Simran Bains BSc Hons

EXPLORING MEN'S QUALITATIVE ACCOUNTS OF PSYCHOLOGICAL THERAPY IN FORENSIC HOSPITALS

Section A: What are Adult Male Service Users' Experiences of Psychological Therapy in Secure Services?

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Section B: An Exploration of the Stories Black Men Tell About Their Experiences of Psychological Therapy in Forensic Hospitals

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A thesis submitted in partial fulfilment of the requirements of
Canterbury Christ Church University for the degree of
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To my dear parents, thank you for your enduring encouragement and for your sacrifices which have paved the way for my achievements. Thank you to my friends for keeping me laughing, with special thanks to Niki and Milly.

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Summary of Major Research Project

Section A

This systematic literature search aimed to explore adult male's qualitative experiences of psychological therapy in forensic hospitals. Through Thematic Synthesis, three themes emerged: 'barriers to engagement', 'factors aiding engagement' and 'outcomes'. Clinical implications and recommendations are considered.

Section B

This study aimed to explore the stories Black men's tell about engaging with psychological therapy in a forensic hospital. 10 men from two forensic hospitals participated in semi-structured interviews, which were transcribed and analysed using Rhizomatic Narrative Analysis. Participants told three stories: the story of trying psychological therapy for the first time, the story of the impacts of psychological therapy and the story of their recovery journey. Ten voices were used to tell these stories. Clinical implications and recommendations are considered.

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Section A

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Abstract

Background: Compared to women**,** men are less likely to help-seek or engage with psychological therapies in community settings due to stigma and gender-role conflict. However, engagement with psychological interventions is encouraged in secure services. As such, this review aimed to explore men's experiences of psychological interventions in secure services.

Method: A systematic search of three databases (Web of Science, PsycInfo and Applied Social Sciences Index and Abstracts) was conducted and 11 papers were included in the review, which represented 104 participants. The quality of papers was appraised using the Critical Appraisal Skills Programme checklist for qualitative studies. The 'results' and 'findings' sections of papers were analysed and synthesised using Thematic Synthesis.

Results: Participants found it difficult to engage with psychological interventions in secure services due to concerns about confidentiality, coercion and feeling stigmatised due to gender identity or offence histories. Despite these barriers, many men built trusting relationships with their psychologist, valued the peer support from groups and were felt more hopeful about their futures.

Conclusion: Men may require more support when first engaging with psychological interventions. Ideas for facilitating engagement may include exploring men's relationship to help, offering preparatory work and considering ways to maximise autonomy in restrictive environments.

Keywords: men, secure services, experiences, psychological interventions

Introduction

A Note on Language

The majority of literature in this area adopts a binary understanding of gender and as such, refers to the binary language ‘men’ and ‘women’. This language has been employed in this review in order to accurately synthesise the data as they have been recorded. It is acknowledged that this binary categorisation is essentialist, reductionist and likely to miss the nuances in experiences, since men and women are not a homogenous group.

Gender Norms and Mental Health Service Utilisation

The gender gap in mental health service utilisation is well documented: men are less likely to report (National Health Service Digital [NHS], 2016) or seek support for mental health difficulties (Office for National Statistics [ONS], 2022a), compared to women. Of men who do help-seek from psychological services, a substantial proportion (approximately 45%) disengage (Seidler et al., 2021). NHS Talking Therapies (formerly known as Improving Access to Psychological Therapies [IAPT]) attrition rates offer a starker picture, with 70% of men not completing therapy, compared to 30% of women (NHS Digital, 2022).

A widely accepted hypothesis for this gender gap is the influence of societally-prescribed beliefs about how men and women should be or gender norms. Western masculine gender norms align stoicism, success, autonomy and aggression with masculinity (Jansz, 2000). Gender-role conflict refers to the distress experienced by individuals when they feel unable to conform to or feel restricted by these norms. As such, thoughts, feelings and behaviours that conflict with these attributes, such as those appearing to demonstrate weakness or vulnerability, are rejected (Yousaf et al., 2015). It has been argued that psychological professions employ an approach that favours emotional literacy and vulnerability (Westwood & Black, 2012) which may provoke a gender conflict in men who align themselves with hegemonic (societally dominant) masculine norms (Addis & Mahalik, 2003). Though ideas

about what constitutes masculinity are not homogenous (Lohan, 2007), adherence to traditional male gender norms has been a barrier to mental health help-seeking and service utilisation (Galdas et al., 2005; Mahalik et al., 2007; McDermott et al., 2018). Men have also reported to disengage from therapy when they felt they did not have adequate autonomy or involvement in decision-making about their care and treatment (Kwon et al., 2023; Seidler et al., 2018).

It seems men may appreciate the acknowledgement of gender role conflict when engaging with services, as some men disengaged from therapy as they felt their beliefs about help-seeking were not sufficiently explored or considered (Seidler et al., 2018; Seidler et al., 2021). In addition, they felt their therapist did not make the necessary effort to orient or engage them in the therapeutic process which impacted their willingness to engage (Seidler et al., 2018). These factors are related to issues with service provision as opposed to the men themselves.

Stigma and Mental Health Service Utilisation

Stigma is another widely recognised barrier to mental health help-seeking and service engagement (Clement, 2014; Corrigan, 2004) Public stigma is a concept that exists relationally and societally whereby persons are perceived to be "tainted" if they have or appear to identify with a "discrediting" attribute (Goffman, 1963, p.3). These societal views can then be internalised, making individuals subject to self-stigma (Pederson & Vogel, 2007) where they hold negative views about themselves. Whilst perceived public and self-stigma affects men and women, the impact may be stronger for men than for women (Pederson & Vogel, 2007). Indeed, some men experience engaging with therapy as shameful and research posits therapists could spend time on cultivating self-compassion to counter the obstructive forces of self-stigma (Heath et al., 2017; Seidler et al., 2021). Again, this is a factor relating to service provision as opposed to the men themselves.

Consequences of Men's Mental Health Help-Seeking Behaviour

The consequences of poor mental health help-seeking or engagement with psychology services for men are devastating; men are three times more likely than women to die by suicide (ONS, 2022b). Men are also more likely than women to be sectioned under the Mental Health Act (NHS Digital, 2021). This may relate to men presenting to mental health services when in crisis (Biddle et al., 2004). It may also be because men have different profiles of distress in comparison to women (Rosenfield & Smith, 2010; Smith et al., 2018). Women are more likely to direct their emotional pain inwards and internalise their distress which negatively influences their self-perception. Contrastingly, men are more likely to display externalising behaviours such as antisocial behaviour and substance dependency (Rosenfield & Smith, 2010; Brownhill et al., 2005). These coping strategies may be viewed as indicating a higher level of need than can be provided in community settings, even resulting in enforced residential settings.

Secure Services and Psychological Engagement

Secure mental health services offer multidisciplinary care and treatment to those detained under the Mental Health Act (MHA, 1983, amended 2007), with complex mental health and risk needs. These services operate at the intersection of law and psychiatry, with people being detained to safeguard their own health and safety, or to protect the public. As such, evidence of rehabilitation and a reduction in risk level is usually required for individuals to progress to discharge (Tapp et al., 2013). This is especially the case in forensic mental health services (FMH), where there is the additional responsibility of attending to patients' offending behaviour (Merkt et al., 2021).

One way of evidencing improved risk and rehabilitation is through engagement with psychological interventions (Gudjonsson & Young, 2007; Miles, 2016); indeed, it is viewed favourably by key multiagency stakeholders involved in a patient's care (Miles, 2016). This

is achieved through the provision of psychological assessment, risk assessment and individual and/or group therapy (Gudjonsson & Young, 2007). Non-engagement and non-completion of psychological interventions is also an issue in secure services, with non-completion rates ranging from 15-80% (McMurran et al., 2010; McMurran & McCulloch, 2007).

Review rationale

It is important to understand how men experience psychological therapy in secure services, given that it is an integral part of their care and treatment, and somewhat of a 'measure' of commitment to improvement by professionals involved in their care. Existing reviews focussing on men's experience with psychological therapies, privilege community settings (Sagar-Ouriaghli et al., 2019; Seidler et al., 2021) and those that address secure services tend to centre on quantitative feedback (Baldwin & Beazley, 2023; MacInnes & Masino, 2018; McIntosh, 2021; Paterson et al., 2018). Hence this report aims to review the existing qualitative literature that explores how adult males experience psychological interventions in secure services. Service users are widely recognised as experts in their care and treatment (Tait & Lester, 2018) and there is increasing prioritisation of incorporating their views into service and therapy development (Tait & Lester, 2018; Thornicoft et al., 2002). Attending to qualitative research privileges the service user voice and the outcomes of this could support psychologists working in these settings to better understand the factors that facilitate and hinder engagement with psychological therapies.

Method

Systematic Search

Preliminary scoping searches were conducted in March and April 2023 to identify key search terms. Table 1 displays the final search terms which were used on 3rd May 2023 to systematically search abstracts of three electronic databases: Web of Science, PsycInfo and Applied Social Sciences Index and Abstracts (ASSIA).

Table 1.

Review search terms.

Search Term
secure service OR secure hospital OR forensic hospital OR secure unit
AND
therapy* OR psychology* OR psychotherapy* OR therapeutic engagement
AND
qualitative OR thematic analys* OR interpretative phenomenological analys* OR IPA OR grounded theory OR discourse analys* OR content analys*
NOT
Intellectual diasb* OR learning disab*

Figure 1 outlines the screening process, as informed by the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) transparent reporting guidance (Page et al., 2021). This process involved removing duplicates and screening titles, abstracts and full texts after applying the inclusion criteria (Table 2). Since this review is interested in the experiences of adult males detained under the mental health act, other types of secure services such as prisons, were excluded. This review is also concerned with discrete episodes of psychological intervention that form part of the care provided by secure services. As such, therapeutic communities have been excluded as these are unique forms of intervention where prolonged participation in the environment forms the intervention.

The references of eligible papers were checked for relevant papers, which were also included in the screening process. Two such papers met the inclusion criteria and were included in this review. At the end of this process, 11 studies remained and were included in this review.

Figure 1.

PRISMA flowchart of the screening process.

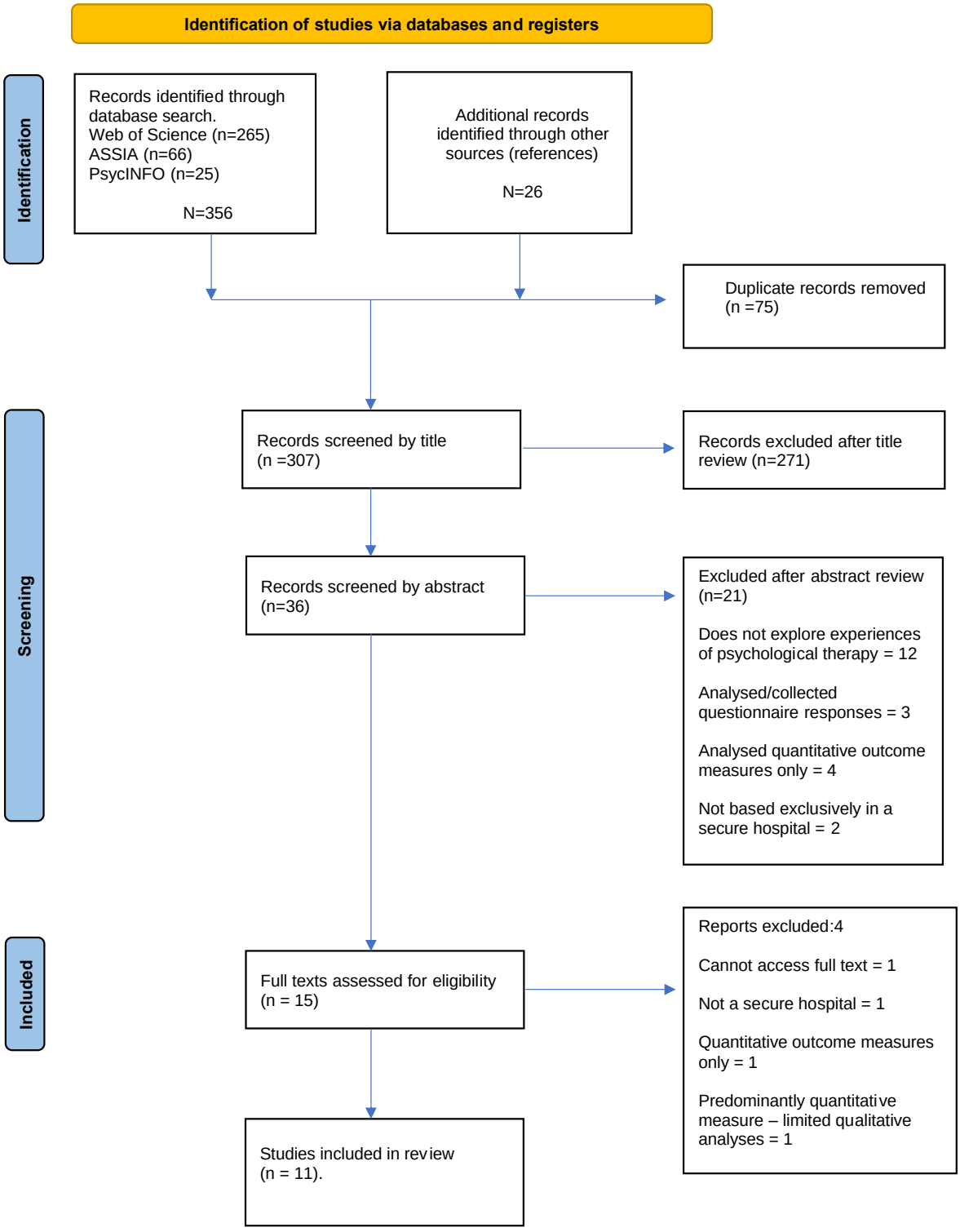

Table 2.

Inclusion and exclusion criteria.

Inclusion Criteria	Exclusion Criteria
Adult male service users	Intellectual/Learning Disabilities
Secure services	Prisons
Qualitative data captured by interviews	Therapeutic communities
Published in a peer-review journal	Adolescent, adult female or older adult
Published in English	Studies with quantitative data or insufficient qualitative data collection methods (surveys or predominantly quantitative data collected with a small subset of participants participating in interviews)

Synthesis

Included papers were synthesised in accordance with Thomas & Harden's (2008) guidelines for Thematic Synthesis, as documented in Table 3 below. This method is an appropriate method for synthesising qualitative studies, particularly those that centre on people's views or experiences (Thomas & Harden, 2008).

Table 3.

Thematic synthesis process.

Step	Process
1	As systematic search was conducted by searching electronic databases with the finalised search terms. All papers generated from this search were screened against the inclusion/exclusion criteria and following the PRISMA transparent reporting guidance.
2	The quality of eligible papers was appraised to ascertain if and how much the papers should contribute to the review findings. The Critical Appraisal Skills Programme (CASP) checklist for qualitative studies was used to assist with this.
3	Each line of the 'results' or 'findings' section of papers was coded in terms of its meaning and content. Each code was added to a code bank, with new codes generated as required. This process of inductive analysis ensures the codes and themes are generated from the data and makes it easier to translate concepts across studies.
4	Codes were then reviewed for their similarities and differences and the grouped together. New codes were created that captured the meaning of these groups of codes. These groups are referred to as descriptive categories that remain close to the data.
5	Analytic themes were generated that go beyond the content of the original studies and draw together concepts from the papers that help to answer the review questions.

Overview of the Papers

All papers included in this review took place in the United Kingdom (UK), in forensic settings with forensic populations, and included a total of 104 male participants. Five studies explored experiences of a specific psychological intervention, whereas six studies focussed on more general therapeutic experiences. The key features of each paper are summarised in Table 4, where papers are presented chronologically, starting with the most recently published study.

Methodological Appraisal

Each paper included in the review was assessed for quality using the Critical Appraisal Skills Programme (CASP) checklist for qualitative studies (CASP, 2018; Appendix A), which informed the methodological appraisal below. This is a widely used tool (Hannes & Macaitis, 2012), designed for assisting decision making when appraising the quality of qualitative studies. As advised, a scoring system has not been employed in conjunction with the tool (CASP, 2018). Overall, all studies were of a medium to strong quality and were considered suitable for inclusion in this review, in line with Thomas and Harden's (2008) guidance. A summary of the CASP review is displayed in Appendix B.

Research Aim and Design

All papers clearly stated the research aims which broadly focussed on exploring participants' views and experiences of psychological interventions. All papers employed an appropriate qualitative methodology to investigate these aims; five studies utilised Thematic Analysis (TA) and the remaining six used Interpretative Phenomenological Analysis (IPA).

Table 4.
A summary of the papers included in the review.

Study	Service	Aim	Participants	Ethnicity	Analysis	Intervention	Key findings
Hussain et al. (2020)	Medium secure (x2)	To explore men's experiences of engaging in psychological therapy in a forensic mental health setting	9	2x Mixed White and Caribbean 1x African-Caribbean 1x Mixed White and Asian 2x White British 1x Mixed Ethnicity 1x Black African 1x White Irish	IPA	Participants had engaged in a variety of interventions included short-term 1:1, long-term 1:1 and intensive group psychological therapy.	Masculine gender norms presented barriers to engaging with therapy. Despite initial apprehensions participants were able to experience supportive therapeutic relationships, which led to self-development.
Simms-Sawyers et al. (2020)	Low secure	To explore forensic inpatients' experiences of perceived coercion to engage with psychological assessment and treatment	10	2x Black 7x White 1x Mixed	TA	Explored psychological assessment and treatment more broadly.	Participants felt coerced to engage with psychological therapies, resulting in feelings of frustration and wanting to resist. Participants were able to build positive alliances but this was sometimes compromised by the psychologists' dual role.
Davies et al. (2019)	Medium secure	To gain explore service users' experience of ACTp in a forensic setting.	10	No data	TA	Acceptance and Commitment Therapy for Psychosis (ACTp) over 10 weeks. 8 participants received this 1:1, 2 participants received this in a group.	Participants had positive experiences of ACTp which lead to mental health improvements, self-acceptance and equipped them with coping skills.
Bowden et al. (2017)	Medium secure (x2)	To explore service users' perspectives of a sexual offending therapy.	6	No data	TA	Stage 1: Foundation programme (26 sessions) focussing on psychoeducation and problem solving. Stage 2: Sexual Offending Therapy, 10-13 months, based on CBT[a] principles.	Despite initial apprehensions, participants were able to confront their pasts and improve their sense of self. They appreciated the preparatory group and peer support.
Ware et al. (2016)	High secure	To explore the experiences of individuals'	4	3x White British 1x Black British	IPA	Mentalisation Based Therapy, 18 months weekly group sessions with 1:1 follow ups as required.	Participants were initially apprehensive and felt pressure from clinical teams to complete the group. However they were better able to

		participating in group MBT.					mentalise and reflect, which resulted in improved behaviour and affect regulation.
Lord et al. (2015)	Medium secure	To explore how service users experience therapeutic engagement with clinical psychologists and the factors that influence engagement	10	No data	IPA	Explored experiences of therapeutic engagement with clinical psychologists and not specific interventions.	Participants reflected that a lack of control and their therapist being from a 'different world' presented barriers to engagement. Though some found it difficult to trust their therapist, some benefited from the therapists' listening and caring qualities.
Flinn et al. (2013)	High secure	To explore participants' experiences of a motivational group.	10	7x White British 2x Caribbean 1x Asian	TA	Forward Motion Motivational Group (FMMG) based on CBT and MI[b]. 12-week programme.	Participants initially felt pressure to engage in the group. Through peer and facilitator support, many participants reported benefits of engagement. However, some did not.
Willmot & McMurran (2013)	High secure	To explore the views of patients with a diagnosis of personality disorder on the process of change during treatment	12	No data	TA	Explored participants' experience of therapeutic change and not of a specific therapy intervention.	Participants felt they understood themselves and others more and gained skills to manage their mental health. Peer and therapist support helped to normalise their experience and engender hope.
Clarke et al. (2013)	High secure	To explore personal narratives about the process of engaging (or not) in offence focussed group-work.	17	14x Caucasian 3x Black	TA	Sex Offender Group, based on CBT. The three groups reviewed lasted 59, 66 and 88 weeks.	Peer support was a powerful vehicle of change, however those with stigmatised offences struggled with peer views of this. The importance of confidentiality and trust, and limits of this was explored.
Mason & Adler (2012)	High secure	To explore past experiences of therapeutic group work.	11	No data	IPA	Explored experience of therapeutic groups but unclear which therapeutic groups had been participated in	Participants spoke to the importance of choice and the perceived lack thereof in deciding to engage. The importance of trusting relationships was highlighted as well as expected outcomes of completing the groups.
Ritchie et al. (2010)	Special hospital	To explore dual-diagnosis patients' perspectives on a	5	No data	IPA	Drug and alcohol relapse prevention programme based on CBT and MI. Involves 28x 3-hour sessions	Participants spoke to the importance of interpersonal relationships with peers and therapists. Participants felt

		relapse prevention programme.					they gained relational and coping skills.

[a] Cognitive Behavioural Therapy

[b] Motivational Interviewing

Participants and Recruitment

Whilst the CASP does not explicitly explore the reporting of participant demographics, it felt important to review the level at which this was reported as it provides a sense of the diversity of samples.

All papers offered some commentary on the diagnoses participants had received, and all but one study (Mason & Adler, 2012) offered some indication of participants' ages. Hussain et al. (2020) presented the most detailed and specific overview of participants across a variety of categories including education level, ethnicity and length of detention. Mason & Adler's (2012) paper was the briefest, offering just a generic statement about participant diagnoses. Ethnicity was reported in five studies (Clarke et al., 2013; Flinn et al., 2013; Hussain et al., 2020; Simms-Sawyers et al., 2020; Ware et al., 2016), as was length of detention (Bowden et al., 2017; Clarke et al., 2013; Hussain et al., 2020; Simms-Sawyers et al., 2020; Willmot & McMurran, 2013), making these demographic categories the least frequently reported, along with education level, which was only reported in one study (Hussain et al., 2020).

Recruitment strategy was generally well reported. Three studies used opportunity (Bowden et al., 2017; Lord et al., 2015; Mason & Adler, 2012), three used purposive (Clarke et al., 2013; Simms-Sawyers et al., 2020; Ware et al., 2016) and three used random sampling (Flinn et al., 2013; Ritchie et al., 2010; Willmot & McMurran, 2013) in two studies the sampling method was unclear (Davies et al., 2019; Hussain et al., 2020). Six studies (Clarke et al., 2013; Davies et al., 2019; Hussain et al., 2020; Lord et al., 2015; Ritchie et al., 2010; Ware et al., 2016), relied on indications by ward staff or Responsible Clinicians (RCs) to inform which patients met the inclusion criteria. This is logistically appropriate, however choices may have been biased by selecting those who were perhaps known to have responded more favourably to interventions and thus could have influenced the findings. Only Lord et al. (2015) and Mason & Adler (2012) acknowledged this bias.

Four studies (Bowden et al., 2017; Flinn et al., 2013; Ritchie et al., 2010; Ware et al., 2016) interviewed participants who had completed the specific psychological intervention being investigated. Mason & Adler (2012) and Simms-Sawyers (2020) interviewed those currently engaging with psychological interventions as well as those who were not. Clarke et al.'s (2013) study mainly interviewed group completers but also included two participants who had dropped out and one who had declined the group. Hussain et al.'s (2020) study interviewed those who had engaged with a minimum of six psychology sessions but the extent of psychology engagement was unclear, which was a similar issue in Lord et al.'s (2015) study. Davies et al.'s (2019) study did not explicitly mention whether participants had completed the Acceptance and Commitment Therapy (ACT) intervention, however, this was inferred from the information presented.

Relationship Between Researcher and Participants

The majority of studies referenced who conducted the interviews. It is important to know whether interviewers were known to participants and whether they were directly involved in offering the intervention being investigated because this may influence the likelihood of socially desirable answers being presented. Flinn et al. (2013) and Ritchie et al.'s (2010) participants were interviewed by people who had a therapeutic relationship with them. This is understandable as both papers were service evaluations, which decreases the likelihood of external resources being able to be implemented for interviews. Both papers acknowledged this limitation and took credibility measures to mitigate against this, as discussed further it the 'Data Analysis' section below.

Most studies acknowledged researcher bias in some measure, noting their influence on participant's providing socially desirable answers (Bowden et al., 2017; Flinn et al., 2013; Hussain et al., 2020; Ritchie et al., 2010; Simms-Sawyers et al., 2020). Mason & Adler (2012) and Willmot & McMurran (2013) did not provide a commentary on this. What is

more, is that Willmot & McMurran's (2013) study only included participants that were deemed to have made therapeutic progress by their clinical team. The bias and subjectivity inherent in this was not acknowledged.

The location of interviews was less widely reported or acknowledged. In the four studies that did reference this, the interviews were completed in private rooms on the wards (Davies et al., 2019; Lord et al., 2016; Simms- Sawyers et al., 2020; Ware et al., 2016). It would make logistical sense for these locations to have been used, however, it might be important to know this as, if interviews were completed in rooms where participants had received therapy, this may have further positioned the interviewer (even external interviewers) as in alignment with their inpatient psychology teams. This may have influenced the feedback provided by participants. Lord et al. (2016) was the only paper to acknowledge this.

Ethical Issues

All studies except Ware et al. (2016) indicated study approval from either a Research Ethics Committee (Hussain et al., 2020; Lord et al., 2015; Mason & Adler, 2012; Ritchie et al., 2010; Simms-Sawyers et al., 2020; Willmot & McMurran, 2013) or through their local research audit department (Bowden, et al., 2017; Clarke et al, 2013; Davies et al., 2019; Flinn et al, 2013). All aforementioned studies also offered some commentary on ethical considerations including consent procedures and right to withdraw. Ware et al (2016) did not explicitly mention how study approval was given and did not comment on ethical considerations beyond approaching Responsible Clinicians for consent to approach eligible participants. Given that it is a peer-reviewed article, it is likely that these measures were followed.

Data Collection and Analysis

All studies employed semi-structured interviews which was an appropriate data collection method to address the research question. All studies also provided an overview of the analysis process.

All studies, except Simms-Sawyers et al. (2020), indicated the steps taken to increase the credibility and validity of their data analysis. This included independent audits (Lord et al., 2016; Ritchie et al., 2010; Ware et al., 2016), involving co-authors in coding or theme generation process (Bowden et al., 2017; Clarke et al., 2013; Davies et al., 2019; Flinn et al., 2013; Hussain et al., 2020; Lord et al., 2016; Mason & Adler, 2012; Willmot & McMurran, 2013) and receiving support from an IPA research support group (Hussain et al., 2020; Lord et al., 2015). Lord et al. (2015) and Ware et al. (2016) referenced the use of a reflexive diary/log to support their analysis.

The data analysis information provided in Mason & Adler's (2012) paper was relatively brief, making it difficult to ascertain if the data analysis was sufficiently rigorous. In Clarke et al.'s (2013) paper, interviews were not audio recorded due to security protocols on the ward. Instead, notes were taken by hand and the researchers acknowledged how the content of these notes may have been biased by the researcher. Though another member of the research team was involved in reading transcripts and code generation, here too it is difficult to judge whether the data collection method was sufficiently rigorous.

Four studies (Bowden et al., 2017; Clark et al., 2013; Flinn et al., 2013; Ware et al., 2016) interviewed participants some years after they completed specific psychology groups, yet only Ware et al. (2016) and Flinn et al., (2013) acknowledged the limitations of this method regarding the retrospective bias and reliability of participants' accounts.

Findings and Value

All studies had clear statements of findings and contributed something of value to the research base.

Critical Synthesis

Overview

Three analytical themes and 14 subthemes were obtained through data analysis. Appendix C displays an extract of a coded paper, as an example of the coding process. Appendix D captures the progression of themes and Appendix E documents which papers contributed to each theme and subtheme. Bowden et al. (2017) and Lord et al. (2015) were the most conceptually rich papers. Wilmott & McMurran (2013) and Ritchie et al. (2010) contributed to the fewest subthemes. Each theme and subtheme had fair representation across a number of papers. All papers were deemed to be moderate to high quality, so each study contributed equally to theme development. It should be noted that Lord et al.'s (2015) paper explored engagement with clinical psychologists and other staff in secure care. Only the findings clearly related to this review and attributable to engagement with psychologists were analysed.

Theme 1: Barriers to Engagement

This theme captured participants' views of the factors that hindered their willingness or ability to engage with psychological interventions. This theme was comprised of five subthemes: apprehensions, challenges in the therapeutic relationship, identity, "it's not a choice, I have to do it" and the secure environment.

Subtheme 1a: Apprehensions

Participants described feeling "*apprehensive*" (Bowden et al., 2017) before engaging with psychological interventions. For some, this scepticism was related to previously completing psychological interventions and being doubtful about the benefits of revisiting this. For

others, the interventions were novel and participants "*didn't know what to expect*" (Flinn et al., 2013). There was a sense that engaging with psychology would involve confronting difficult material that had previously been guarded against. As such, some men reported being "*full of fear*" Bowden et al., 2017) about whether they would be able to cope with this process and whether opening up would set them back.

"I'd already done it before and I'd find it boring. It's going over old ground' (Mason & Adler, 2012).

"I had some anxiety about starting the group and I didn't know what to expect…I was worried about how I would cope" (Ware et al., 2016).

Subtheme 1b: Challenges in the Therapeutic Relationship

Several participants reflected on the difficulties of connecting with their therapists, due to coming from a different "*world*" (Lord et al., 2015). Participants wondered whether these different worlds, based on education level or different cultural backgrounds, could be bridged:

"I just categorise them as up there, and me down there you know" (Lord et al., 2015).

Other participants reflected on psychologists' 'dual role' being a barrier to the development of their relationship. There was the impression that risk management is "*mainly their job*", meaning some men felt they had to "*hold back in conversation"* (Lord et al., 2015). As such, some men felt unable to explore material that felt important, due to fears about how this would impact their progression to discharge.

"I haven't wanted to talk about things I would really like to discuss like escaping or absconding…carrying sharp weapons…I think they would reduce my leave" (Simms-Sawyers, 2020).

Subtheme 1c: Identity

Some participants referenced how aspects of their identity, or ascribed identity, made it difficult to engage with therapy. Some participants detailed how difficult it was to confront their offences when there is a strong societal condemnation of perpetrators of that offence. This sometimes created splits in sexual offending groups whereby those who had offended against adults were hostile towards those who had offended against children.

Other participants spoke to their experiences of engaging in therapy as a man. Several participants reported a desire to not appear "*weak*" or "*soft*", as this conflicted with their "*alpha male"* identity (Hussain et al., 2020). One participant was hesitant to "*talk*" to female staff in case he offended them (Lord et al., 2015). However, another participant felt it was beneficial to speak with a female therapist, whom he likened to a "*mother*" and felt he would have been unable to have experienced the same comfort with exploring his past if he had a male therapist (Lord et al., 2015).

"Nobody wants to be seen as someone who is vulnerable…I'm the alpha male, I'm not vulnerable, I'm not anything, I'm top dog" (Hussain et al., 2020).

"I think this feeling of shame that I had for being a sex offender, I mean it was crippling. It stopped me from fully acknowledging my responsibility really" (Bowden et al., 2017).

Subtheme 1d: "It's Not a Choice, I Have to do it"

In several studies, participants referenced feeling "*forced*" or "*coerced*" into attending psychology sessions (Bowden et al., 2017). Participants frequently mentioned that they were not "*consulted*" about participating in psychology and that it was instead "s*omething the team had decided*" for them (Hussain et al., 2020). This expectation to engage made some participants feel "*under pressure*" (Ware et al., 2016), particularly as they felt key stakeholders involved in their care viewed engagement with psychology favourably: "*one of the things people look at is how much you are engaging*" (Simms-Sawyers et al., 2020). As

such, attending psychological interventions was seen as "*part…of the way to get out*" (Mason & Adler, 2012) or a way to progress through their care pathway. Some participants described how this positioned psychology as a means-to-an-end, which lead to superficial engagement: "*If you're being told you have to do MBT [Mentalisation-Based Therapy] you just turn up every week because you've got to, you probably don't fully engage because you don't want to be there*" (Ware et al., 2016). Another participant felt that engaging with psychology was one way to "*play…the system*" to "*get through it…quicker"* (Simms-Sawyers et al., 2020).

"I thought I had to do it because if I hadn't done it then I couldn't move forward and I just felt under pressure" (Flinn et al., 2013).

"on one occasion, I errr, I didn't go on my psychology and it was looked upon in a negative way by my doctors and in my ward round. And they said that I shouldn't do that again [if I did] they said that I will be getting my leave reduced" (Simms-Sawyers et al.., 2020).

"How much choice do you have about your engagement in a high secure hospital? None, you have to do it or you won't go to your RSU [Rehab Support Unit]" (Mason & Adler, 2012).

Subtheme 1e: The Secure Environment

A few men spoke to the environmental factors unique to secure services that impaired their willingness to engage with psychological interventions. Men spoke to the challenges of living in the environment where they were receiving therapy, an environment marked by surveillance on several levels, including between peers. A few men worried about whether they could "*fully trust the other patients*", fearing that their confidential information would "*end up all around the hospital*" (Mason & Adler, 2012). Indeed, some men actually experienced confidentiality breaches which resulted in getting "*beaten up*" (Clarke et al., 2013) or struggling to "*open up as much*" (Clarke et al., 2013).

Another participant struggled with the side effects of an antipsychotic medication that impaired his ability to concentrate or participate in interventions. Participants across a few

studies expressed a wish for nursing or ward staff to be involved in the group as some participants felt "*they don't fully appreciate what is going on*" (Clarke et al., 2013). This was furthered by experiences of staff not being cautious about announcing that participants had to attend the sex offender group.

"The nursing staff should be trained enough to know when you're having a rough group and how to help you through that…when they come back on the ward" (Bowden et al., 2017).

"I got beaten up for going to group. Everyone knows that's what you're going for…I've been in my room and a member of staff has come and shouted 'time for sex offending group' in front of patients for everyone to hear" (Clarke et al., 2013)

Theme 2: Factors Aiding Engagement

This theme captured participants' views of the factors that helped them to engage with psychological interventions. This theme encompassed the following five subthemes: a positive alliance, "sharing experiences", orientation, meeting people "on their level" and involvement in care.

Subtheme 2a: A Positive Alliance

A number of papers documented the development of a strong therapeutic relationship between participants and their psychologist. The importance of trust was acknowledged, with an understanding that this takes time to foster: "*Unless I've got to know him over a period of time, I wouldn't sort of open up to him much*" (Lord et al., 2015). Once established, many participants valued this relationship, which was experienced as unique:

"I like speaking to psychologists because they're the only people I can really talk to" (Simms-Sawyers et al., 2020).

Working collaboratively "*as a team*" (Hussain et al., 2020) was another important aspect of this relationship which supported the creation of a mutual caring, and meaningful bond.

"Listening to me, that was one of the best things ever. Not a lot of people listen these days" (Hussain et al., 2020).

"They're helpful, caring, they just want to see people get out of their old ways and move on with their lives" (Simms-Sawyers, 2020).

Subtheme 2b: "Sharing Experiences"

Participants greatly appreciated the mutual sharing of stories in group interventions, as they discovered that their story "*wasn't exceptional or radically different from other people's*" (Bowden et al., 2017). It was "*comforting*" (Davies et al., 2019) to have their experiences normalised and participants felt they could "learn from" (Flinn et al., 2013) their peers, which was experienced as motivational. Connecting with others' stories of overcoming difficulties engendered "*hope*" for some men (Willmot & McMurran, 2013). Some men felt that peers were able to speak to each other and hold each other to account impactfully, in ways that professionals could not; there was a reflection on how professionals "*can't say the things we can say*" (Clarke et al., 2013).

"Finding out that I wasn't the only one…the problems I have…it was quite comforting" (Davies et al., 2019).

"If they can get out there must be some hope for me" (Willmot & McMurran, 2013).

Subtheme 2c: Orientation

Participants spoke to the benefits of feeling adequately prepared before engaging with psychological interventions. For some, this meant being well informed about the nature of a group. Those who felt they were not well informed explained that this felt anxiety provoking as they were not sure what to expect.

For other participants, foundational groups were experienced as helpful in preparing them for accessing more "*intense*" groups (Flinn et al., 2013). These groups helped to orient

participants to the group structure, expectations and helped participants gain confidence with sharing their stories.

"it's like an initiation thing…instead of being put in the main group and you're kind of scared off…you wade in the shallow end and then go deep" (Bowden et al., 2017).

"It just sort of prepared me in terms of the format…like a good stepping stone really to other psychology work environment" (Flinn et al., 2013).

Subtheme 2d: Meeting People "on Their Level"

Participants spoke to how engagement with interventions was improved when facilitators or therapists considered ways to make the session material accessible to all.

The employment of a wide range of learning materials was valued by participants. Case studies (Bowden et al., 2017), role plays (Flinn et al., 2013; Ritchie et al., 2010), videos and metaphors (Davies et al., 2019) helped participants to meaningfully connect with the material, and "bring home the information" (Bowden et al., 2017). Participants also appreciated having materials they could review in their own time such as handouts (Davies et al., 2019) to consolidate the learning from their psychological interventions.

Participants appreciated when psychologists considered their individual needs when working with them, either through adapting the pace of sessions or by speaking "*to people on their level*" (Lord et al., 2015) with "*jargon-free language*" (Flinn et al., 2013).

"The pictures and the videos like the bus driver metaphor, that as really helpful…I pinned that to the back of my door. Visually it was helpful" (Davies et al., 2019)

"It was adapted to fit all three people within the group…it's made to fit me as a person…it means I can learn better" (Bowden et al., 2017).

Subtheme 2e: Involvement in Care

One participant explained the importance of being "*involved in your own care because they can't decide something without you*" (Lord et al., 2015). He went on to explain that

being "forced" to engage with a psychological intervention is counterintuitive as it would affect the effort one puts into the group. This feeling was echoed by other participants who were able to "*jointly make decisions*" (Lord et al., 2015) in their care and treatment, and subsequently found the intervention "*enjoyable*" (Ware et al., 2016).

"It's paramount isn't it, you have got to be involved in your own care, because they can't decide something without you, you know what I mean? …they can lead you to water but if you don't want to drink it, you don't want to drink it'…if you are forced to do it, you are not going to put the effort into it" (Lord et al., 2015).

"One of the reasons why I found it a bit enjoyable was because I knew I didn't have to finish it to leave" (Ware et al., 2016).

Theme 3: Outcomes

Participants reflected on their perceptions of the outcomes of their therapeutic engagement. This theme is comprised of the following four subthemes: therapy-specific skill development, improved relationships, self-improvements and hopes for the future.

Subtheme 3a: Therapy-Specific Skill Development

In spite of the various aforementioned challenges, in almost all of the studies participants spoke to the multitude of benefits they had acquired. Participants who engaged with a particular therapy model referenced the therapy-specific skills they had successfully employed outside of the intervention.

"DBT; that helped me to understand my emotions and regulate them" (Willmot & McMurran, 2013).

"None of us actually realised that we were using our mentalisation based therapy skills. Because you don't just used MBT in the group, you use it" (Ware et al., 2016).

Subtheme 3b: Improved Relationships

Several participants reflected on how engaging with psychological therapy led to improvements in their social relationships. Participants felt they were better able to extend empathy and compassion towards others. Where previously participants may "*attack*" or have "*punched*" someone (Ware et al., 2016), they felt better able to regulate their emotions and "*speak…actions…not act on…actions*" (Ware et al., 2016).

"It changed my relationship socially because I wasn't really as sociable as what I am now due to the unhelpful thought that I had about other people, so socially I am better from ACT therapy" (Davies et al., 2019).

"A feel a bit more confident now talking to people" (Ritchie et al., 2010).

Subtheme 3c: Self-Improvements

The majority of papers documented that participants felt they had gained more "*insight*" (Davies et al., 2019) into themselves and their past offences. By reflecting on the past, participants felt more able to understand themselves and as a result, "*accept*" (Bowden et al., 2017) themselves. This consequentially led to an improved relationship with themselves as well as a reduction in mental health distress for some participants.

"The voices don't distract me anymore…it's learned me how to cope" (Davies et al., 2019).

"It made me learn not to hate yourself, but learning to accept who you are, accept that you're a person who's done some bad things. And those bad things don't make you who you are. Well not entirely, they make up an aspect of you. But they're not who you are as a person completely, you're not the crime' (Bowden et al., 2017).

Only one paper (Flinn et al., 2013) captured views from participants whereby several participants felt they had not reaped any benefits from the group they participated in:

"I didn't get anything from it, it was a waste of time it went on too long and it was stupid" (Flinn et al., 2013).

Subtheme 3d: Hopes for the Future

Having engaged with psychological interventions, many participants who were feeling hopeless and as though they "*wouldn't see the outside world again*" (Willmot & McMurran, 2013), reported being able to hold more hope for their "*future beyond this hospital*" (Flinn et al., 2013). One participant felt motivated to continue engaging with "*other courses*" (Flinn et al., 2013).

"Before I didn't really care about my future…I didn't set any targets, have any goals, whereas now I do look at my future and I look at setting a goal for where I'm going to be this time next year" (Willmot & McMurran, 2013)

"I am looking forward to the future more now than I have done and that is from doing this work" (Davies et al., 2019).

Discussion

This review sought to explore men's experiences of psychological therapy in secure services through a systematic review and a thematic synthesis of 11 studies. Overall, participants had a mixture of positive and challenging experiences.

Given that primary care psychological therapy statistics suggest that men are less likely to help-seek or complete therapy (NHS digital, 2016; ONS 2022a), it is perhaps unsurprising that participants reported feeling apprehensive about commencing therapy in secure services. Though not documented, it is likely that for many men this was their first experience of psychological therapy. As such, it makes sense that men appreciated being orientated to the format of groups through explanations or preparatory work. This finding is consistent with existing literature where insufficient support to acclimatise to therapy was experienced as a barrier to engagement (Seidler et al., 2018).

Though participants across all studies were men, it is interesting that reflections about this aspect of identity in the context of experiences of psychological therapy was only referenced in two studies (Hussain et al., 2020; Lord et al., 2015) This is likely reflective of the types of questions participants were asked; perhaps the questions were less likely to address or explore this. As such, it may not be an aspect of identity that the men have reflected on themselves, independently. This also raises the issue about whether leaving out questions exploring the role of identity in engagement is indicative of whether similar omissions are made in therapeutic settings. Existing literature suggests this may be the case (Seidler et al., 2021; Seidler et al., 2018). Those who did connect with their experience of engaging with therapy as a man, spoke to the gender role conflict this presented; a finding which may have been anticipated given the similar experiences in community settings (Galdas et al., 2005; Mahalik et al., 2007; McDermott et al., 2018). An additional identity that was difficult to confront was that of a sex offender. This was present in three studies (Bowden et al., 2017; Clarke et al., 2013; Simms-Sawyers et al., 2020). Whilst this was not relevant in all studies, due to the type of intervention being explored, it is interesting that offending identities did not feature in more studies, since all participants were of a forensic population.

Almost all papers spoke to the unique challenges inherent in engaging in psychological therapy in a forensic secure service. The boundaries of confidentiality were tested when residing with peers who were also present in therapy groups, which had notable consequences for those who had offended in ways deemed to be socially unacceptable. One participant reflected on the challenges of trying to engage in sessions whilst being on strong antipsychotic medication. Though this experience is not unique to inpatient services, it is common for individuals in these services to be prescribed medications with side effects that impair concentration and energy levels. A further complicating factor for engagement was the psychologist's dual responsibility of co-facilitating a therapeutic relationship whilst attending

to risk. This compromised participants' comfortability with disclosures and the extent to which they felt able to trust their therapist.

Many participants spoke to the lack of control they had in their care pathways. They acknowledged the implicit, or at times, explicit coercion they experienced which led to feelings of disempowerment, and impacted whether participants felt able to wholly engage with the intervention. Those who were involved in decision making about their care and treatment greatly valued this, which may be due to its congruence with the masculine gender norm of autonomy (Jansz, 2000).

Despite these challenges, almost all papers included commentary from participants about what they had gained from engaging in the therapeutic process. These benefits were far reaching including improved relationship with the self and others, the acquisition of skills and coping strategies, and improved mental wellbeing. By participating in group programmes, participants felt their experiences were normalised and felt encouraged by hearing stories of people similar to them overcoming hardships. These shared stories were instrumental in helping individuals to extend compassion to themselves, and to be able to hold hope for the future. Perhaps this group support and modelling helped men to resolve the gender role conflict that may be present when engaging with psychological therapies and confronting one's vulnerability (Addis & Mahalik, 2003). Of importance was that despite several accounts of the challenges of a psychologist's 'dual role', many participants were able to benefit from a trusting and positive therapeutic alliance.

Not all participants reaped benefits from psychological intervention, yet accounts of this nature were only included in Flinn et al,'s (2013) study. This raises issue of whether participants felt able to bring experiences like this to their interviews or if the scope of interview questions captured narratives of psychology being unhelpful as well as helpful. The papers reviewed included a range of programme completers, those who had disengaged and

those who declined. It may be that, whilst there were difficulties in experiences with psychology in these settings, participants generally found interventions helpful. However, it is also plausible responses were influenced by the location of the interviews, by who facilitated the interviews as well as fears about repercussions of 'negative' feedback on participants' discharge pathway. Hence, this finding should be interpreted with caution.

Implications

The present findings offer insights into the factors that could facilitate engagement with psychological interventions in secure services. Psychologists may benefit from considering the unique challenges facing men who are encouraged to engage with therapy in these settings. Such challenges may include considering their relationship to help and whether this constitutes a gender role conflict for them. If so, such men may appreciate this being explored together, before they participate in more intense psychological therapies. Psychologists could also encourage the exploration of matters of sameness or difference in therapy to ensure there is space to consider how this may or may not interrupt the therapeutic process.

Considerations for how to maximise autonomy, empowerment and involvement in decision-making could be beneficial. It is acknowledged however, that there is a tension between the extent to which this can be actualised given it is a restricted environment in which deprivation of liberty is in place.

Low-intensity, psychoeducational interventions as foundational, preparatory work may help the men grasp the nature and format of group work. Efforts to consider interactive and engaging ways for the men to connect with the therapeutic material including roleplays and videos, may also be appreciated.

Psychologists could also encourage ward staff's discretion when they are readying individuals for therapy sessions. Maintaining confidentiality about the nature of the group amongst staff and peers may be one way to safeguard participants from harm due to attending

interventions focussing on offences that are deemed to be socially unacceptable. Groups or interventions of this nature could be referred to as ‘men’s group’ instead of ‘sex offending group’, for example.

Limitations and Future Directions

The studies sample a small proportion of the total men engaging with psychological interventions in forensic secure services, all of whom reside in the UK. A substantial number of included studies also offered no indications about ethnicity or socioeconomic background, making it difficult to ascertain if samples were representative of the wider population of men in secure services. Hence, the findings should be interpreted and generalised with caution both within and outside of the UK as services, contexts and individual characteristics are likely to vary.

This review additionally focussed on one aspect of identity when, in reality, individuals are comprised of a number of visible and invisible aspects of identity (Burnham, 2012). It would be beneficial for future reviews in this area to consider experiences through the lens of intersectional identities (Crenshaw, 1989). Future studies in this area may wish to consider alternative qualitative methodologies to IPA and TA, which may elicit slightly different stories or feedback.

It is acknowledged that the ideas summarised in this review does not capture the full richness of contributions across papers. The ideas that were privileged and included in the themes may have been influenced by researcher’s interest in this area.

Conclusion

This review explored men’s experiences of psychological therapy in secure services. Men faced several challenges to engagement including factors relating to the secure environment, aspects of their identity and challenges in the therapeutic relationship. Despite these

challenges, many participants reaped benefits from the relationships built within groups or with their psychologist. Such benefits lead to improved relationships with the self and others.

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Simran Bains BSc Hons

EXPLORING MEN'S QUALITATIVE ACCOUNTS OF PSYCHOLOGICAL THERAPY IN FORENSIC HOSPITALS

Section B

An Exploration of the Stories Black Men Tell About Their Experiences of

Psychological Therapy in Forensic Hospitals

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Abstract

Background: The nuanced experience of Black men in secure forensic mental health services warrants attention since they are overrepresented in these services. Of particular interest is their experience of psychological therapy given this is an integral part of care pathways in such services.

Aim: To explore what stories Black men tell about engaging with psychological therapy in a forensic hospital. To see if aspects of participants' identity, the context in which therapy was offered and the meaning making of their recovery journey, featured in the narratives.

Method: 10 male participants across two forensic hospitals in England (one high secure, one low secure) engaged in semi-structured interviews. Interviews were audio recorded, transcribed and analysed using rhizomatic narrative analysis.

Results: Participants told three stories: the story of trying psychological therapy for the first time, the story of the impacts of psychological therapy and the story of their recovery journey. These stories were told through utilising ten distinct voices including the 'cagey' voice, the voice of connection and the hopeful voice.

Conclusion: Despite challenges in approaching and engaging with psychological therapy, all participants reported some benefits. Implications and recommendations for future research are explored, including the necessity of attending to intersectional identities.

Keywords: Black men, forensic, secure services, experiences, psychological interventions

Introduction

A Note on Language

A substantial proportion of research exploring experiences of people who identify as Black, Asian, Brown, dual-heritage or indigenous to the global South, employs terminology that groups these identities together. Examples include 'ethnic minorities' or 'Black, Asian and Minority Ethnic (BAME)'. Such terminology positions Whiteness as the default, therefore racializing these identities (Ahsan, 2020; Campbell-Stevens, 2020; Lim, 2020). As such, where research discusses outcomes for 'ethnic minorities' or 'BAME' individuals, this paper adopts the terminology 'People of the Global Majority' (PoGM) instead, as an attempt to move away from colonialist language. 'Black' is used in this paper to refer to individuals of African or Caribbean descent.

Secure Mental Health Services and Psychology

Secure mental health services support individuals who are detained under the Mental Health Act ([MHA], 1983, amended 2007), due to complex mental health needs and being a high risk to themselves or others. In secure forensic mental health services (FMHS), the individuals also have an offending history. Care and treatment are mandated in these services which creates a tension between the psychiatric and forensic/legal disciplines since the provision of care has to be balanced with containing risk, addressing offending behaviour and evidencing rehabilitation/recovery, in order to progress to discharge (Merkt et al., 2021; Tapp et al., 2013). Leamy et al.'s recovery framework (2011) suggests that mental health recovery journeys are difficult but rewarding, are aided by supportive others, involve overcoming stigma and holding hope for the future, amongst other characteristics.

Psychological interventions in secure FMHS include psychological assessment, risk assessment and individual and/or group therapy (Gudjonsson & Young, 2007). As such, they are an integral part of care pathways, with engagement viewed favourably by key

stakeholders (Miles, 2016). This has been perceived as coercive by some service users (SUs; Simms-Sawyers et al., 2020) and professionals (Miles, 2016), as individuals in these studies felt they would not progress to discharge unless they participated in psychological therapy. Occupying the dual role of assessing risk and offering a containing, therapeutic space for the SUs is also a challenge for psychologists in this setting (Merkt et al., 2021), with research indicating that this can impair the development of a therapeutic alliance (Simms-Sawyers et al., 2020) and exacerbate distrust (Maruna, 2011), and existing power imbalances between the client and therapist (Miles, 2016;).

Disparities for Black Populations in Secure FMHS

The mental health inequalities for Black communities in secure FMHS are well documented: compared to their White counterparts, Black individuals are less likely to voluntarily access mental health support in primary care (Bhui et al., 2018; Harwood et al., 2021). Instead, they are more likely to enter mental health services later, when in distress, through the Criminal Justice System (Care Quality Commission, 2011; Harwood et al., 2021). As a result, Black individuals are almost five times more likely to be detained under the Mental Health Act (National Health Service [NHS] Digital, 2023) compared to their White counterparts. In inpatient settings, Black populations are subject to higher incidents of restraint (Arya et al., 2021), seclusion (Arya et al., 2021), readmission (Payne-Gill et al., 2021), longer stays in hospitals (NHS Digital, 2020) and are 10 times more likely to be placed on a Community Treatment Order (NHS Digital, 2020).

The MHA data reports outcomes for gender and ethnicity separately. These data also demonstrates that men are more likely than women to be detained under the MHA (NHS Digital, 2020). This may suggest that Black men are particularly vulnerable in these settings.

A Case for Black Men

Improving mental health inequalities for ethnically minoritized groups has been a Government and NHS priority for a number of years (Department of Health and Social Care 2021; Department of Health, 2005; NHS England & NHS Improvement, 2020). One way to do this is to consider how psychological interventions are experienced to ensure they are best meeting SUs' needs. The data above suggest that the unique experience of Black men in secure FMHS warrants further attention.

Crenshaw's (1989) Intersectionality Theory elucidates how multiple and overlapping (intersecting) social identities are associated with varying levels of privilege, oppression and power, which shapes a person's experiences. This framework underscores the importance of considering the influence of the two salient components of Black men's identity, their ethnic identity and their gender identity, on how psychological interventions are experienced or if they are even considered as an option. These will now be considered in turn.

Black Men and Psychological Therapy: The Contribution of Ethnic Identity

Stigma is a widely acknowledged barrier to mental health service utilisation (Clement, 2014) and is the process whereby an individual is perceived less favourably, either by themselves or others, if they identify with a "discrediting" attribute (Goffman, 1963, p.3). Stigma has been shown to play a substantial role in the decision to engage with mental health services for Black communities (Mantovani et al., 2016; Ward et al., 2013). Gary (2005) suggests that PoGM have to face the double-stigma of racism, such as the stereotype of being 'big, Black and dangerous' (Prins, 1993), as well as the stigma of having a mental health difficulty. This stigma, coupled with the racial history of psychiatry and clinical psychology (Fernando, 2017) and the substantial inequalities in forensic services, leads to mistrust, further inhibiting mental health service utilisation (Keating & Robertson, 2004). This, in turn,

may perpetuate circles of fear (The Sainsbury Centre for Mental Health, 2002) whereby Black SUs see services as dangerous and vice versa.

Furthermore, different cultures have different understandings about the origins of mental health distress and how to seek support for this (Gopalkrishnan, 2018). Some Black communities, for example, conceptualise mental health difficulties as being ungodly or as the result of possession by evil spirits (Adewuya & Makaniuola, 2008; Mantovani et al., 2016). As such, religious coping strategies are favoured over Western coping strategies such as medication and psychological therapy (Ward et al., 2013).

There is a paucity of research into the experience of therapy for Black men, or PoGM more widely, in secure settings, especially forensic hospitals. Research in prisons showed that therapy did not meet the needs of PoGM; it was experienced as culturally insensitive, SUs felt misunderstood and reported feeling victimised and stereotyped by staff (Hunter et al. 2019; Patel & Lord, 2001). Similar results have been found in therapeutic communities (Brooks et al., 2012), where SUs felt as though they needed to sacrifice their cultural identity to 'fit' the therapy and that discussions regarding racialised experiences were not facilitated well (Jones et al., 2013).

Research in community settings may offer further insights into how psychological therapy is experienced. This research suggests that language barriers and an inadequate accommodation of cultural and religious needs were experienced as barriers to engaging with services (Jolley et al., 2009; Memon et al., 2016; Watson et al., 2019). Experienced and anticipated racism along with cultural stereotyping, were further barriers to engagement and disrupted the development of a trusting therapeutic alliance between service users (SUs) and healthcare professionals (Islam, 2015; Jolley et al., 2009; Memon et al., 2016). These results are consistent with research that focusses specifically on the unique experiences of Black

individuals in community mental health services (Devonport et al., 2022; Gaston et al., 2016; McLean et al., 2003).

Black Men and Psychological Therapy: The Contribution of Gender Identity

Stigma is also a powerful deterrent to mental health service utilisation for men. Judd et al. (2008) posits that the stigma of struggling with mental health may interact with societally-prescribed beliefs about men (masculine gender norms) such as strength and self-reliance (Addis & Mahalik., 2003), which may heighten the negative effect of stigma on service utilisation. Indeed, research indicates that stigma and traditional masculinity norms had an obtrusive influence on decision making about approaching or engaging with psychological therapy for men (Clement, 2014; Galdas, et al, 2005; Mahalik, et al., 2007; McDermott et al., 2018) and Men of the Global Majority (Memon et al., 2016). Ideas about what constitutes masculinity are influenced by multiple factors. Franklin (1987) suggests that Black men adhere to different masculinity norms due to the different social reality they face compared to their White counterparts. From Mincey et al.'s study (2013), Black masculinity encompassed Western ideas of masculinity such as handling responsibilities, as well as ideas about what it means to be a Black man, such as experiencing negative stereotypes and having to be strong to overcome these. Research has demonstrated that adherence to Black masculine norms was associated with increased public stigma which may influence attitudes towards mental-health help-seeking in Black men (Coleman-Kirumba et al., 2023). Taking an intersectional approach, Powell et al. (2016) found negative effects of ethnicity-related stress and adherence to masculinity norms as barriers to health help-seeking for Black men.

Rationale and Aims: Taking an Intersectional Approach

Despite a growing body of research on mental health disparities, much of the research in this area tends to partition different aspects of identity, either exploring ethnic identity or gender identity, for example. The absence of an intersectional approach to this research and

the MHA data may mean that the unique experience and needs of Black men in secure FMHS is overlooked. There is also a paucity of research into the experiences of therapy for PoGM individuals in secure settings, especially forensic hospitals.

Given the above, and the importance placed on engagement with psychological therapy in FMHS, this project sought to explore the experiences of Black men engaging with psychological therapy in a forensic hospital. The research questions are summarised below:

a) What stories do Black men tell about engaging in psychological therapy in a forensic hospital?
b) Does the context in which Black men are offered therapy (forensic hospital) feature in the narrative? If so, how?
c) Do any aspects of Black men's identity (their ethnicity or masculinity) feature in the narrative? If so, how?
d) Do the narratives depict how the participants made sense of their recovery journey?

These research questions align with Narrative Analysis approaches which are interested in the stories individuals construct to make sense of their lives and experiences (Willig, 2013). Rhizomatic Narrative Analysis (RNA) was chosen as it was born out of post-structuralist approaches which argue that narratives are comprised of multiple, and at times contradictory voices. It suggests that narratives are non-linear and are not always coherent or structured. Whilst traditional Western conceptualisations of narratives are grounded in coherence and temporally organised plots (Bruner, 2002), rhizomatic approaches are grounded in the assumption that features of a narrative are not universal. As such, RNA is deemed to be a culturally-oriented approach to narrative analysis, which is suitable for this study as it

prevents the imposition of Western structures on the participants' narratives (Muwanga-Zake, 2010).

The feedback from this research could help to reduce the likelihood of iatrogenic harm and inform culturally appropriate interventions. Hence, this project maps onto several NHS values: commitment to quality of care, improving lives, everyone counts and working together for patients.

Method

Participants

Qualitative research studies in this area have interviewed between eight and 10 participants (Askola et al., 2016; Donaghy-Spire et al., 2015; Hui, 2017). Hence, 10 participants were recruited through convivence sampling from two forensic hospitals in England: one medium secure and one low secure hospital. The inclusion criteria are presented in Table 1 and participant characteristics are summarised in Table 2.

Table 1.

Inclusion criteria

Inclusion Criteria
Aged 18 and above
Individuals identifying as male
Those identifying as Black, Black British, African, Caribbean or mixed Black heritage
Participated in a minimum of three psychological sessions, regardless of drop out
Risk assessment that deemed the individual is safe for lone working
Proficient in verbal English
Capacity to consent
Stable mental health

Table 2.

Participant characteristics

Participant characteristics	Number of participants
Total number of participants	10
Age in years	
25-34	4
35-44	4
45-54	2
Ethnicity	
Black	1
Black African	3
Black British	3
Black Caribbean	2
Mixed White and Black Caribbean	1
Psychological Intervention History	
Individual sessions	7
Group therapy	9
Psychological Intervention Focus	
Offence/risk focussed work	7
Coping Skills	8
Other	7

Design

This research aligned with the ontological position of social constructionism which posits that there is no single objective reality and instead multiple realities that are constructed through social and cultural interactions (Willig, 2013). Semi-structured interviews were conducted and analysed using RNA.

Procedure

Eligible participants were identified by their clinical care teams based on the inclusion criteria. These individuals were invited to attend an informal information session facilitated by the researcher and expert by experience (EBE) consultant. The aims of these sessions were to review the information sheet (Appendix F; Appendix G for easy-read version) with prospective participants and to answer questions. Interest in the research was higher than anticipated and as such, advertising on wards ceased earlier than expected. In order to shortlist interested parties, participants' care teams were approached to consider who would be most able to tolerate and engage with interviews. Shortlisted participants had two weeks to consider their participation and clinical teams were contacted thereafter to confirm who wished to take part. The remaining participants were placed on a reserve list and informed via easy-read documents (Appendix H) that they would be interviewed if somebody could no longer participate in the study. Interviews were then scheduled at a time that suited participants.

Before interviews, participants had the opportunity to review the information sheet and ask questions. During this process, the individual's capacity to consent to the interview was assessed. Interviews were conducted on a private room on the ward and were audio recorded on a password protected Dictaphone. The interviews were conducted over the course of two weeks and the length of interviews ranged from 27.02 to 47.42 minutes.

Expert by Experience Consultant

The EBE consultant was an integral part of the research team. He had substantial experience of service user involvement initiatives and had lived experience of the prison system and of being a Black man. The EBE supported the co-construction of the interview schedule (Appendix I) and advised on the language and presentation of information sheets and advertising posters. He also co-facilitated the information sessions. Whilst he was

positioned as part of the research team, it was hoped that through speaking to his lived experience and EBE work, he was perceived as a relatable figure that helped to somewhat shift the inherent power imbalances, when meeting with the research team. The EBE also supported with the dissemination of the results to the hospitals in which the research took place. He was reimbursed for his time and efforts.

Data Analysis

RNA explores narratives through the adoption of Deleuze and Guattari's (1976) metaphor of a rhizome. A rhizome is a dynamic underground root system which symbolises the network of multiple, unpredictable and incoherent connections individuals make when sharing stories. Rhizome thinking views the telling of each narrative as temporary; the entryways taken are dependent on the audience and context in which stories are told. As such, it is argued that 'a view of the whole is impossible' (Sermijn et al., 2008, p.637). In summarising narratives then, the process is likened to creating a 'patchwork quilt' (Deleuze and Guattari, 1987, pp. 474-500). This is in contrast to a coherent, streamlined narrative which they likened to an 'embroidered quilt' (Sermijn et al., 2008, p.634). The key features of RNA are summarised in Table 3 below. Other studies employing RNA (Loots et al., 2013; Saadi, 2020) used a listening guide (LG; Woodcock, 2016) to assist with analysis. The LG is an established method of psychological analysis which maps the stages for tuning into polyphonic voices (Gilligan et al., 2003). As such, it is frequently used in narrative research (Woodcock, 2016), and aligns well with RNA. It is also an appropriate tool to use in voice-centred narrative research with minoritized groups and can be implemented as required to suit various research methods (Woodcock, 2016). Since the aforementioned studies only employed the first and third steps (listening for the plot and polyphony of voices, respectively) of the LG in order to ensure the analysis remained true to RNA principles, this study did the same. These two steps formed the first two steps of analysis in this research,

and are described in more detail in Table 4, which offers a summary of the analysis process. The analysis only began once all interviews were complete and an example of a coded transcript can be found in Appendix J.

Table 3.

Principles of Rhizomatic Analysis

Principle	Explanation
Multiple entryways	The rhizome can be entered from any direction; there is no singular point that captures 'the truth'. Truths are instead seen as multiplicitious and socially constructed. Hence, socio-cultural context of the stories is considered, as well as considering who the narratives were performed to.
Connectivity	Each point of the rhizome can be connected with any other point. The rhizome is not hierarchical or structured.
A-signifying ruptures	When a point in the rhizome is ruptured, it grows new connections. This represents shifts in the narrative.
Cartography	Rhizomes are open to change and have multiple, non-hierarchical entryways like maps; no one entry point on a map is deemed as superior. Rhizomes are not permanent fixtures like tracings.

Table 4.

Data analysis process

Step	Process
1	Listen for the plot noting emotional resonance, repetitions, contradictions, omissions, silences and one's own reflections as a reader. The socio-cultural context of the stories was considered at this point.
2	Listening for the polyphony of voices by tracking recurring voices. Once identified, transcripts were read several times, focussing on each voice in turn and colour coding content relating to each voice.
3	Combining the polyphony of voices by 'quilting' (the narratives together to form a patchwork narrative (Deleuze & Guattari, 1987)

Quality Assurance/Validity

RNA views the researcher as part of the rhizome as they are active in the co-construction of narratives and in which entryways are explored further (Sermijn et al., 2008). A reflexive diary (abridged version can be found in Appendix L) was maintained throughout the study to allow reflections on researcher subjectivity and biases. Prior to participant interviews, the researcher engaged in an interview with a colleague external to the project to examine preconceptions, expected findings and the relationship to the topic matter. These reflections were documented in the reflexive diary along with reflections, observations and responses after interviews and across transcription and analysis. Also documented were reflections on the researchers' positioning relative to the participants. The researcher's subjectivity is deemed to be a resource in narrative analysis (Patnaik, 2013).

Ethical Considerations

Participants were provided with information sheets stating that participation was voluntary, that their information would be held securely and confidentially. Participants were reminded that they had the right to terminate interviews or withdraw their data up to two days after interviews as transcription may have started by this point. It was noted that this would not affect their care and treatment in hospital or legal rights. Before interviews, participants provided written consent (Appendix M) for their participation. Interview recordings were deleted once they had been transcribed anonymously, with sensitive or identifiable data redacted. Ethical approval for this research was provided by London Stanmore Research Ethics Committee (Appendix N), and Research and Development approval was provided by the NHS Trust in which the research took place (Appendix O).

Results

Overview

Synthesising the findings of a rhizomatic approach is challenging as to do so compromises the principles underpinning the approach, such as infinite connections and multiplicity (Sermijn et al., 2008). As such it is noted that the following results are presented as just one of the infinite possibilities of a time- and context-bound self-presentation (Sermijn et al., 2008).

When asked to tell their story of engaging with psychological therapy in a forensic hospital, participants told three stories through ten voices: their story of trying psychological therapy for the first time, the impact of psychological therapy and the story of their recovery journey. These stories will be referred to as ‘chapters’ that make up the wider story of engaging with psychological therapy in a forensic hospital. This terminology was chosen as it is non-hierarchical and does not imply linearity; the order of the presented chapters should not be misunderstood as the presentation of a linear story. This approach to the presentation

of results was chosen to ensure the principles of RNA were retained whilst balancing the need for a coherent account of the results. A summary of the chapters and associated voices is documented in Table 5 below, and a table of chapter progression is displayed in Appendix K. The names of each chapter were chosen with participants in mind, to ensure the language was accessible. Where possible, participants' own words were used in order to stay as close to their experience as possible, for example, The 'Cagey' Voice.

Table 5.

A summary of the stories told by participants

Chapter	Voices used to tell the Stories
Trying Psychological Therapy for the First Time	'Cagey' Voice The Voice of Being 'Not Normal' 'Is Psychology for Me?' Voice The Decisive Voice
Impact of Psychological Therapy	Voice of Self-Improvement 'Surprised' Voice Voice of Connection
Recovery Journey	Voice of a Painful Past Worried Voice Hopeful Voice

Eight participants offered accounts that drew on a wide range of experiences. Two of the accounts were narrower in scope: one focussed predominantly on the benefits of psychological therapy and one focussed more on his recovery journey.

Trying Psychological Therapy for the First Time

The stories in this chapter centred on the caution with which participants approached psychological therapy, the barriers stigma posed to engagement, the process of considering whether psychology was 'for' them, and how they reached the decision to engage with therapy. Four voices emerged in the telling of this story, by eight participants. This chapter was a natural entry to the rhizome as all participants spontaneously entered stories of this nature, without prompting. Overall, the voices generally told stories of difficulty.

'Cagey' Voice

The 'Cagey' voice was used to capture the experience of venturing into an unfamiliar territory, as none of the men had tried psychological therapy prior to being in hospital. Through the use of colloquial phrases such as "*big wig",* some participants spoke to their socially constructed preconceptions about working with a psychologist, who is in in position of power:

"I felt like I had my own…erm (5 second pause) sort of point of view on it already. I just thought, erm…just another big wig…another psycho shrink sort of thing, erm…just gonna try and erm…put me in a box…label me erm…with that title. It would mean that I'm just a statistic" (Participant 1).

Other participants also reflected on the power of a psychologist in contributing to decisions on their care pathway, which led to concerns about how honest they could be in their disclosures. As such, participants spoke to initially feeling "*cagey*" (Participant 8) in their sessions, as they feared they would "*incriminate*" (Participant 9) themselves and therefore "*spiral…downwards into the mental health care services and dim my chances of freedom*". (Participant 8). Here, a sense of danger and a fear for the perceived consequences of disclosures was palpable and linked with the context in which these stories were told.

Overall, this voice was characterised by an air of caution, with the narratives told using this voice often involving pauses, silences and filler words. It was situated in the past tense ("*I was cagey*", "*at the time I thought",* "*I didn't like the idea*"), which seemed to indicate this was a previously held belief and one that may have been updated as they gathered new information or experiences about psychological therapy in forensic hospitals.

The Voice of Being 'Not Normal'

In approaching psychological therapy, some participants explained having to grapple with the perceived stigma attached to those who do engage in therapy:

"To do psychology, you have to be not normal…I feel like it's a bit of a taboo" (Participant 1).

This voice was echoed in other accounts, who connected with the double-stigma of engaging with therapy as a man. Here, reflections centred on how therapy felt incongruent with masculinity norms of being "*strong*" (Participant 1). Instead, there was a felt sense that one would be viewed as "*weak*" if they were to "*talk to someone about… problems… especially a professional person*" (Participant 7). Some participants included colloquial phrases such as "man up" in their accounts, perhaps speaking to how societal discourse and gender norms had been inherited and adopted by participants.

*"For a man to go through the mental health people look at like, 'what's he really got to complain about?' kind of thing. Yeah, or they say *sarcastically* 'man up'". (Participant 3).*

This phrase was said with a sarcastic tone which seemingly indicated that the participant did not wholly agree with the phrase, yet continued to feel conflicted by what it suggested about men and mental health, and perhaps shame around this.

The 'Is Psychology for Me?' Voice

This voice encompassed a dilemma about whether psychology could be viewed as an "*option*" (Participant 7) for participants. Some felt that psychology was more aligned with

"*Western medicine"* and as such, was "*not something Black men find themselves doing*" (Participant 10). Others reflected on how the notion of engaging with psychological therapy conflicted with how mental health difficulties were understood in their upbringings and the associated messages about the ways to cope with these difficulties. For example, one participant reflected on how "*voodoo and Black magic…are embedded in Black culture*" and how this may "*make it difficult for Black men to engage in psychology because they might see that as being maybe demonic or…not Godly*" (Participant 7), with "*they*" referring to Black men themselves. As such, he reflected that people were encouraged to "*deal with…problems through religion*", which was corroborated in another participant's account. Here, the participant connected with a joke made on a comedy show which resonated with his personal beliefs about who psychology is 'for' and also links with societal or culturally held beliefs:

"It was on a comedy that I heard it but it… said 'Black people need church and White people need therapy' and I thought to myself it kinda does make sense in terms of it being a cultural thing" (Participant 3).

Further to this, two participants considered how social class influences who can access psychological therapy and therefore who can view it as a viable option:

"Like someone working class might need to go church more 'cause they can't afford the therapy…people who are more like middle class, upper class can afford to have therapy" (Participant 3).

"With it being on the NHS is quite helpful for people in these settings 'cause like a lot of young Black males won't be able to afford that kind of therapy in the community" (Participant 9).

Generally, this voice was spoken with discomfort. Participants' perceived differences seemed to be at the forefront of their minds, as they considered whether these differences posed too great a barrier to consider psychological therapy as an option.

The Decisive Voice

The other voices discussed so far in this chapter seemed harmonious and in tune with each other. For most participants, the Decisive Voice represented an a-signifying rupture in the rhizome, or in other words, a break or shift in the narratives told by the other voices in this chapter. As such, it seemed the Decisive Voice explained how some participants resolved the aforementioned voices, and ultimately made the decision to engage with psychological therapy. This voice was grounded in the context in which the narratives were told, as participants connected with the idea of psychology being seen as a "*ticket out of here*" (Participant 7). This voice was characterised by authority and decisiveness, with sentences feeling smoother and more matter-of-fact, with fewer pauses. It was spoken with neutrality or an air of acceptance. Many participants reflected on how engaging with psychological therapy felt "*mandatory*" (Participant 1) and how this positioned them as choiceless: they either engaged or they became "*stuck in the system*" (Participant 5).

"I would say that it's mandatory. If I didn't do it then I wouldn't be able to get like, to be working towards discharge. I feel a little bit annoyed, a bit pissed off about it but I feel I just have to get it over and done with" (Participant 1).

"You either work with them or you're against them and if you work with them then you will see results, you would achieve…your goals" (Participant 5).

The use of the word "*them*" seemed to indicate an oppositional dynamic with their care team, which may suggest that whilst the decision on whether to engage with psychology had been resolved, perhaps the underlying feelings regarding power imbalances or the lack of choice had not been resolved at this point.

Contrastingly, two participants felt their multidisciplinary team was alongside them and therefore trusted their recommendations to engage with psychological therapy. As such,

despite the aforementioned voices, they approached engaging with psychology for the first time with openness, expressing that they would "*give it a go*" (Participant 10).

"Whatever we're talking about in ward round or whatever erm will benefit me obviously that's from a clinical perspective that psychology's obviously recommended to me for a reason. Obviously, it was needed as part of my therapy along with medication" (Participant 9).

"I was thinking that it was part of my treatment being in hospital so even though that I never done it before, I think that it must be something good" (Participant 10).

Participant 9's repeated use of the word "*obviously*" may highlight the authority that professional opinion carries – that it simply must be true.

Impact of Psychological Therapy

In this chapter, participants spoke to the impact of engaging with psychological therapy. This included an improved understanding about themselves, the prospect of being surprised that they were experiencing benefits through engaging with therapy, and reflections about connecting with their therapist or peers. Three voices were used to share stories in this chapter.

Voice of Self-Improvement

This voice was employed in the telling of stories centring on the self-improvement participants attributed to engaging with psychology. Participants felt this was an "*enlightening*" (Participant 2 and 8) experience where they were able to "*express*" themselves (Participant 4) and gain "*insight*" (Participant 7) into why they were in hospital and struggling with mental health difficulties.

"I really enjoyed them. I feel like a weight was lifted off my shoulders, I feel like I can get understanding from the…psychologist about why I made certain decisions and how those decisions affected my behaviour and my mental state" (Participant 9).

"It's just helpful to get answers or understanding…I heard once when people don't understand things, they can fear them…I can possibly reflect or look back on when I did groups or saw a psychologist and have an understanding of what someone or me myself is going through" (Participant 3).

Other participants reflected on the skills they had gained through engaging with psychology:

"You'll be able to talk instead of er getting angry and crashing, fighting physically and lashing out…just letting it out so it doesn't have to build up…become lighter physically and mentally" (Participant 4).

"That compassion enable us to forgive ourselves and also forgive our fellow human being" (Participant 2).

Idioms were utilised more frequently in this voice compared to other voices, examples of which included "*opened my mind*", "*weight was lifted*", "*getting it off my chest*". This may be reflective of the language that is used in society when discussing mental health but could also reflect a need for metaphors or figurative speech to capture an experience that is difficult to put into words.

'Surprised' Voice

Five participants told the story of the impact of psychological therapy through a surprised voice. This voice connected to the voices in the 'Trying Psychological Therapy for the First Time' chapter whereby participants did not expect to reap benefits from therapy.

"In the beginning you just want to get on with it but then again in the middle of couple sessions you seem to try to find out more about yourself" (Participant 10).

"At first I wasn't really keen on doing any psychology groups…but…the more sessions I was doing erm I realised that actually erm it's quite helpful" (Participant 7).

"Before this had started, I wouldn't have thought that I would have needed or would benefit from psychology but it's really good" (Participant 8).

Participants were also surprised by their psychologist's attempts to understand them and engage with therapeutic material in a way that made sense to them. This voice therefore connected with another voice in this chapter, the Voice of Connection.

"I'm influenced by rap gangstas…psychologist said to me what I was feeling was real because the musician has say those words in their songs and it was surprising to me, [they] talk to me about rap, something I get, and help me express myself that way" (Participant 6).

"[they] said 'well maybe we don't have to agree the whole way, there may be parts we agree to and parts we disagree to and it's fine' and I didn't expect that…thought [they] wouldn't get me…try change how I see the world" (Participant 8).

Voice of Connection

Seven participants told stories about the impact of psychological therapy through the Voice of connection. These stories typically focussed on connection with their therapist who they felt able to build strong therapeutic alliances with. There was a recognition that the parameters of this relationship are unique compared to social relationships, which helped some participants feel more at ease with trusting their psychologist. Participants generally felt their views were respected and felt confident in the expertise of the person they were working with.

"I don't expect no repercussions or consequences of what I'm saying to the psychologist 'cause I know it's confidential" (Participant 9).

"We builded a bond, like I can trust [them]" (Participant 5).

"I think [they are] quite a good professional and [they] worked well with me you know. Treat every person individually, things like that and you know erm just knowing your way around something in psychology" (Participant 1).

Interestingly, entries to the rhizome on this topic were generally not independently broached and were more frequently responses to prompts introduced by the interviewer. Perhaps participants were not in the habit of reflecting on the therapeutic relationship, perhaps it felt unsafe or perhaps it was so matter-of-fact that it did not warrant further attention: *"well, I'm the patient, they're the psychologist" (Participant 1).*

One participant was able to connect with his psychologist, through drawing parallels to psychological therapy from his religious coping mechanism before entering hospital.

"if I felt bad about something I would repent…to God so they got, they quite similarity, is basically talking about it and putting your trust in someone else" (Participant 10).

When participants were prompted further about their therapeutic relationship, eight participants used the Voice of Connection to focus more on their sameness with their therapist as opposed to potential gender or ethnicity differences. This contrasted to the voices in the 'Trying Psychological Therapy for the First Time' whereby participants' cultural or gender identities were at the forefront of their minds.

"It don't matter what gender…We're all human init, like skin, bone, got a brain, got a heart, got a mind…just talk to them…it could be White, Black, Asian whatever, it's not a problem" (Participant 5).

Most participants chose not to elaborate further on their relationship with their therapist, seemingly indicating that regardless of differences in ethnicity or gender, participants were able to connect with their therapists. This theme of ones' humanness was mirrored in one participant's reflections about connecting with his peers in a therapy group, which had a transformational and normalising effect for him:

"Hearing other stories from other patients how they got here, what their offences were, what their past experiences were, it kind of made me feel that I wasn't alone and that I erm

well we all go through problems…when you share it makes you feel good…that's what made me changed my perception of doing psychology" (Participant 7).

For two participants, the Voice of Connection related to challenges in connecting with their psychologist or in having their experience understood, based on their different heritage and upbringings:

"I don't know where I could touch base with racism with my psychologist team so I feel like it's one of them things that I better off leave unsaid 'cause I don't know where to start…I feel like…it's different…working with a Black person to a White person…like obviously they're clinical psychologists don't get me wrong but they might not fully, fully, fully understand…being young Black and a male in Britain" (Participant 9).

"It was very difficult for me because I'm a foreigner and I was finding it difficult to speak English correct or long sentence wise because a lot of the time it was slang, I was talking slang" (Participant 4).

Recovery Journey

This chapter encompassed stories about participants' journey through mental health systems and working towards discharge. It also captured stories about the circumstances that had led to participants' detention in hospital and hopes and apprehensions about the future.

Voice of a Painful Past

Six participants began stories about their recovery journey by reflecting on the difficult life experiences that had led them into mental health services. Whilst participants felt it was necessary to address the "*cobwebs*" (Participant 2) they came to hospital with, they acknowledged how "*tough*" (Participant 10) this process was. This voice was spoken with vulnerability, as participants moved from their 'cagey' selves to a self that was confronting material they had previously guarded against. There was a desire to avoid this difficult content but a recognition that it was beneficial and worth enduring in the long-term.

"It's not easy…'cause I was young, I did shed tears" (Participant 6).

"It can be difficult because of what you're talking about…'cause you wanna hide things that you don't want to express. Could be abuse…could be family problems…if you abused drugs" (Participant 4).

"It's like bringing up the past, sometimes you don't wanna go back to the past…at first I felt like, is it really worth doing it? but then after a while…I kinda felt easier within myself, I felt peace…so it was therapeutic" (Participant 5).

"Talking about your index offence is something very difficult and painful but what makes it easier is the person opposite you" (Participant 10).

"It's tough because you finish the psychology and then you leave the room and you're left on your own and those things can…emerge again so that was a bit difficult" (Participant 2).

Participant 10 connected the Voice of a Painful past with the Voice of Connection, suggesting that the process was made bearable as he was accompanied and supported on his reflection journey.

The Worried Voice

Two participants used this voice to connect with worries about what would happen following discharge from hospital. This related to experiences they had had themselves but also through observing the experiences of others in hospital. This voice was spoken with apprehension and caution.

"I just feel like this isn't real life, this isn't really the real test. I could go through this with flying colours…but struggle in the community. I've been out in the community…and got recall" (Participant 9).

"I don't just want to be stuck in the system… in and out of hospital all my life…there's people in the system that are 50, 60, 70 and they're all the same…keep coming back" (Participant 5).

Hopeful Voice

Four participants told stories about their recovery journey through the Hopeful Voice, indicating their hopes for the future and for life after hospital. For some participants, these hopes were related to "*moving on*" (Participant 4) on their discharge pathways, being able to do the things they enjoy such as "*go cinema"* (Participant 4) or getting their "*own accommodation*" (Participant 10). Others felt energised by what they could achieve such as further education.

"Psychology and just talking about my life and obviously myself, just reflecting on my life what I've been doing in my lifetime. It just makes me think well, there's more to life than just doing drugs, crime, going to hospital, going to prison, coming back out, going back in the same cycle and then you're back to square one" (Participant 5).

"The work I was doing actually was giving me that hope where I'm able to talk to people when I'm angry…that's when you don't lash out, then that's the evidence to show the psychotherapy I was doing was helping me for the better" (Participant 4).

This voice presented a natural coda to the participants' narratives as all interviews ended with hopeful thoughts about the future. This voice had an energised quality as participants pondered over how their life could be. Stories told with this voice were told with importance, perhaps signifying the importance of holding hope for the future.

Discussion

This study sought to explore the stories that Black men tell about engaging with psychological therapy in a forensic hospital. Of particular interest, was whether the context in which therapy was offered featured in the narratives, along with aspects of participants' gender and/or ethnic identity and the meaning-making around their recovery journey.

The vast majority of participants told stories about approaching psychological therapy for the first time, which is not surprising given that this was a novel experience for all

participants. The “cagey” feelings participants reported has been well documented in other studies exploring individuals’ experiences of psychological therapy in secure services (Simms-Sawyers, 2020). Indeed, this is an inherent tension in forensic services whereby psychologists occupy dual roles of risk management and therapeutic support (Merkt et al., 2021) leading to distrust in the therapeutic relationship. The context in which therapy was offered therefore featured substantially in these stories. In line with other research conducted in secure services (Simms-Sawyers et al., 2020), many participants made the decision to engage with therapy out of perceived necessity, though some trusted in the judgement of their care teams. However, after engaging in the process, all participants reported some benefits from psychological therapy, namely clarity on the life experiences that had contributed to their difficulties and current situation, as well as connecting with their therapist or peers. Participants therefore told stories about the impact of psychological therapy.

Aspects of participants’ identity featured in the narratives when participants grappled with considering whether therapy was ‘for’ them, based on their ethnic identity, gender identity, religious identity and social class. Consistent with existing literature (Mahalik et al., 2007; McLean et al., 2003), approaching psychological therapy for the first time constituted a gender role conflict for men who subscribed to traditional masculine gender norms. Cultural conceptualisations of mental health introduced a dilemma in approaching psychology, as these conceptualisations had associated support avenues such as religious activities, instead of psychology. This finding is similar to Ward et al.’s (2013) findings. Unlike Mincey et al.’s study (2013), aspects of intersectional identity (such as gender identity and ethnic identity) were discussed separately, as opposed to reflections centring on Black masculinity or ‘being’ a Black man.

Participants told stories of their recovery journey that also included the meaning they had made of this. This usually started with reflections on the necessity to confront and address

painful pasts, in order to progress with self-improvement and ultimately, to discharge. Addressing this past seemed to be an emotional hotspot (Loots et al., 2013) as many participants spoke to the difficulty of addressing difficult life events, along with a deep regret for the time lost in services. However, by doing so, they were able to understand themselves better, develop new skills such as self-compassion and were able to see a more hopeful future. These reflections were consistent with Leamy et al.'s recovery journey framework (2011), along with reflections in the broader narrative of the positive influence of connectedness to supportive others, the transformational benefits of psychological therapy and overcoming stigma. However, some had apprehensions about not wanting to repeat the same cycle. As such, the context of a forensic hospital was also present in the narrative here.

Interestingly, the entries to each chapter generally happened spontaneously for most participants. The most prompts were offered when asking participants about their story of their relationship with their therapist. Though some participants did broach this topic independently, the reflections generally did not include any aspects of gender or ethnic identity differences, even when prompts for elaboration were provided. In fact, most participants seemed to dismiss the prompt, assuring the interviewer that this was not an issue in their therapy. This was an interesting pattern considering that reflections about identity featured in the narratives of 'Trying Psychology for the First Time' chapter. This was also surprising since reflections of this nature seemed at the forefront of the men's minds in the informal information sessions, as documented in the research reflective diary. Perhaps these reflections were more readily accessible with the presence of the EBE, who shared aspects of participants' ethnic and gender identity, along with lived experience of secure services, compared to within interviews with a female interviewer. As noted in the reflective diary, many participants commented on the interviewer being a woman, suggesting this was something they were mindful of.

Also absent from most narratives were reflections on whether the therapy met their cultural or identity needs, which was surprising given that existing literature had indicated difficulties in this area (Islam, 2015; Memon et al., 2016; Watson et al., 2019). This may raise the question of whether this mirrors a similar discomfort in addressing this topic in the therapy. As captured in the reflective diary, the interviewer noted some unexpected discomfort and apprehension when asking prompts relating to ethnic identity which was not present when posing questions on gender identity. This was due to fears and assumptions that ethnic identity may be more sensitive than gender identity. This may represent the reality of addressing and exploring areas of difference which could offer an explanation as to why this exploration might be avoided in therapy. It also raises queries about whether the men felt they could bring their full selves; perhaps the participants felt they had to sacrifice their cultural identity to 'fit' the therapy, as Jones et al., (2013) found in their study. Indeed, one participant chose not to bring experiences of racism due to uncertainty about whether his experience would be understood, and one participant struggled to communicate in the 'right' way, as he was used to communicating with slang.

Implications

Psychologists could consider ways to build relationships with SUs in an informal capacity to help psychologists establish an identity outside of the multidisciplinary team (MDT) and perhaps dispel preconceptions about being a "big wig". Such informal contact may involve spending more time on the wards.

Psychologists working in this setting may find it helpful to explore the influence of SUs' cultural, ethnic and gender identities on their relationship to help-seeking and engaging in the therapeutic process, particularly at the start of therapy. Though this may not feature in everyone's stories, creating a space for this might support the building of a foundation to discuss the therapeutic relationship, particularly matters of sameness or difference that might

be interrupting or neglected in the therapeutic process. This may also help clinicians to extend compassion and understanding if a SU is ambivalent about engaging with therapy, and to consider ways forward. Psychologists extending curiosity about cultural or religious references that are important to SUs may help them to tailor and personalise the therapy in line with their interests and beliefs, particularly in the early phases of therapy, when establishing a rapport.

Secure FMHS could also consider the impact of being detained due to forensic and mental health needs. As such, attention to destigmatising these two elements of SUs care may be beneficial. Whilst only one participant reflected on their experiences of group-based work, it may highlight the benefits of this for reducing shame, stigma and promoting connection to peers. Given this, and how positively participants responded to the EBE, an informal space where participants can connect with peers or EBEs may also support with reducing stigma and considering psychological therapy as an option.

Limitations and Future Directions

Whilst the interviewer was external to the service, the interviews were conducted in rooms on the ward that were often used for therapy. The interviewer was also escorted to the wards by a member of the inpatient psychology team. This may have positioned the interviewer as in alignment with the internal psychology team, thus impinging the freedom with which participants shared their stories. Furthermore, the knowledge that interviews were recorded, transcribed and that anonymised quotes would be included in this report could have further exacerbated feelings of 'caginess', mirroring the apprehensions about approaching psychological therapy and whether their disclosures could be used against them.

Participants were also selected by their MDTs on the eligibility criteria and whilst this was logistically appropriate, there may have been unconscious biases at play with who was deemed suitable to participate. Furthermore, convenience sampling was employed due to

time constraints. Purposive sampling may have ensured a more representative sample was obtained that captured the views of those who are at different stages in their care pathways, and those who may have chosen to disengage with therapy.

Loots et al. (2013) argue that a multitude of data collection methods are best suited to a RNA approach, in order to complement the multiple entryways principle. Due to the nature of this project, multiple interviews were not feasible, however this was compensated for by the maintenance of a research diary documenting field notes. Future research in this area may wish to employ different data collection methods alongside multiple interviews such as focus groups or reflective diaries for the participants.

The participants were also still active participants in forensic mental health systems. The stories told by Black men who have been discharged may differ and may not involve the same caution about whether shared information would harm their discharge pathways. Caution should be exercised when generalising the findings across other contexts regarding Black men as this study only sampled a small subset of the total number of Black men engaging with psychological interventions in forensic hospitals.

Finally, it may be beneficial to conduct some research with therapists in this setting to explore their comfortability with exploring matters pertaining to the role of hidden and visible aspects of identity and difference in therapy.

Conclusion

This study heard three stories that Black men tell about engaging with psychological therapy in a forensic hospital. These stories were: ‘trying psychological therapy for the first time’, ‘benefits of psychological therapy’ and their ‘recovery journey’. The findings highlighted the importance of attending to aspects of intersectional identity. Future research could focus on experiences of Black men who disengaged from psychological therapy or who have been discharged from forensic hospitals.

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Appendix A

CASP Checklist for Qualitative Studies

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Appendix B

Summary of CASP checklist

Study	Clear aims?	Qualitative method appropriate?	Research design appropriate?	Recruitment strategy appropriate?	Data collection appropriate?	Researcher and participant relationship considered?	Ethical issues considered?	Data analysis sufficient?	Clear findings?	Research valuable?
Hussain et al. (2020)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Simms-Sawyers et al. (2020)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Davies et al. (2019)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Bowden et al. (2017)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Ware et al. (2016)	Yes	Yes	Yes	Yes	Yes	Yes	Can't Tell	Yes	Yes	Yes
Lord et al. (2015)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Flinn et al. (2013)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Willmot & McMurran (2013)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Clarke et al. (2013)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Mason & Adler (2012)	Yes	Yes	Yes	Yes	Yes	No	Yes	Can't Tell	Yes	Yes
Ritchie et al. (2010)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Appendix C

Extract of a Coded Paper

This has been removed from the electronic copy

Appendix D

Table of Theme Progression

Initial themes	Secondary themes	Analytical themes
• Expected outcomes • Apprehensions • Power • Coercion • Stigma of being a man in therapy • Coercion • Secure environment • Relationship with the therapist • Emotional/vulnerable experience	• Apprehensions • Challenges of psychological therapy	Barriers to engagement
• Relationship with the therapist • Relationship with others/peers • Preparation/orientation • Person-centred care • Accessibility	• Connectedness • Meeting people where they are/at their level	Factors aiding engagement
• Self-understanding/insight • Skill development/coping strategies • Hopes for the future • Self-reflection • Address matters from the past • Improved view of self/self-esteem	• Self-improvement • Benefits of psychological therapy	Outcomes

Appendix E

Theme Contribution by Each Paper

	Barriers to Engagement					Facilitators to Engagement					Outcomes			
Study	Apprehensions	Challenges in the Therapeutic Relationship	Identity	"It's not a Choice, I Have to do it"	The Secure Environment	A Positive Alliance	"Sharing Experiences"	Orientation	Meeting People "on Their Level"	Involvement in Care	Therapy-Specific Skill Development	Improved Relationships	Self-Improvements	Hopes for the Future
Hussain et al. (2020)		X	X	X		X			X			X	X	
Simms-Sawyers et al. (2020)	X	X	X	X		X							X	X
Davies et al. (2019)							X		X		X	X	X	X
Bowden et al. (2017)	X	X	X	X	X	X		X	X				X	
Ware et al. (2016)	X			X	X		X			X	X	X	X	
Lord et al. (2015)		X	X	X	X	X	X	X	X	X			X	
Flinn et al. (2013)	X			X		X	X	X	X				X	X
Willmot & McMurran (2013)							X				X		X	X
Clarke et al. (2013)		X	X		X		X							
Mason & Adler (2012)	X			X	X			X		X				X
Ritchie et al. (2010)							X		X			X	X	

Appendix F

Participant Information Sheet

Faculty of Science, Engineering and Social Sciences
Canterbury Christ Church University

Date: 23.03.23
Version number: 9
IRAS Project ID: 319011
Ethics approval number: 23/LO/0175

Salomons Institute for Applied Psychology
One Meadow Road, Tunbridge Wells, Kent TN1 2YG
www.canterbury.ac.uk/appliedpsychology

Information about the research

Study title: An exploration of Black men's experiences of psychological therapy in forensic hospitals

Hello. My name is Simran Bains and I am a trainee clinical psychologist at Canterbury Christ Church University. I would like to invite you to take part in a research study which is being supervised by Dr Sharlene Akinyemi (Clinical Psychologist) and Professor Margie Callanan (Clinical Psychologist and Director of Salomons Institute for Applied Psychology).

Before you decide whether to take part, it is important that you understand why the research is being done and what it would involve for you.

You can talk to others about the study if you wish.
Part 1 tells you the purpose of this study and what will happen to you if you take part.
Part 2 gives you more detailed information about the conduct of the study.

What is the purpose of the study?
We recognise that Black men are overrepresented in forensic hospitals and so we are interested in exploring and understanding experience of this group in order to help with the development of culturally appropriate interventions and improving the clinical outcomes for this group in addressing this. We also know that engagement with psychological therapy is encouraged as part of your care in forensic hospitals but that many Black men have had either poor or no experiences of psychological therapy in community settings. Hence, the aim of the study is to understand the experience of Black men engaging with psychological therapy in these settings. We are particularly interested in exploring if your sense of identity affected your experience of psychological therapy. Identity means how you see yourself. Parts of your identity that may be important to you could include your background (ethnicity, where you grew up and

culture), being a man (your gender identity/masculinity) or your religion or spirituality. Your contributions can refer to your experiences of therapy in forensic hospitals other than where you currently reside, if applicable.

Why have I been invited?
I am inviting people who meet the criteria below to participate in the study:

- Individuals who identify as male
- All men who identify as Black, Black British, African, Caribbean or mixed Black heritage, irrespective of diagnosis or offence
- Those who have participated in a group or individual psychological therapeutic intervention for a minimum of three sessions, in a forensic hospital. This includes those who decided not to complete this
- Those with a risk assessment that specifies that the individual is safe for lone working
- Individuals who have been assessed as having capacity to consent to and participate in the research study.
- Those who are proficient with verbal English.

There will be 10 participants in total.

Do I have to take part?
Participation in the study is voluntary and will not affect the care and treatment you receive in hospital (positively or negatively), nor will it affect your legal rights. It is up to you to decide whether to join the study. If you agree to take part, I will ask you to sign a consent form. You can withdraw at any time up to one week after completing the interview, as anonymisation and transcription may have started by this point. Withdrawing from the study will not affect the standard of care you receive or your legal rights.

What will happen to me if I take part?
If you are interested in participating in the study, you can attend an informal session on the wards facilitated by myself and Ricardo. Ricardo is an expert by experience which means he has engaged with psychological therapy in a forensic setting before, so he knows what it is like. You will have the opportunity to ask any questions. If you decide you want to participate in the research, you will be asked to sign a written consent form.

I will then arrange a face-to-face interview with you, at a time that is convenient for you. The individual interview will last up to 90 minutes, but you can stop at any time. Comfort breaks will be offered if you ask for one or if I think it might help you to have one. I will ask you some questions about your experience of engaging with psychological therapy in forensic hospitals, focussing on how you see yourself (your identity). I will not investigate any information related to your background or offence(s). After the interview, your ward psychologist will check-in with you and offer you a debrief which you can accept or decline.

You feedback is valuable and we want to make sure that your contributions are captured accurately, which is why the interview will be audio recorded. This recording will help me to typed out your interview and analyse it. More information about how this recording is used and stored is included in Part 2. If, for any reason, you lose capacity to consent during the interview, your interview transcript will not be included in the study.

Expenses and payments

You will receive a £10 Amazon voucher following completion of the interview, as a thank you for your participation.

What will I be asked to do?

- Talk with me and/or the expert by experience consultant before the study to make sure you understand what is involved in the study and to ensure you are happy to participate.
- Participate in an interview that will last up to 90 minutes about your experiences of psychological therapy in a forensic hospital.

What are the possible disadvantages and risks of taking part?
This interview will take up some of your time, although we hope you will consider it a good use of your time. We recognise that talking about your past experiences of psychological therapy might bring up some emotions for you. We will try our best to make sure you feel comfortable, and you can stop the interview at any time. I can support you in the interview if you required.

What are the possible benefits of taking part?
The information you share will support psychologists to better understand the experience of psychological therapy for Black men in forensic hospitals. This will likely lead to improvements in the quality of therapy on offer and will ensure psychologists take into account the experience of Black men accessing therapeutic support in these settings.

What if there is a problem?
Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. The detailed information on this is given in Part 2.

Will information from or about me from taking part in the study be kept confidential?
Yes. The recording and transcription will be confidential and stored securely on a password protected Dictaphone and computer. Recordings will be deleted as soon as possible following transcription and data analysis. The anonymised transcripts will be stored in the Institute's office in a locked cabinet for 10 years and then destroyed. I will not include any identifiable information in the transcription of your interview or in the write up of the study. I may include anonymised, unidentifiable quotes from you interview in the write up of the study. You will be provided with a unique participation identification number and/or an alias which will be used on all of your documentation for the research.

Your anonymised transcript may be reviewed by the project supervisors, Dr Sharlene Akinyemi and Professor Margie Callanan, as well as regulatory authorities to monitor the quality of the research.

We will follow ethical and legal practice and all information about you will be handled in confidence. There are some rare situations in which information would have to be shared with others. The details are included in Part 2. Your care team at the hospital will know you are taking part in the study.

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

Part 2 of the information sheet

What will happen if I don't want to carry on with the study?
Your participation is voluntary and you can decide to withdraw from the interview at any time before or during the interview. You also have the right to withdraw your recording up to one week after completing the interview, as anonymisation and transcription may have started by this point. You do not have to provide a reason for your withdrawal and it will not affect your legal rights or the care and treatment you receive in hospital. After the interview, your ward psychologist will check-in with you and offer you a debrief which you can accept or decline.

Concerns and Complaints
If you have a concern about any aspect of this study, please ask to speak to me and I will do my best to address your concerns. You can contact me by leaving a message on the 24-hour voicemail phone number **[redacted].** Please leave a contact number and say that the message is for Simran Bains and I will get back to you as soon as possible. If you remain dissatisfied and wish to complain formally, you can do this by contacting Dr Fergal Jones, Clinical Psychology Programme Research Director, Salomons Institute for Applied Psychology [redacted]

If, through the process of participating in this study, you decide you are unhappy with an aspect of your care, you can speak to the Patient Advice Liasson Service (PALS) by calling **[redacted]** or emailing [redacted] Monday to Friday 9am to 5pm. You can find more information on the provided PALS sheet.

How will we use information about you?
We will need to use information from you and your inpatient care team for this research project. This information will include your initials, name and contact details. People will use this information to do the research or to check your records to make sure that the research is being done properly. People who do not need to know who you are will not be able to see your name or contact details. Your data will have a unique code number instead. We will keep all information about you safe and secure. Once we have finished the study we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study.

When might you share information about me?
The only time I would share information with your care team would be if, as a result of something you told me, I were to become concerned about your safety or the safety or someone else. If you become distressed in the interview, I will let your care team know. I will let you know beforehand if I intend to share this information with your team. In the event that concerns about a psychologist's practice are raised, this will be discussed with the project supervisors and addressed as appropriate. I will keep you informed about this process.

What are your choices about how your information is used?
You can stop being part of the study at any time, without giving a reason, but we will keep information about you that we already have. We need to manage your records in specific ways for the research to be reliable. This means that we won't be able to let you see or change the data we hold about you.

Where can you find out more information about how your information is used?
You can find out more about how we use your information at:

- www.hra.nhs.uk/information-about-patients/
- Our leaflet available from www.hra.nhs.uk/patientdatanadresearch
- By asking one of the research team

- By sending an email to Simran Bains at [redacted] Dr Fergal Jones, Clinical Psychology Programme Research Director, Salomons Institute for Applied Psychology [redacted]
- By ringing us on [redacted]. Please leave a contact number and say that the message is for Simran Bains and I will get back to you as soon as possible.

What will happen to the results of the research study?
An information sheet summarising the research findings will be provided to all participants, service users and staff in the hospital. We intend to publish the results in an academic journal. Anonymised quotes will be used from the interviews but no identifiable information will be published.

Who is sponsoring and funding the research?
Canterbury Christ Church University.

Who has reviewed the study?
All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by London Stanmore Research Ethics Committee.

Further information and contact details
If you would like more information about the research project, if you have any questions, or would like advice as to whether you should participate, you can email me at [redacted] or you can leave a message for me on a 24-hour voicemail phone line at [redacted]. Please leave a contact number and say that the message is for Simran Bains and I will get back to you as soon as possible.

If you have any concerns about the study, please do not hesitate to contact me using the information above. If you would like to complain formally, you can contact Dr Fergal Jones, Clinical Psychology Programme Research Director, Salomons Institute for Applied Psychology [redacted]

Each participant will be given a copy of this information sheet and a signed consent form to keep.

Appendix G

Easy-Read Participant Information Sheet

Salomons Institute for Applied Psychology
One Meadow Road, Tunbridge Wells, Kent TN1 2YG
www.canterbury.ac.uk/appliedpsychology

Date: 23.03.23
Version number: 5

Easy-Read Information About the Research

Study title: An exploration of Black men's experiences of psychological therapy in forensic hospitals

Hello. My name is Simran Bains and I am a Trainee Clinical Psychologist at Canterbury Christ Church University.

I would like to invite you to take part in a research study.

Who else is on the research team?

Project supervisor: Dr Sharlene Akinyemi (Clinical Psychologist)

Project supervisor: Professor Margie Callanan (Clinical Psychologist and Director of Salomons Institute for Applied Psychology)

Expert by experience consultant: Ricardo. Ricardo is an expert by experience which means he has engaged with psychological therapy in a forensic setting before, so he knows what it is like.

Why are you doing the study?

It is known that Black men are overrepresented in forensic hospitals.

It is also known that some Black men have either unsatisfactory or no experience of psychological therapy in the community but you are encouraged to engage with psychology as part of your care in hospital. So, we (the research team) are interested in better understanding what it is like to engage with psychology as a Black man in a forensic hospital.

We are most interested in exploring if your sense of identity has affected your experience of psychological therapy.

Identity means how you see yourself.

Parts of your identity that might be important to you could include:

- Your background (ethnicity, where you grew up and culture)
- Being a man (your gender identity/masculinity)
- Your religion or spirituality

Why have I been invited?

You have been invited to take part in the study if you are a Black, Black British, African, Caribbean or mixed Black heritage man.

There will be 10 participants in total.

Do I have to take part?

It is completely your choice whether you want to take part in the study or not.

Your decision will not affect your care and treatment in hospital and will not affect your legal rights.

Simran and Ricardo will be on the ward on **[redacted]**. This is a great chance to ask questions or find out more information about the study.

What will happen to me if I take part?

If you choose to take part, I will ask you to sign a consent form.

Simran will arrange a one-to-one interview with you, at a time that works for you.

The interview will last up to one and a half hours (90 minutes), but you can stop at any time. Comfort breaks will be offered if you ask for one or if I think it might help you to have one. A ward psychologist will check in with you after the interview and offer an informal debrief, if you would like one.

I will ask you some questions about your experiences of engaging with psychological therapy in forensic hospitals. The questions will focus on how you see yourself (your identity).

I will not find out any information related to your background or offence(s).

Your voice and story is important and I want to make sure I remember it properly.

To help me, I will audio record the interview. This recording will help me to type up and analyse the interview.

How will we use information about you?

We will need to use information from you and your inpatient care team for this research project. This information will include your initials, name and contact details. People will use this information to do the research or to check your records to make sure that the research is being done properly

People who do not need to know who you are will not be able to see your name or contact details. Your data will have a unique code number instead.

We will keep all information about you safe and secure. Once we have finished the study we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study.

Will my information be kept confidential?

All information collected during the interview will be anonymised kept strictly confidential.

The recording and transcription will be private and stored securely on a password protected Dictaphone and computer.

Recordings will be deleted as soon as possible following transcription and data analysis.

The anonymised transcripts will be stored in the Institute's office in a locked cabinet for 10 years and then destroyed.

I will not include any information that identifies you when I type up the interview or in the write up of the study.

I may use quotes from your interview in the write up of the study but these will not include any information that can identify you.

The anonymised transcripts may be reviewed by the project supervisors, Dr Sharlene Akinyemi and Professor Margie Callanan as well as regulatory authorities to monitor the quality of the research.

What are your choices about how your information is used?

You can stop being part of the study at any time, without giving a reason, but we will keep information about you that we already have. We need to manage your records in specific ways for the research to be reliable. This means that we won't be able to let you see or change the data we hold about you.

Where can you find out more information about how your information is used?

You can find out more about how we use your information at:

- www.hra.nhs.uk/information-about-patients/
- Our leaflet available from www.hra.nhs.uk/patientdatanadresearch
- By asking one of the research team
- By sending an email to Simran Bains at [redacted] or Dr Fergal Jones, Clinical Psychology Programme Research Director, Salomons Institute for Applied Psychology [redacted]
- By ringing us on [redacted]. Please leave a contact number and say that the message is for Simran Bains and I will get back to you as soon as possible.

When might you share information?

The only time I would share information with your care team is if I was worried about your safety or someone else's, or if you become really upset in the interview.

If I am worried about a psychologist you have worked with, I will discuss this with the project supervisors and we will take further action as needed.

I will always let you know if I plan to share information for these reasons.

Payment

You will receive a £10 Amazon voucher following completion of the interview, as a thank you for your participation.

What are the possible downsides of taking part?

The interview will take up some of your time but we hope find it a good use of your time.

Talking about your past experiences of psychological therapy might bring up some difficult feelings for you.

You can stop the interview at any time I can support you in the interview if needed.

I will let your care team know if you become really upset in the interview and I will let you know before I do this.

What are the possible benefits of taking part?

Your story can help psychologists to better understand what it is like to engage with psychological therapy as a Black man in a forensic hospital.

This will likely improve the quality of therapy.

Complaints if there is a problem

If you are worried about any part of the study, please speak to me and I will do my best to help with this.

You can contact me by leaving a message on the 24-hour voicemail phone number **01227 927070.**

Please leave a contact number and say that the message is for Simran Bains. I will get back to you as soon as I can.

If you still feel unhappy, you can complain formally by emailing Dr Fergal Jones (Clinical Psychology Programme Research Director at the Salomon's Institute for Applied Psychology): fegal.jones@canterbury.ac.uk

If you decide you are unhappy with an aspect of your care, you can speak to the Patient Advice and Liason service by calling **[redacted]** or emailing [redacted] Monday to Friday 9am to 5pm.

You can find more information on the provided PALS sheet.

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

You can stop the interview at any time.

If you change your mind about taking part in the study, you can ask us not to include your interview up to one week after your interview.

This is because I may have started to write up and analyse your interview by that point.

What will happen to the results of the study?

All participants, service users and staff will be given a summary of the results of the study.

We intend to publish the results in an academic journal.

Quotes will be used from the interviews but no identifiable information will be published (they will be anonymous).

Who is funding the research?
Canterbury Christ Church University.

Who has reviewed the study?
London Stanmore Trust Research Ethics Committee. This committee looks over the research to make sure your interests are protected.

Appendix H

Easy-Read Reserve List Sheet

Salomons Institute for Applied Psychology
One Meadow Road, Tunbridge Wells, Kent, TN1 2YG
www.canterbury.ac.uk/appliedpsychology

Date: 22.06.23
Version number: 1

Easy-Read Information About Interview Reserve List
Study Title: An exploration of Black men's experiences of psychological therapy in forensic hospitals

Thank you for expressing your interest in this research project.

Lots of people were interested in taking part.

Unfortunately, we can only interview 10 people so we have chosen to interview those who have had more experiences of psychological therapy.

We can add your name to a reserve list. This means that if anyone drops out of the research or cannot take part in the interview, we will invite someone from the reserve list to take part instead.

When the study is finished, we would like to share the results with you and find out what you think.

A member of the research team will hold a workshop at the hospital to feedback on the results and provide a space for discussion. You will be invited to attend.

You can choose if you would like to take part in the results workshops.

Appendix I

Interview Schedule

Introductory questions

The interview will begin with some introductory questions to ease the participant into the interview and collect demographic information. These questions will include:

- What is your age?
- How long have you been in secure services?
- What is your leave status?
- What goals are you currently working on independently or with your team?
- How long have you been at this hospital?
- What is your understanding of psychological therapy?
- What therapy have you engaged with in this hospital and other hospitals?
- Did you complete this psychological therapy? If not, how many sessions did you attend?
- Have you accessed psychological therapy before? If so, how did you find this? If not, why do you think that was?

Interview questions

Please tell me your story of your experience of engaging with psychological therapy in a forensic hospital.

Topic area prompts:

- Context
    - Please me your story of receiving psychological therapy in a forensic hospital.
- Ethnic and gender identity
    - Tell me more about your masculinity/being a man/your experience of identifying as Black and receiving psychological therapy in a forensic hospital
    - Tell me your story about being a Black man and receiving psychological therapy in a forensic hospital
    - Tell me your story about your background (where you grew up/your culture/your religion) and receiving psychological therapy in a forensic hospital
- Relationship with therapist
    - Tell me the story of your relationship with your therapist
    - Tell me your story of being a Black man in your therapeutic relationship with your (White female?) therapist
- Meaning making/sense making of recovery journey
    - Tell me the story of your recovery journey
    - Tell me your story of being a Black man and recovering in a forensic hospital

Appendix J

Coded Transcript

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Appendix K

Table of Chapter Progression

Initial themes	Secondary themes	Analytical themes
• Novel experience • Preconceptions/Scepticism • Stigma of mental health/engaging with therapy • Masculinity • Cultural conceptualisations of mental health • Cultural coping mechanisms • Coercion • Autonomy/involvement in care • Relationship/trust in MDT • Psychology as an option • Deciding to engage • Identity	• New experience • Stigma • Deciding to engage	Trying psychological therapy for the first time
• Development of coping strategies/skill development • Therapeutic relationship • Unexpected benefits • Supportive relationships with others • Normalising/destigmatising • Self-understanding	• Connectedness • Self-improvement	Impact of psychological therapy
• Challenges of confronting the past • Hopes for the future • Worries for the future • Symptom recovery • Temporal narratives of recovery	• Challenges in recovery journeys • Benefits in recovery journeys	Recovery journey

Appendix L

Abridged Research Diary

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Appendix M

Consent Form

Date: 23.03.23
Version number: 4
IRAS project ID: 319011

Salomons Institute for Applied Psychology
One Meadow Road, Tunbridge Wells, Kent TN1 2YG

Ethics approval number: 23/LO/0175
Participant Identification number for this study:

CONSENT FORM

Proposed Title of Project: An exploration of Black men's experiences of psychological therapy in forensic hospitals
Name of Researcher: Simran Bains

Please initial box

1. I confirm that I have read and understand the information sheet dated 23.03.23 version 9 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time up to one week after the interview, without giving any reason, without my care and treatment or legal rights being affected. ☐

3. I understand that data collected during the study may be looked at by the project supervisors, Dr Sharlene Akinyemi and Professor Margie Callanan. I give permission for these individuals to have access to my anonymised interview transcript. ☐

4. I agree to the audio of my interview being recorded on an encrypted Dictaphone. ☐

5. I agree that anonymous, unidentifiable quotes from my interview and other anonymous data may be used in published reports of the study findings. ☐

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

7. I understand that I will have a copy of my signed consent form, that the researchers will have a copy for the study and that my care team will receive a copy for my notes. ☐

Participant Name:	Signature:	Date:
Name of person taking consent:	Signature:	Date:

Appendix N

Ethical Approval

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Appendix O

Anonymised Trust Research and Development Approval

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Appendix P

End of Study Report to Ethics Committee

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Appendix Q

Author Guideline Notes for Chosen Journal

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Appendix R

Easy-Read Feedback about the Research

To be circulated to participants on 05.07.24, as a feedback presentation to the Trust will also be delivered on this date.

Salomons Institute for Applied Psychology
One Meadow Road, Tunbridge Wells, Kent TN1 2YG
www.canterbury.ac.uk/appliedpsychology

Date: 15.04.24
Version number: 1

Easy-Read Feedback about the Research

Study title: An exploration of Black men's experiences of psychological therapy in forensic hospitals

Last year, I interviewed 10 Black men about their experiences of psychological therapy in forensic hospitals.

This information sheet will share what we learned from those interviews

Trying psychology for the first time

Everyone I spoke to said their first time trying psychological therapy was in a secure service.

This made people feel nervous about what was okay to share with their psychologist and whether they could trust them.

Some people shared that engaging with psychological therapy made them feel not normal and that it did not match their ideas of what a man is or how a man copes.

They also spoke about how struggling with mental health feels taboo.

Some men were not sure if psychological therapy was for them.

They told me about how they grew up with the idea that religion and church is a way to get help for difficulties. Psychological therapy did not feel like an option until they came to hospital.

Some men decided to try psychological therapy because they felt they had to.

Others felt that it was recommended for a reason so decided to try it as they trusted their care teams.

Impact of psychology

Everyone said psychological therapy had helped them with something. This surprised some people who did not expect this.

Most people said they understood themselves better.

Some people felt they connected well with their therapist or peers in therapy groups. Others were not sure if they could connect fully with their psychologist or if their psychologist would understand all of their experiences like racism.

Recovery journey

Some men told me psychological therapy was challenging because they had to talk about painful past experiences that led to them being in hospital.

Some men were hopeful about their futures after discharge. Others were worried about repeating the same mistakes that led them into hospital.

Recommendations

We think psychologists could explore different parts of people's identity (like being a man, being a Black man) when working with Black men in forensic hospitals, to see if it affects starting psychological therapy.

We also think psychologists could personalise therapy by including religious or cultural references that are important to the people they work with.

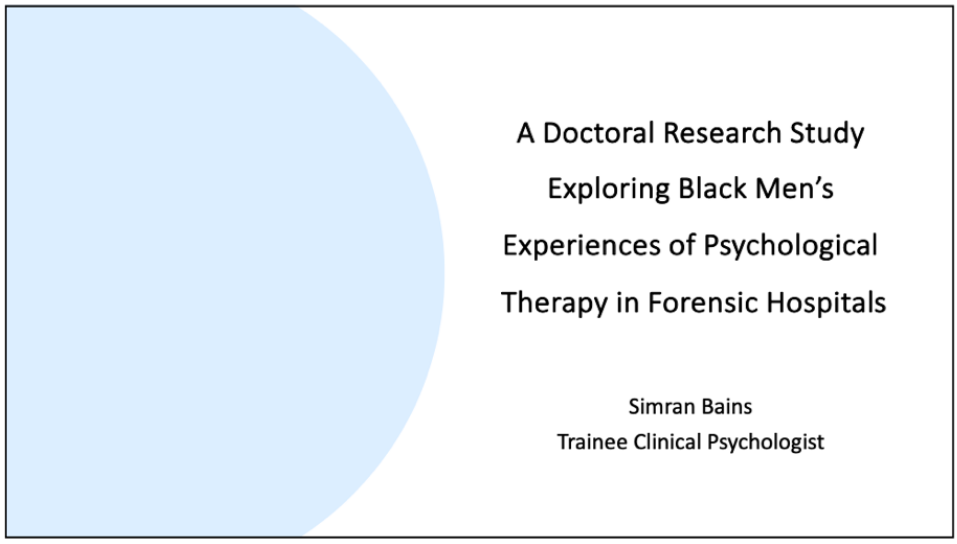
We thought about ways psychologists could help make mental health and psychological therapy feel less taboo. Group work seemed helpful but so did talking to someone who had been through the system already.

Thank you to everyone who took the time to share their story with me!

Appendix S

Slides from the Feedback Presentation to the Trust

To be delivered to the Trust on 05.07.24.



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Agenda

- Background
- Aims
- Method
- Results
- Conclusions
- Reflections
- Implications
- Limitations
- Breakout Rooms

3

Background

- Inequalities in mental health outcomes for People of the Global Majority (PoGM)
- Disparities in outcomes for Black men in secure services
- Paucity of research in inpatient settings
- Existing research focusses on PoGM experiences or men's experiences
  - Fails to capture unique experiences of Black men considering their intersectional identity (ethnic identity and gender identity) and how this relates to engagement in psychological therapy
- Consideration of the context of a forensic hospital
  - Dual role of psychologists
  - Circles of fear

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Aim

To explore what stories Black men tell about engaging with psychological therapy in forensic hospitals.

- Does the **context** in which they are offered therapy (forensic hospital) feature in the narrative? If so, how?
- Do aspects of Black men's **identity** feature in the narrative? If so, how?
- Do the narratives depict how the men made sense of their **recovery journey**?

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Method

1

Eligible participants identified by their care teams.

Inclusion criteria presented on the next slide

2

Prospective participants invited to attend informal information sessions on the ward facilitated by Ricardo and Simran

3

Interest was higher than anticipated so the inclusion criteria was refined. 10 men were interviewed and 3 were placed on a waitlist.

Interviews were recorded, transcribed and analysed using narrative analysis

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Inclusion Criteria

- Identify as male
- Identify as Black, Black British, African, Caribbean or mixed Black heritage
- Participated in a group or 1:1 psychological therapeutic intervention
- Minimum of 3 psychology therapy sessions in a forensic hospital
- Includes those who withdrew from the intervention
- Risk assessment - safe for lone working
- Capacity to consent and participate
- Proficient with verbal English
- Those most able to tolerate and engage with an interview

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Participants

Participant characteristics	Number of participants
Total number of participants	10
Age in years	
25-34	4
35-44	4
45-54	2
Ethnicity	
Black	1
Black African	3
Black British	3
Black Caribbean	2
Mixed White and Black Caribbean	1
Psychological Intervention History	
Individual sessions	7
Group therapy	9
Psychological Intervention Focus	
Offence/risk focussed work	7
Coping Skills	8
Other	7

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Results

Trying psychological therapy for the first time

- 'Cagey' voice
- Voice of 'not being normal'
- 'Is psychology for me?' voice
- Decisive voice

The impact of psychology

- Voice of self-improvement
- 'Surprised' voice
- Voice of connection

Recovery journey

- Voice of a painful past
- Worried voice
- Hopeful voice

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Trying psychological therapy for the first time: 'Cagey' Voice

"just another big wig…just gonna try and erm…put me in a box…label me…it would mean that I'm just a statistic"

Fearing they would "incriminate" themselves and therefore "spiral…downwards into the mental health services and dim my chances at freedom"

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Trying psychological therapy for the first time: Voice of 'not being normal'

"To do psychology, you have to not be normal…I feel like it's a bit of a taboo"

A felt sense they would be viewed as "weak" if they were to "talk to someone about problems"

"For a man to go through the mental health people look at like, 'what's he really got to complain about? Kind of thing. Yeah or they say 'man up'"

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Trying psychological therapy for the first time: 'Is psychology for me?' Voice

"Black people need church and White people need therapy"

"Like someone working class might need to go to church more 'cause they can't afford therapy"

Therapy was "not something Black men find themselves doing" as it conflicted with cultural understandings about mental health

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Trying psychological therapy for the first time: Decisive Voice

"I would say it's mandatory. If I didn't do it then I wouldn't be able to get like, to be working towards discharge"

"You either work with them or you're against them and if you work with them then you will see results"

"I was thinking that it was part of my treatment being in hospital so even though I never done it before, I think that it must be something good"

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Impact of psychological therapy: Voice of self-improvement

"I really enjoyed them. I felt like a weight was lifted off my shoulders"

"It's just helpful to get answers or understanding"

"That compassion enable us to forgive ourselves and also forgive our fellow human being"

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Impact of psychological therapy: 'Surprised' voice

"In the beginning you just want to get on with it but then again in the middle of a couple session you seem to try to find out more about yourself"

"Before, I wouldn't have thought that I would have needed or would benefit from psychology but it's really good"

"psychology said to me what I was feeling was real because the musician has say those words in their song and it was surprising to me. [they talk to me about rap, something I get"

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Impact of psychological therapy: Voice of Connection

"We builded a bond, like I can trust [them]"

"I don't know where I could touch base with racism with my psychologist team so I feel like it's one of them things that I better off leave unsaid"

"Well, I'm the patient, they're the psychologist"

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Recovery Journey: Voice of a painful past

"It can be difficult because of what you're talking about…'cause you want to hide things you don't want to express"

"It's tough because you finish the psychology and then you leave the room and you're left on your own"

"Talking about your index offence is something very difficult and painful but what makes it easier is the person opposite you"

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Recovery Journey: Worried Voice

"This isn't real life, this isn't the real test. I've been out in the community before and got recall"

"I don't just want to be stuck in the system…in and out of hospital all my life"

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Recovery Journey: Hopeful Voice

"It just makes me think there's more to life than just doing drugs, crime, going to hospital, going to prison and coming back out"

"The work I was doing actually was giving me that hope where I'm able to talk to people when I'm angry"

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Conclusions

Aim: To explore what stories Black men tell about engaging with psychological therapy in forensic hospitals.

- Does the **context** in which they are offered therapy (forensic hospital) feature in the narrative? Yes, mainly in stories about approaching psychological therapy for the first time, but also in the recovery journey.
- Do aspects of Black men's **identity** feature in the narrative? If so, how? Yes but predominantly in stories about approaching psychological therapy for the first time.
- Do the narratives depict how the participants made sense of their **recovery journey**? Yes, depicting the necessity to confront painful pasts in order to reap self-improvement benefits and to progress to discharge.

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Reflections

- Apprehension when posing questions centering on ethnic identity
- Difference in narratives in the informal information sessions vs. interviews
  - Aspects of identity that felt most salient and therapist/interviewer fit
  - 'Cagey' voice and fears of 'consequences' of less favorable views
- Experience of completing research in a forensic service

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Implications

- Building informal relationships outside of MDT - rapport
- Explore influence of service users' cultural, ethnic and gender identities (Social Graces) on their relationship to help-seeking/engaging with therapy
- Consider relevant adaptations to therapy e.g. including religious or cultural references that are important to Black men
- Consider what types of interventions are offered e.g. narrative, life story or past-orientated work based on the Voice of a Painful Past
- Consider interventions/strategies to destigmatise mental health and detention e.g. peer support or contact with EBEs

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Limitations

- Interviewer may have been positioned as part of psychology team by participants which may have influenced what stories were told
- Narratives may be different from Black men who are no longer detained in hospitals
- Possible biases at play re: who was selected for interviews
- Purposive sampling could have ensured a more representative participant pool (including advertising on all wards)
- Barrier to EBE involvement

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Breakout Rooms

- How will this research shift how you deliver therapy to Black men?
- What ideas do you have about engaging Black men in therapy/research given the barriers to engagement (e.g. cagey voice)
- How could we make better use of EBEs?

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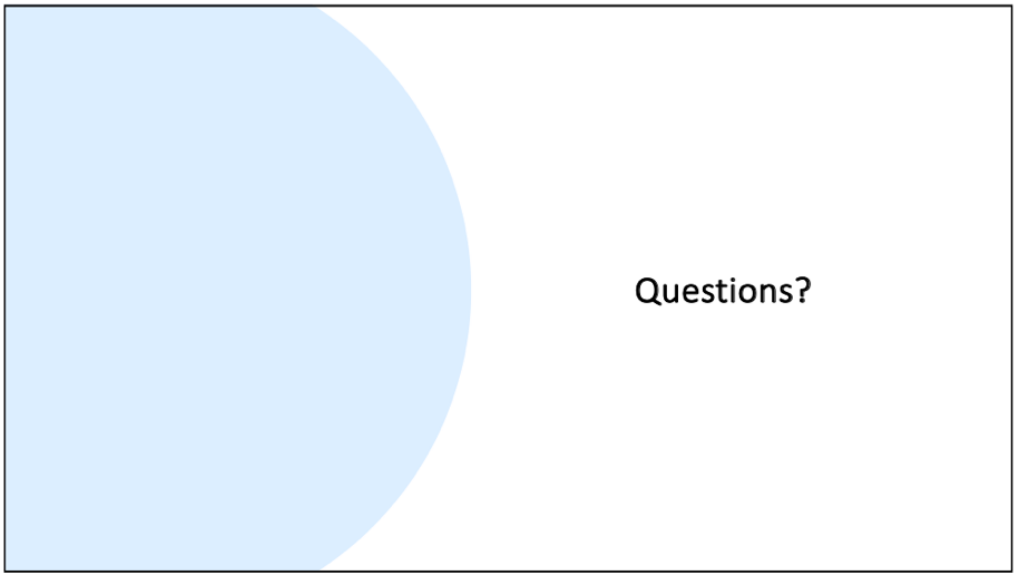

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