exactly, that's right, [cross talk] they don't do it, and they don't even do it afterwards, you know when things have been sorted, so [cross talk] there was an event with = Grace one day = it went on and then the patients were writing letters about = Grace = until late in the evening then if the staff had actually come and talked with everyone, while the others dealt with = Grace = they, if like another one of the managers was to come up and sat and talked again in the evening it would have been better but then I didn't do that.</p>
	<p>214 K OK. So you would like to see somebody available to talk to [cross talk]</p>
<p>..Talking </p> <p>.Staff / manager ii </p> <p>..Explore feelings </p>	<p>215 E After that, yeah, to sit down and actively, openly talk to people about their feelings, what happened, you know, there and then, and then for a manager soon as they've got time, later on, come and do it again.</p>
	<p>216 K OK.</p>
<p>..Talking </p>	<p>217 E They could even just have the people that saw it, whatever it was, and take them into the MDT room and have conversations, discussions about it. Much more healthy than what happened on = that day =.</p>
	<p>218 K Do you, I mean, what kind of format would you like to see that, would that be a one-on-one type thing or would you be happy in a group?</p>
<p>..Group discussion </p>	<p>219 E I think, I think it would have to be the group that, you know, saw it, or a part of it, to begin with</p>
	<p>220 K OK</p>
<p>.Staff / manager inp </p> <p>..Group discussion </p>	<p>221 E And if it's not all the ward they could go into the MDT room, as I say, but yeah they should, people that have spectated [seen it] [cross talk] they need, they need input there, they don't need to be bouncing off the walls and talking to each other</p>
	<p>222 K OK</p>
<p>..Staff-on-Patient </p> <p>..Screaming / Shouting </p> <p>..Staff apologies </p>	<p>223 E Then = for staff = to come back in and say I'm sorry I shouted at you</p>
	<p>224 K OK</p>
<p>..Incompetent </p>	<p>225 E They didn't even report the injuries this other girl's got, = Identifiable Information Removed = it could have been dealt with so much better</p>
	<p>226 K And is there anything else that you think they could do? Anything that might help? Kind of settle the unit down or</p>
<p>..Lack of activities </p>	<p>227 E I wish we had more decent activities, I'll give = them their = due = they're = trying really hard to get things moving = they really are = but you know, can only do so much</p>
	<p>228 K OK</p>

Appendix W

Thematic Analysis Process

Table W

Processes adopted for Braun and Clarke (2006) six phases of thematic analysis.

Thematic Analysis Phase	Processes
1: Familiarising yourself with the data.	Rigorous and thorough transcription. Transcription process facilitated close reading and familiarity with data set. Repeated reading of the data fostered familiarity with breadth and depth of content. Participated in 'active reading' of transcripts, identified and made notes and recorded ideas for coding.
2: Generating initial codes.	Worked systematically and back and forth through the data coding basic segments encompassing the whole data set, organising data into different data-driven (semantic) codes, using MAXQDA computer software. Codes were matched with data extracts, ensuring all extracts were coded and extracts for each code were collated. As many potential themes as possible for each data segment were coded.
3: Searching for themes.	Sorted different codes into prospective themes within MAXQDA, considered the relationship between different levels of themes.
4: Reviewing themes.	Critically examined identified themes, evaluating whether there was sufficient data extracts to support them, and whether they 'fitted' in their own right or required splitting into separate themes or incorporating within other themes. Re-read entire data sets and evaluated validity of identified themes in relation to content of data sets and whether these accurately reflected original content.
5: Defining and naming themes.	Identified and described nature of developed themes. Organised themes with an accompanying narrative outlining content and descriptive account detailing a detailed analysis. Considered how themes fitted within broader context of the data in relation to the research question. Ensured clarity regarding what themes represent, and what they do not represent.
6: Producing the report.	Identified, selected and included quotations from the data set within results in order to offer adequate evidence for identified themes. Embedded quotations within an analytic narrative to illustrate constructed interpretations and avoid simple descriptive accounts.

Appendix X

Critical Appraisal of the Current Study

Table X1

CASP quality appraisal of the current study.

Quality Appraisal Criteria									How valuable is the research?*
Clear statement of aims?	Qualitative methodology appropriate?	Appropriate research design?	Appropriate recruitment strategy?	Appropriate data collection?	Relationship – participant relationship considered?	Consideration of ethical issues?	Rigorous data analysis?	Clear statement of findings?	
2	2	2	2	2	2	2	2	2	Findings related to previous theory, research, policy and practice. Further research identified. Limitations and implications presented. Transferability of findings, and limits to this, discussed.

Note. * contribution of the study to existing knowledge, consideration of findings in relation to current practice, policy, or literature base, areas identified for further research, transferability of findings discussed; 2 = yes; 1 = can't tell; 0 = no

Table X2

QualSyst quality appraisal of the current study.

Quality Appraisal Criteria										Summary Score
1. Question / Objective	2. Study Design	3. Context	4. Theoretical Framework	5. Sampling Strategy	6. Data Collection	7. Data Analysis	8. Verification Procedure	9. Conclusion	10. Reflexivity	
2	2	2	2	2	2	2	1	2	2	19/20 = 0.95

Note. 2 = yes; 1 = partial; 0 = no