



CREATE

Canterbury Research and Theses Environment

Canterbury Christ Church University's repository of research outputs

<http://create.canterbury.ac.uk>

Copyright © and Moral Rights for this thesis are retained by the author and/or other copyright owners. A copy can be downloaded for personal non-commercial research or study, without prior permission or charge. This thesis cannot be reproduced or quoted extensively from without first obtaining permission in writing from the copyright holder/s. The content must not be changed in any way or sold commercially in any format or medium without the formal permission of the copyright holders.

When referring to this work, full bibliographic details including the author, title, awarding institution and date of the thesis must be given e.g. King, Richard S. (2015) Forensic care needs of women diagnosed with a personality disorder. D.Clin.Psych. thesis, Canterbury Christ Church University.

Contact: create.library@canterbury.ac.uk



Richard Simon King BSc (Hons) PGDip MSc

FORENSIC CARE NEEDS OF WOMEN DIAGNOSED WITH A PERSONALITY
DISORDER

Section A: The Relational Needs of Women in Forensic Inpatient Care who Attract a
Personality Disorder Diagnosis

Word Count: 8,000 (1,198)

Section B: Peer Relationships of Women with a Diagnosis of Borderline Personality
Disorder in Forensic Care

Word Count: 7,990 (1,200)

Overall Word Count: 15, 990(2,398)

A thesis submitted in partial fulfilment of the requirements of
Canterbury Christ Church University for the degree of
Doctor of Clinical Psychology

March 2015
SALOMONS,
CANTERBURY CHRIST CHURCH UNIVERSITY

Acknowledgements

Firstly, I wish to thank my wife Lara for her huge help and sacrifice in keeping the family going during my training and in supporting me through this project. My son Ned has taught me how to approach life and my daughter Iris has radiated serenity and they both constantly rejuvenate my spirit.

I would like to thank my research participants who showed great enthusiasm for the study and gave freely of their time.

I wish to thank my supervisor John McGowan for his advice and encouragement throughout the project and to Laura Pipon-Young for all her help and support which made this as such an interesting study to undertake. Also I wish to thank Dr Clare Mechergui for her great help with recruitment and to Catherine Watts for consultation and support throughout the research.

Summary of MRP Portfolio

Forensic Care Needs of Women Diagnosed with a Personality Disorder

Section A is a systematic literature review that seeks to identify the relational needs of women diagnosed with Personality Disorder (PD) in forensic care and how well these needs are met. Women in forensic care tend to have experienced high levels of adversity during their childhood including abuse and also social inequality due to their gender. This background is frequently associated with women who receive a diagnosis of personality disorder. There is a higher prevalence of this diagnosis for women in forensic care compared to men. PDs are characterised by interpersonal dysfunction and emotional regulatory problems. Such women's needs and recovery are therefore more likely to be focused upon relational needs. Forensic services historically were designed around the needs of men. However, more recently the relational needs of women have become highlighted in national policy. This review has the aim of identifying the relational difficulties and needs these women face with both care staff and their peers and how this relates to their recovery.

Section B is an empirical paper, "Peer relationships of women with Borderline Personality Disorder (BPD) in forensic care" and provides an account of a grounded theory study which entailed interviews with women who had received a diagnosis of borderline personality disorder and been residents in inpatient forensic care. The emergent theoretical model described modes of existing within the ward that may be focused upon survival, or towards deeper relating with one's peers that has the potential to either maintain relational problems or facilitate recovery

Section C provides supplementary information in the appendices, some of which are not referred to in the text but are described in the contents list.

Contents

Section A

The Relational Needs of Women in Forensic Inpatient Care Who Attract a Personality Disorder Diagnosis

	Page
1. Abstract.....	2
2. Introduction.....	3
2.1 Routes Leading to Forensic Care.....	3
2.2 Survivors of Developmental Adversity Pathologised by Medical Categorisation.....	4
2.3 Attachment.....	5
2.4. Characteristic Relational Difficulties and Treatment Needs.....	6
3. Purpose of the Literature Review.....	8
3.1. Rationale.....	8
3.2. Aim of the Literature Review.....	9
4. Methodology.....	9
4.1. The Literature Search.....	9
4.2. Method for Critiquing the Literature.....	10
5. Results of the Literature Search.....	11
6. The Literature Review.....	13
6.1. Relational Problems Faced in Forensic Care by Women with a PD Diagnosis.....	13
6.1.1. Managing Separations.....	14

6.1.2.	The Impact of the Forensic Environment.....	17
6.1.3.	Difficulties Within Peer Relationships.....	19
6.1.4.	Expressions of Distress Through Violence and Self-harm.....	22
6.1.5.	Barriers to Therapeutic Relationships with Staff.....	26
6.1.6.	The Significance of the Range of Relational Problems.....	28
6.2.	Relational Needs of Women in Forensic Care.....	30
6.2.1.	The Most Significant Relational Qualities of Forensic Wards.....	30
6.2.2.	Meeting Women's Relational Needs.....	32
6.2.3.	Reflections on the Empirical Studies of Women's Relational Needs.....	34
6.3.	The Therapeutic Nature of Relationships.....	35
6.3.1.	How Relationships Help with Making Positive Change.....	36
6.3.2.	The Forensic Recovery Model and Significance of Relationships...	37
6.3.3.	Reflections on the Therapeutic Potential of Relationships.....	40
6.4.	Overall Discussion of the Review in Relation to Broader Theory...	41
6.5.	Limitations of the Research.....	44
6.6.	Conclusion.....	45
6.7.	Implications for Future Research.....	45
	References.....	46
	Figure 1: Results of the Literature Search.....	11

Section B

Peer Relationships of Women with a Diagnosis of Borderline Personality Disorder in Forensic Care

	Page
1. Abstract.....	2
2. Introduction.....	3
2.1. Forensic Care.....	3
2.2. Women's Relational Needs.....	3
2.3. Diagnostic Labels.....	4
2.4. Attachment.....	5
2.5. Forensic Admission.....	5
2.6. Peer Relationships.....	6
2.7. Peer Relationships and Recovery.....	7
2.8. The Value of Group Treatment Settings.....	7
2.9. Rationale.....	9
2.10. Aim of the Research.....	10
3.0 Method.....	11
3.1. Participants.....	11
3.2. Sampling Strategy.....	12
3.3. Ethics.....	13
3.4. Design.....	13

3.5.	Materials.....	15
3.6.	Procedure.....	16
3.7.	Data Analysis.....	17
3.8.	Quality Assurance.....	18
4.0	Results.....	20
4.1.	Overview of the Model	20
4.2.	Interactions That Set the Functioning Mode for Interpersonal Behaviour.....	22
4.2.1.	The Ward Conditions.....	22
4.2.2.	Personal Conditions.....	23
4.2.3.	Experiences with Peers in Other Contexts.....	24
4.3.	The Surviving Mode.....	25
4.3.1.	Getting On With Each Other.....	25
4.3.2.	Domesticating the Social Environment.....	26
4.4.	The Relating Mode.....	27
4.4.1.	Connecting With Peers.....	28
4.4.2.	Attempting to Receive Help and Support From Peers.....	31
4.4.3.	Supporting and Helping Peers.....	34
4.5.	Recovery Developing Through Peer Relationships.....	36
5.0.	Discussion.....	40
5.1.	The Significance of Women's Peer Relationships in Forensic Care	40
5.2.	Interpersonal Difficulties and Coping Strategies.....	41

5.3.	Recovery Through Peer Relationships.....	43
5.4.	Methodological Quality and Research Limitations.....	45
5.5.	Future Research.....	48
5.6	Clinical Implications.....	49
6.	Conclusion.....	50
	References.....	51
Figure 1. Peer Relationships of Women with Borderline		21
Personality Disorder in Forensic Care and the Implications for		
Recovery.....		

	Page
Section C:	
Appendices	
Appendix 1: Literature Search Methodology.....	2
Appendix 2: Summary of Studies.....	5
Appendix 3: Participant Demographic Data.....	15
Appendix 4: NHS Ethics Approval Letter.....	19
Appendix 5: Research and Development Department Approval Letter.....	23
Appendix 6: Research Advert.....	25
Appendix 7: Participant Information Sheet.....	26
Appendix 8: Participant Consent Form.....	31
Appendix 9: Information to Care Co-ordinators.....	33
Appendix 10: Protocol for use of Dictaphone.....	35
Appendix 11: Confidentiality Form For Transcriber.....	37
Appendix 12: Interview Schedule.....	39
Appendix 13: Interview Transcript.....	42
Appendix 14: Grounded Theory Main Categories, Sub-categories, Focused Codes and additional coded data examples...	59

Appendix 15: Participant Feedback Form.....	84
Appendix 16: Summary of Participant Feedback.....	91
Appendix 17: Research Diary.....	92
Appendix 18: End of study Summary report to NHS Panel	100
Appendix 19: Journal Submission Guidelines for Publication....	102

Richard King BSc (Hons)PGDip MSc

MAJOR RESEARCH PROJECT

SECTION A : THE LITERATURE REVIEW

The Relational Needs of Women in Forensic Inpatient Care who Attract a Personality
Disorder Diagnosis

Word Count: 8,000 (1,198)

May 2014

SALOMONS

CANTERBURY CHRIST CHURCH UNIVERSITY

1. Abstract

Women's forensic wards were established to improve safety and to better meet the specific care needs of women (Parry-Crooke & Stafford, 2009). Until recently, forensic services were designed largely around men's needs (Long & Dolley, 2012) despite women being likely to have different needs due to differing offence profiles, and women being more likely to have received a Personality Disorder (PD) diagnosis and be victims of abuse (Long & Dolley, 2012). To understand their forensic needs requires an understanding of consequences of their difficulties and social histories. This systematic review sought to develop an understanding the relational needs of women with a PD diagnosis in forensic inpatient care. The findings identified difficulties for women with managing separations, re-traumatising environments and in relationships with staff and peers. These problems were compounded by women feeling stigmatised by staff and fearful of their peers. Women's violence was associated with particular types of interpersonal difficulty and relational distress and violence was itself used for a great range of functions. By contrast, positive relationships with staff could lead to a more secure relational style and cohesion with peers could aid emotional management. The review highlights the significance of relationships for this group of women in their recovery in forensic care. It also reveals a continued need for longitudinal research to better understand the function of women's relational behaviour and to consider the ways their experiences of peer relationships affect their forensic recovery trajectory.

Keywords: social milieu, forensic, personality disorder

2. Introduction

This systematic literature review examined the relational needs of women in forensic inpatient care who have attracted a diagnosis of Personality Disorder (PD). This group of women typically have high rates of childhood abuse and have experienced both social and gender inequality. The term “personality disorder” is applied to people with a range of difficulties but is characterised by impairments of identity, sense of self, unstable relationships, poor impulse control and fear of abandonment (American Psychiatric Association, 2013). Therefore, it is particularly important to understand the specific relational difficulties women who have received this diagnosis face when in forensic care, how well their relational needs are met, and the significance of relationships upon recovery.

2.1. Routes Leading to Forensic Services

Women represent the minority of forensic inpatients, with estimates between 10-15% of the forensic population (Long & Dolley, 2012). Significant gender differences have been identified in the presentation of offending profile, pathways into services, social profiles and psychopathology (Sarkar & di Lustro, 2011). Whilst men were more likely to have committed a violent crime, such incidences were very low for women. Women tended to have committed fewer crimes and these were mainly associated with poverty or were drugs-related offences. The lower severity of women’s violent attacks led to calls that women were being placed in too high a level of security and containment in services that were designed primarily around men’s offending profiles (Long, Fulton & Hollin, 2008).

2.2. Survivors of Developmental Adversity Pathologised by Medical Categorisation

Dolan and Whitworth (2013) reported that in contrast to men, over half of the women in forensic care had a history of childhood sexual abuse which was particularly prevalent for those women who attracted a PD diagnosis (Keulen-de-Vos et al, 2011). Parry-Crooke and Stafford (2009) have advised that women in forensic care are best understood as survivors of abuse but Aitken et al, (2010) explained that women's resultant needs were poorly met by services.

The medical diagnosis of PD has been heavily criticised, including the disproportionate level of women receiving the diagnosis of Borderline Personality Disorder (BPD) (Lester, 2013), which included those in the forensic population (Sarkar & di Lustro, 2011). Brendel (2002) argued that the use of the medical diagnosis has pathologised and blamed women for their response to adversity and that psychiatric diagnosis does not capture the person's context, experiences or adaptive practices. Moreover, these behaviours and relational style are understandable and adaptive in the face of the invalidating and abusive social circumstances that shaped their lives where few opportunities for coping with adversity were open to them (Lester, 2013). King (2014) believed that in addition to the blaming nature of the diagnosis, stigma and prejudice towards those women who attract a PD diagnosis was ingrained within mental health services and affected how they were treated and impacted upon their self-worth. Forensic admission itself can be stigmatising (Jeffcote & Travers, 2004) and whilst likely to involve complex dynamics between women, their care staff and their peers. Verhaeghe, Bracke and Bruynooghe (2008) argued that such dynamics were poorly understood.

2.3. Attachment

Attachment theory offers an understanding of how an individual's cognitive and emotional response within relationships is largely determined by their developmental experiences. This theory describes the affective interpersonal relationships which first develop from birth in the early primary care relationships (Jeffcote & Travers, 2004). The degree to which a child has their needs for support and safety adequately and consistently met guides the development of their attachment style and their expectations of the availability and quality of future care. Pfafflin and Adshead (2003) explained how this then guides care-seeking behaviour especially in times of threat and continues to guide social functioning throughout life. The degree to which the child experiences their thoughts and feelings being contained and fed back to them by their carer also influences their social and emotional development (Mikulincer & Shaver, 2007). If 'care' has been abusive development will be impaired and as adults their relationships with others will be likely to trigger threat and intense difficult to control states of arousal (Blatt and Levy, 2003).

Meyer and Pilkonis (2005) found that people who attracted a PD diagnosis had attachment strategies that impaired emotional regulation, sense of self, developmental trajectory and maintenance of relationships. Relational behaviour for this clinical group has been characterised by approach-avoidance social dynamics and sensitivity to rejection (Lorenzini & Fonagy, 2013). Problems interpreting social relationships together with high arousal can lead to a tendency for cycles of angry withdrawal then compulsive care-seeking.

The attachment model has been increasingly applied to forensic settings to better understand staff-patient relationships (Rich, 2006). Admission to a forensic ward

causes sudden separations and the need to form new relationships with care staff. This is likely to activate powerful attachment anxiety as offers of care from staff are likely to be met with fear based upon previous experiences of abusive care (Pfafflin & Adshead, 2003).

2.4. Characteristic Relational Difficulties and Treatment Needs

Whilst the medical concept of PD is problematic those who receive the diagnosis tend to share common interpersonal difficulties. Social difficulties are characterised by intense relationships that swing between idealisation and fear of abandonment, belief that the social environment is malevolent and that they themselves are vulnerable and inherently unacceptable to others (Gunderson, 2007). Such beliefs are understandable in relation to their adverse developmental experiences (Stepp, Hallquist, Morse & Pilkonis, 2011).

Based upon this clinical group's characteristic personal histories and relational difficulties then a relational focus is vital, but Parry-Crooke and Stafford (2009) explained that historically mental health services have failed to understand and meet the relational needs of women. Kaplan and Surrey (1984) argued that women's relational needs are more significant to their health and wellbeing than for men. They contended that men's normative development leads to individuated lives whereas women live largely in reference to their various relationships with their sense of self being organised around maintaining affiliations and relationships. However, for women admitted to secure services their developmental experiences are likely to have excluded them from normative relational development.

Mainstreaming Gender and Women's Mental Health (The Department of Health, DoH, 2003) was produced to address gender social inequalities and produce services sensitive to women's needs. It provided specific guidance for developing forensic services for women, including women-only wards to provide both a safer environment and a focus upon meeting their relational needs. Nedderman, Underwood, and Hardy (2010) concluded that as women are intrinsically more motivated to connect with others, and in connection develop a sense of self and self-worth, then a relational focus to treatment is central. They explained that for women who have known significant disconnection, isolation, and marginalisation then restored interpersonal functioning also provides the foundation for hope.

The National Mental Health Implementation Unit (NMHIU, 2010) emphasised that women's relational needs had been overlooked and women required a high level of relational security and an opportunity to heal and recover from severe abuse and trauma and to empower and to maintain and develop social networks, particularly with children and family. However, this may be hard to achieve as forensic admission is associated with separations from family, powerlessness and close observation which could unwittingly be re-traumatising (DoH, 2003). Parry-Crooke and Stafford (2009) explained that forensic environments needed to change to meet women's relational needs and they placed an emphasis on relational security with staff and the development of a sense of peer community. However, Long, Fulton and Hollin (2008) concluded there was actually little known about women's forensic relational needs. Long Dolley and Hollin (2011) found that despite much service planning being based on assumptions of forensic gender differences there had been little gender analysis. They concluded that this clinical group of women had specific needs due to their inter-personal histories but there had been little empirical evidence to guide interventions.

The forensic recovery model emphasises personal growth, adaptation, relational needs, individualised care and empowerment (Drennan & Aldred, 2012) and is thought to better target women's forensic needs than a purely medical approach for overcoming the effects of abuse and social inequality. It has not been empirically tested in forensic care but in other settings the model has been shown to improve subjective wellbeing and functioning of people who have received a BPD diagnosis (Katsakou et al, 2012).

3. Purpose of the Literature Review

3.1. Rationale

Women tend to have different personal profiles and routes into forensic services than men. They are more likely to have a history of adversity and childhood abuse and this will have impacted upon their emotional and social development including their attachment characteristics, expectations and experiences of relationships. In the face of limited resources to cope their distress may be expressed through substance abuse, self-harm and violence. Such behaviours have tended to result in a PD diagnosis which risks obfuscating the social determinates of women's distress and difficulties. Intense distress within the context of relationships is viewed as central in the diagnosis of PD and improvement in interpersonal functioning is believed to be a key to recovery.

The need to ensure safety and to promote a relational focus for recovery with both staff and between peers led to the establishment of women's wards (Parry-Crooke & Stafford, 2009). However, intense emotions are likely in response to offers of care (Lorenzini & Fonagy, 2013) and little is known about what women's relational needs are in forensic care (Long, Fulton & Hollin, 2008). Therefore it is essential to identify

the relational problems experienced by women in this environment, how well these needs are met and the significance of relationships upon their recovery.

3.2. Aim of the Literature Review

1. What are the relational problems faced by women with a diagnosis of PD when in forensic care?
2. What are the relational needs of women with a diagnosis of PD in forensic care, and how well are they met?
3. In what ways can relationships with staff or peers either contribute therapeutically or impede the recovery of women with a diagnosis of PD in forensic care?

4. Methodology

4.1. The Literature Search

An electronic literature search was undertaken of peer reviewed research using Cochrane Database of Systematic Reviews (2005-present), Google Scholar, MEDLINE (1946-present), Psycinfo (1806-present), Social Policy and Practice, Cinahl, Web of Knowledge, and Zetoc data bases. Searches took place up until April 2014. The search terms used were social milieu and forensic/prison, forensic and women, secure services and women, peer relations and women, forensic/secure and personality disorder, and personality and recovery.

The search was limited to papers published in English. All retrieved abstracts were read and included if they pertained to women's forensic inpatient experiences with

participants over the age of 18 years. If there were also male participants then some form of gender analysis was required. Participant samples had to include women who had received a diagnosis of PD but could also include participants with other diagnosis. All participants must have been in inpatient forensic care. Papers were excluded if no participants had a diagnosis of PD and mixed gender studies were excluded if there was no gender analysis.

Two authors were contacted to verify the gender of participants and one contacted to verify the diagnosis of participants. Authors who had been involved in more than three of the selected papers were also contacted and this yielded one further study that was in press.

See Appendix 1 for full methodology.

4.2. Method for Critiquing the Literature

The quantitative studies were described and evaluated based upon Mann's (2003) criteria for reporting qualitative studies. This provided a framework for systematically evaluating a research paper section by section and for addressing the adequacy of research method to answer the research question and the reliability, validity and transferability of findings. The qualitative studies were evaluated using guidelines for qualitative research in psychology by Elliott, Fischer and Rennie, (1999). These guidelines were established through a peer consultation process to provide a set of standards for ensuring rigour in the conducting and reporting of qualitative research. The qualitative research papers were systematically evaluated and reported against these standards.

5. Results of Literature Search

The following section provides an overview of the results of the literature search.

Country	Inpatient Context	Participants	Participants Diagnosis	Research Method
12 Britain	2 High Secure	6 Female only	7 PD only	7 Quantitative
2 Sweden	8 Medium Secure	12 Males included	11 PD and other disorders	8 Qualitative
3 Canada	1 Low	5 Staff included		3 Mixed method
1 Australia	7 Mixed			

Figure 1: Results of the Literature Search

18 studies met the inclusion criteria and are described in Appendix 2. The following five small scale British qualitative studies investigated inpatients experiences of forensic care including their adjustment to forensic admission and the significance of relationships with staff, peers and family. Carr (2013) conducted focus groups to understand the process of adjustment for women in forensic care. Cooke and Bailey (2011) interviewed women about their experiences of forensic care, and Jenkinson (2011) interviewed women to explore their experiences of forensic recovery. Long, Knight, Bradley and Thomas (2012) completed focus groups to identify from the inpatients' perspective what constituted a forensic therapeutic milieu. Parrott (2010) conducted interviews and observation of forensic inpatients to understand the significance pre-existing relationships and relationships with their inpatient peers for coping with inpatient admission.

Five studies employed a quantitative approach and used self-report questionnaires to assess in what ways inpatients relational behaviour was associated with ward characteristics. In Sweden Brunt (2008) measured the characteristics of ward environment and in Britain Dickens, Suesse, Synman and Picchioni (2014), and Long, Anagnostakis, Fox, Silaule, Somers, West and Webster (2011), explored the relationships between level of security, ward characteristics and inpatient gender.

Long, Langford, Clay, Craig and Hollin (2011) examined the significance of the physical environment on the health and wellbeing of inpatients by comparing patient and staff experiences when moved from a British Victorian ward to a modern one. One correlational study by Livingston, Nijdam-Jones and Brink (2012) from Canada, and two studies that employed mixed methods by Brunt and Rask (2007) in Sweden and Nijdam-Jones, Livingston, Verdum-Jones and Brink (2015) in Canada examined how the ward relational climate related to therapeutic progress and recovery.

Two British qualitative studies; Black, Thornicroft and Murray (2012) and Dickens, Lange and Picchioni (2011) took a different approach to relationships and explored the personal meanings associated with a PD diagnosis for forensic inpatients and how they felt this impacted on relationships with staff and peers.

Four studies focused upon experiences and expressions of psychological distress whilst in forensic care, including self-harm and aggression. In Britain Parkes and Freshwater (2012) conducted semi-structured interviews to gain an understanding from women of their experiences of psychological distress whilst in secure care. Three quantitative studies examined male and female forensic inpatients expressions of distress and aggression in the context of relationships with peers and staff. In Australia Daffern, Howells and Ogloff (2007) produced a functional analysis of forensic inpatient

aggression and a similar design was adopted by Nicholls, Brink, Greaves, Lussier and Verdun-Jones (2009) in Canada. In Britain Woods, Reed and Collins (2004) examined the association between aggression and particular interpersonal difficulties and social skills.

6. The Literature Review

The review is organised around the emergent themes of the research. As individual studies may contribute to more than one theme then they may appear more than once in the review. When this occurs an indication is given to where the study first appeared and was critiqued.

6.1. Relational Problems Faced in Forensic Care by Women With a PD Diagnosis

When outlining the priorities for women's forensic services, Parry-Crooke and Stafford (2009) highlighted the importance of meeting women's relational needs, and recognizing the impact of their frequently traumatic and disadvantaged personal histories. Fourteen empirical studies have revealed aspects of underlying relational problems for women when in forensic care.

Studies from different research traditions have identified a range of problems that women inpatients face in forensic care. Standardised self-assessment tools have been completed by both inpatients and their care staff to assess the forensic environment and relational style whilst other research has involved functional analysis of behaviour. Alternatively researchers have started with the premise that the minority status of women in forensic care means it cannot be assumed we can predict the range of their

needs and sought instead to develop an understanding of such needs through the themes that women themselves identified as important.

The relational problems faced by women in forensic are considered in turn in section 6.1. under the following sections; the difficulties women face in managing separations from previous relationships, the particular challenges presented by the forensic environment, peer relationship difficulties, expressions of distress, and barriers to developing therapeutic relationships with staff.

6.1.1. Managing Separations

Parry-Crooke and Stafford (2009) emphasised that in forensic care women inpatients in particular had specific needs regarding maintaining existing relationships and were more likely to have child care responsibilities. Four small scale qualitative studies in Britain (Black, Thornicroft & Murray, 2013; Carr, 2013; Cooke & Bailey, 2011; Parrott, 2010) produced accounts from women's own perspective of painful experiences of separations in forensic care but a lack of understanding or support from care staff.

Women's distress at separations was reported by Cooke and Bailey (2011) who conducted one-off semi-structured interviews with seven women with a diagnosis of PD in forensic care in Britain. Women explained that it was distressing to be placed far from home and whilst they had significant pre-existing relational difficulties their requests for support and advice on developing positive relationships went unmet. In consideration of the quality of the research, the development of themes were clearly described and illustrated with appropriate examples and sufficient participant details. The interviews allowed women's own perspectives to emerge of the relational problems

they faced and how these were poorly understood by care staff despite this being stated as a priority for women's services. However, not all participants had a PD diagnosis so not all the findings may fully reflect the experiences of this clinical group and it is a small study. These issues are common limitations to a number of the studies and are evaluated in section 6.5. regarding the overall limitations the research.

Women described their adjustment difficulties to forensic admission in Carr's (2013) qualitative study. Again they reported feeling unskilled in maintaining pre-existing relationships and felt inadequately supported by care staff. In this study six women diagnosed with a PD in a low secure unit took part in weekly focus groups for six weeks. The research underwent interpretative phenomenological analysis and was clearly presented and grounded in appropriate examples, providing coherence and integration with clear theoretical and practical implications. However, whilst coding is clearly explained the credibility was limited by the absence of quality checks to verify participants agreed with the themes. One aim of the current review is to understand relational problems from participant's own perspectives so this limits to some extent the confidence in the findings.

The significance and difficulty for forensic inpatients of coping with separations along with the misinterpretation of this by care staff, was identified by Parrott (2010) who undertook a qualitative study that examined the importance inpatients placed on their possessions and relationships whilst in forensic care. Seven women and twelve men on single sex wards participated in semi-structured interviews that underwent thematic analysis. These were presented in the report alongside descriptions of the researcher's own observations. Participants were diagnosed predominantly with either a PD or schizophrenia. The author concluded that much behaviour that appeared communal, such as watching television or exchanging goods was actually done in a way

to maintain social distance so instead of identifying with peers and forming relationships, participants were striving to manage separations by focusing upon their pre-existing relationships and spending time alone looking through photographs and objects that maintained that connection. However, being alone was often misinterpreted by care staff as due to difficulties in forming new relationships. The research focus was clear and the author explained this was a council-funded study of the meaning of home and the significance patients gave to their personal belongings. However, the author did not conduct member checking or reflect upon the ways her prior belief of the importance of material objects affected the development of the emerging themes. Material objects may be important, but member checking would help establish their relative importance and improve the confidence that the research represented the participants' perspectives.

In addition to the physical separation and inadequate support, stigma appears to create further difficulties in maintaining relationships. Black, Thornicroft and Murray (2013) conducted a qualitative study to explore the experiences of having a PD diagnosis within the context of forensic care. Two women and eight men participated in semi-structured interviews and data underwent interpretive phenomenological analysis. Both women and men believed that forensic and PD labels caused friends and family to both view them differently and avoid visiting due to fear of forensic units. The authors identified their focus of study clearly. There were many examples of quotations from interviews to support the themes which broadly reflected the phenomena and credibility checks were made. However, whilst it is possible to identify the female participants experiences the sample is very small. Nonetheless the study adds to the understanding of the range of obstacles faced by this clinical group in maintaining significant relationships which are often poorly understood or responded to by care staff.

6.1.2. The Impact of the Forensic Environment

Whilst women inpatients may be struggling to manage separations and feel inadequately supported, the forensic environment itself may also cause distress. Two small scale qualitative studies in Britain (Carr, 2013; Parkes & Freshwater, 2012) examined women's experiences of forensic admission and identified how the environment can trigger painful childhood experiences and be re-traumatising. A further two British correlational studies (Brunt, 2008; Long, Langford & Clay, 2011) highlighted the significance of women's experiences of the physical environment for their general wellbeing, symptomology, and experience of inpatient relationships. These studies demonstrated the need to recognise women's trauma histories but how women can feel over-controlled by care staff in environments that may be more designed to meet men's forensic needs. This runs the risk of forensic admission being re-traumatising.

Carr's (2013) research was critiqued in section 6.1.1. regarding separations, and participants in that study also described how the disempowering nature of admission often triggered painful feelings from childhood. The restrictive environment and repetitive routine were particularly difficult, raising anxiety which could trigger self-harm. In Parkes and Freshwater's (2012) qualitative study in women's high and medium secure care participants explained they felt powerless in forensic wards which again mirrored childhood experiences and often raised uncontainable distress. This distress could escalate into violence towards themselves or others. Eleven women diagnosed with a PD participated in semi-structured interviews and the data thematically analysed. The authors' perspective was clearly presented, the sample well described, and a broad range of demographic details gathered. As all participants had received a PD diagnosis these findings were specific to the review aims and

understanding of how past histories for this clinical group impact upon their admission to forensic care.

Experiences of powerlessness were again noted in a correlational study by Brunt (2008) of women inpatients gender specific needs. This research is described in more detail in section 6.2.2. which focuses upon relational needs as this was the central focus of the study. However, the research also indicated that whilst inpatients and their care staff gave ratings of the ward environment which were largely similar, inpatients rated their autonomy as significantly lower, and feeling controlled higher, than staff predicted.

The impact of the social and physical environment on wellbeing was also highlighted by a quantitative study of inpatient and staff perceptions of social climate first on a Victorian style ward then following ward relocation to a purpose-built unit. Long, Langford and Clay (2011) conducted this correlational pre-post study in Britain with nine transferring women, eight of whom had a PD diagnosis, and ten care staff. Participants completed self-report questionnaires including the Ward Atmosphere Scale (WAS; Moos, 1989) for the four months before and after transfer. The WAS is a self-rating instrument that characterises environment type based upon relational, personal growth, and system maintenance factors. Findings indicated the new ward was associated with lower anxiety and overall better well-being and reduced symptomology and increased relational security. Whilst inpatients still felt somewhat controlled on the new ward and rated control as being higher than staff, this was reduced and may be a result of clinical observations being able to be done more remotely on the new ward. The new ward was rated as being less institutional and more homely. Staff perceptions were similar except they gave significantly lower scores for “control of patients”. The research used appropriate measures, and importantly demonstrated the impact of the

environment on wellbeing including the positive effect of a more homely environment on relationships.

The physical environment appears to contribute to distress and it is particularly worrying that it can re-traumatise this clinical group despite policy urging how this clinical group should be given environments to allow them to heal from the traumas they have experienced (Parry-Crooke & Stafford, 2009). Historically women have been placed in forensic environments that outweighed their containment needs (Parry-Crooke and Stafford, 2009) so it is surprising that none of the authors of the studies presented here have raised concerns about women feeling over-controlled. This issue is examined in the overall discussion of relational problems in section 6.1.6

6.1.3. Difficulties within Peer Relationships

In addition to providing forensic environments that allow women to start to recover, women's wards were designed to improve safety and to allow women's peer support to develop (Parry-Crooke & Stafford, 2009). But these wards were not universally welcomed as some women inpatients indicated they found them anti-normalising and not necessarily safer (Mezey, Hassell & Bartlett, 2005).

Women's forensic peer relationships have been empirically investigated in two ways. Two correlational studies in Britain (Dickens, Suesse, Snyman & Picchioni, 2014; Long, Anagnostakis, Fox, Silaule, Somers, West & Webster, 2011) used self-report standardised questionnaires to compare ward environment, level of security, relational type and clinical progress. These studies indicated that women placed a greater relational focus and emphasis on their peer relationships than did men. However, in some environments supportive peer relationships may be challenging to

achieve. In three qualitative studies (Carr, 2013; Cooke & Bailey, 2008; Jenkinson, 2011) semi-structured interviews provided accounts from women inpatients in British forensic care that revealed that at times women felt ill-equipped and overwhelmed by peer relationships which may indicate why peer cohesion can in some circumstances be difficult to achieve.

The findings from two correlational studies suggested that it may be more difficult, and take longer, to establish supportive peer relationships and sense of safety on wards than to develop therapeutic relationships with care staff. Dickens, Suesse, Snyman and Picchioni (2014) conducted a correlational longitudinal study in Britain of individual patient characteristics and ward climate finding that higher security environments were associated with greater difficulty for women in forming cohesive relationships and feeling safe with peers than establishing a therapeutic relationship with staff. Lower peer support also predicted a decreased sense of safety. Nonetheless women had significantly higher cohesion with their peers than men and an increased perception of safety. 63 forensic inpatients took part between open, low and medium secure wards with 66% of the sample being female and 35% of participants had a PD diagnosis. Ward climate was measured using the Essen Climate Evaluation Schema (EssenCES; Schalast et al., 2008). The EssenCES has a three factor structure measuring cohesion, which refers to the level of peer support, therapeutic hold, which is the extent to which the climate is perceived as supportive of patient's therapeutic needs, and safety. Other assessments were made of risk, diagnosis, clinical presentation and treatment engagement. Measures were repeated three times at six-month intervals. The research purpose was clear and the sample reflected the population from which it was drawn. The measures used were standardised and the research was adequately powered. The demographic details were adequately described as was control of extraneous variables.

This is one of the relatively few studies that explored gender differences in forensic care. It also demonstrated that whilst peer cohesion may be an aim for services it can be hard to achieve especially in higher security environments.

Long, Anagnostakis, Fox, Silaule, Somers, West and Webster (2011) produced a between-groups cross-sectional clinical survey in Britain to assess the relationship between social climate of women's forensic wards, security level and therapeutic progress. 65 female inpatients and 80 staff, in assessment, medium, and low-secure wards took part. The ward environment was assessed using the EssenCES (Schalast et al., 2008), and other standardized measures were also completed to measure the level of disturbed behaviour, psychotherapeutic alliance, treatment engagement and motivation to change. Findings suggested that patient and staff experiences were similar and high-secure wards were associated with a more negative evaluation of peer social climate, being less relationally focused and having greater behavioural disturbance. Therapeutic relationships with staff were easier to achieve even at high security. As patients moved through services, cohesion and safety improved which was important as these factors were also associated with improved treatment engagement and reduced behavioural disturbance. The design of the research meant that no causal interpretations between factors were possible and a preferred method for inferring change would have been through the use of a longitudinal study. Nonetheless the research is important as it highlights that developing cohesive peer relationships in forensic care is challenging, particularly in higher security environments and the importance of doing for inpatients to feel safe.

Jenkinson (2011) conducted a research study that focused particularly upon recovery and is critiqued in section 6.3.2. that addresses this theme. However, in the study participants also spoke of difficulties with their peers including feeling

overwhelmed at times by their peers problems and behaviour. Women often felt ill-equipped to manage these relationships, or the high levels of distress expressed by some women on the ward, and felt a need to protect themselves. Similarly, participants in Cooke and Bailey's (2008) research, which was critiqued in section 6.1.1., explained that at times they were fearful and felt ill-equipped to manage relationships with peers.

Carr's (2013) research focusing upon women's adjustment to forensic admission was first discussed and critiqued in section 6.1.1. Participants in this study also indicated they often felt unskilled to manage the intensity of peer relationships and also struggled when they felt rejected or put down by their peers. In the face of limited ways to cope participants explained this often resulted in social withdrawal.

Forming peer cohesive environments has been emphasised in forensic service policy for women and has been associated with increasing well-being and sense of safety (Long, Anagnostakis, Fox, Silaule, Somers, West & Webster, 2011). As cohesive relationships can be difficult to achieve, especially in higher security wards, and women can feel ill-equipped to manage some peer relationships then to achieve cohesion may require further support from care staff.

6.1.4. Expressions of Distress Through Violence and Self-harm

Whilst women's wards exist to protect safety and develop supportive peer group relationships the impact of the environment and inpatients own interpersonal skill difficulties may make this hard to achieve. In one study interviews were conducted with British female forensic inpatients to understand their experiences of psychological distress when in forensic care (Parkes & Freshwater, 2012). Findings were consistent with research by Carr (2013) discussed in section 6.1.2. of how women in particular can

feel re-traumatised by the forensic environment. This can lead to experiencing uncontainable emotions. The accounts here communicated the intensity of forensic wards, and how poor emotional regulation or interpersonal skills were associated with violence. The meaning of aggressive incidents has been explored in three further studies from Britain and Canada (Daffern, Howells & Ogloff, 2007; Nicholls, Brink, Greaves, Lussier & Verdun-Jones, 2008; Woods, Reed & Collins, 2004) through the functional analysis of aggressive incidents.

Parkes and Freshwater's (2012) study was earlier critiqued in relation to the personal impact of the forensic environment in section 6.1.2. Participants in the study also described the impact of the environment upon their behaviour and how feeling powerless triggered uncontainable emotions leading to destructive acts. These feelings could lead to an impulse to hurt others, which was only averted by re-directing their distress and by harming themselves. This study is important in revealing the cause of aggressive behaviour that is a consequence of uncontainable emotions.

A functional analysis of aggressive incidents by Woods, Reed and Collins (2004) attributed the cause of different forms of aggression to specific communication and social skill deficits. A longitudinal repeated measures study was completed to assess the relationship between risk and communication skills in forensic care in Britain. 500 inpatients from high, medium and low-secure units completed assessments of insight and communication skills, and there was a functional analysis of aggressive incidents. Measures were taken every 12 weeks for a year. There were no significant gender differences and risk was negatively correlated to communication and social skills but different forms of aggression were associated with characteristic communication deficits. Violence was associated with difficulty in deferring to others, maintaining social distance, turn taking and arguments. Poor communication was associated with

verbal aggression and with social performance deficits. The researcher utilised measurements standardised for this clinical group. However, more covert forms of aggression are generally more difficult to spot and could have been less well represented in the data. In fact, such aggression may require more sophisticated interpersonal skills to avoid detection by staff. Nonetheless the findings indicate that violence can be associated with global interpersonal skills deficits and result in relational problems.

A functional analysis of aggressive behaviour in a secure hospital in Australia by Daffern, Howells, and Ogloff (2007) indicated that women forensic inpatients may resort to violence in the face of communication and other interpersonal difficulties. The research aim was to examine the function of aggression and the associations to individual characteristics. Participants completed semi-structured interviews and self-report measures of behaviour characteristics and psychiatric rating scales. Data for aggressive incidents were analysed for 232 inpatients; 56% were women and the main diagnoses were PD and schizophrenia. 502 aggressive incidents occurring during one year were recorded and a behavioural analysis completed. The most common functions of aggression for both men and women were to express anger, force compliance and to avoid demands. However, women were more likely to be repeatedly aggressive and for a wider range of functions; to reduce tension, obtain tangible rewards, or reduce social distance. Characteristics of the inpatients were associated with particular functions of aggression. Women who were socially withdrawn were likely to be aggressive to avoid demands, but depressed patients were more likely to be aggressive to seek increased social support and reduce social distance. However, the research relied upon archival data not collected for research purposes and information such as whether the victim was a patient or staff member is unknown. Clinically it is significant to differentiate those

patients who are socially isolated due to a preference for time alone to those who are in fact depressed. Also it is important that the research identified gender differences in violence which may reflect gender differences in their response to the forensic environment and the attendant relational problems. However, participants were not exclusively those diagnosed with a PD and there may be further specific disorder related differences.

Nicholls, Brink, Greaves, Lussier, and Verdun-Jones (2009) investigated aggressive incidents of forensic inpatients in Canada. A between-group, cross-sectional analysis was completed with 527 forensic inpatients (12% women). The participants completed a mixture of standardised and non-standardised self-report questionnaires and the researchers reviewed patient files and incident forms to complete an incident coding form. The research relied upon retrospective data and whilst instruments designed for the study achieved good inter-rater reliability their validity was not discussed. The results indicated no gender differences for prevalence and frequency of aggression. However, women were more likely to be diagnosed with BPD, and it would seem they were already having difficulty managing distress as they were most likely to attack others following self-harm. The study, like the preceding ones, is important in identifying the difficulties faced in managing emotions. This is likely to be compounded by social skill problems and be used to communicate a broad range of needs.

6.1.5. Barriers to Therapeutic Relationships with Care Staff

It has been highlighted how difficult it may be for women with a PD diagnosis to cope emotionally with forensic admission and forensic care policy has emphasised the importance of care staff developing supportive therapeutic relationships. However, findings from three of the qualitative studies identified how this may at times be difficult to achieve. Inpatients may feel over-controlled, stigmatised, or neglected by care staff which can mirror women's developmental experiences and provoke aggression.

The stigmatising effects of a forensic admission and PD diagnosis were investigated by Black, Thornicroft and Murray (2013) which was critiqued in section 6.1.1 in relation to managing separations. Participants' interviews also revealed relational difficulties with care staff. Both men and women explained they felt that being a forensic patient labelled them as a "bad person". They felt their PD diagnosis was an additional stigma which left them feeling isolated and worthless. They believed that care staff identified them through their disorder, which created a barrier to being understood. Carr's (2013) research was critiqued in section 6.1.1. regarding separations and participants in the study also reported similar barriers with staff and spoke of low self-esteem which was compounded by their diagnosis with some women feeling put down by staff or just seen by their diagnosis.

Forensic inpatients also reflected upon the significance of stigma in Jenkinson's (2011) qualitative study exploring recovery in women diagnosed with PD in secure care. The study was briefly discussed in section 6.1.3. and is now critiqued. Six women took part in semi-structured interviews, which underwent interpretive phenomenological analysis. The participants were recruited from two NHS and one private medium-secure unit. Some participants felt stigmatised by their diagnosis and

felt they were seen as difficult by staff because of it. They spoke of the fear of trying to trust offers of care and how poor relationships, communication problems and feeling stigmatised undermined trust. Perceiving a lack of care painfully mirrored early childhood experiences of neglect. The research report presents the author's perspective clearly and the participant characteristics were adequately described. The theme development is clear and credibility checks were undertaken. Although a small study it helps to bring voice to women's relational experiences in forensic care and the barriers and distress that can be caused in supposed therapeutic relationships.

Parkes and Freshwater's (2012) research was critiqued in section 6.1.2. and their participants also spoke of how feeling invisible to staff was highly distressing as it mirrored painful feelings associated with their childhood. This led to behaviour to get noticed, including attacks towards their care team. This is consistent with Jeffcote and Traver's (2004) theoretical explanation that women may heighten their own attachment behaviour to obtain some attention, even if it is punitive or aggressive attention and identifies a significant barrier to creating the desired therapeutic relationships.

The above studies highlighted the effects of negative experiences with staff. In Nicholls, Brink, Greaves, Lussier, and Verdun-Jones's (2009) study critiqued in section 6.1.4. aggressive incidents by women inpatients were significantly more likely to be targeted at staff and this occurred when making requests to staff or when being escorted to their room or seclusion. The authors do not attempt to interpret why women appear more likely than men to attack staff. However, the previous study by Parkes and Freshwater (2012) identified how attacks may be a way to be recognised. This client group have generally been the victims of abusive 'care' and are likely to be alert and particularly sensitive to any signs of relational threat or abandonment. It is possible that such women may experience denial of requests, or being escorted to seclusion as very

threatening to the attachment relationship. They may have few resources to cope or communicate this distress as indicated by Woods, Reed and Collins' (2004) analysis of aggressive incidents and so resort to violence. This interpretation is consistent with Pfafflin and Adshead's (2004) view that threats to attachment relationships for women generate powerful feelings of abandonment anxiety and rage.

6.1.6. The Significance of the Range of Relational Problems

The reviewed literature revealed the problems faced by women with a PD diagnosis when in forensic care. The very factor which makes it essential they receive relationally focused care to support their recovery from trauma underlines why this clinical group is particularly susceptible to adverse experiences when in forensic care. Difficulties were identified in managing separations, the environment itself, fear of peers, violence and perceived stigmatising views at times and misunderstandings from some care staff (Parkes & Freshwater, 2012).

Whilst a cohesive peer community is desired to promote recovery, women can feel ill-equipped to manage the emotional intensity of forensic peer relationships (Carr, 2013) which can lead to self-harm or aggression which may be used for a wider range of functions than for men (Parkes & Freshwater, 2012). It raises the question of how to ensure safety which may require further investigation to answer. Whilst skill deficits have been investigated the understanding of aggressors emotional needs are more limited. Pfafflin and Adshead (2003) theorised that women may exploit the vulnerable as an aggressive denial of their own dependence and neediness. They believed that to make another person suffer may be a strategy to manage unprocessed pain, shame and powerlessness.

Furthermore, environmental conditions may themselves be associated with aggression. In a study of male forensic inpatients by Daffern, Ferguson, Ogloff, Thomson and Howells (2007) they found a greater continuity between levels of aggression pre and post admission with no association with aggression whilst an inpatient. So whilst there is a need for developing peer cohesion in forensic care this is not straightforward and inpatient safety needs to be ensured.

Forensic services place multiple demands on staff to combine physical, procedural and relational security. Several studies highlighted how women inpatients felt over-controlled by care staff (Brunt, 2008; Long, Langford & Clay, 2011; Livingston, Rossiter & Verdun-Jones, 2011) which some female inpatients attributed to care staff fearing them due to their diagnosis (Black, Thornicroft & Murray, 2013). Jeffcote and Travers (2004) proposed that care staff may struggle with the emotional impact of providing care for women who have had such traumatic lives, resulting in “othering” or control to both defend and distance themselves from the horrors these women have experienced. This distancing is likely to be experienced as highly rejecting by those they care for. Some inpatients felt staff held stigmatising views and only understood them by their diagnosis (Black, Thornicroft & Murray, 2013; Carr, 2013). The connections between the women’s behaviour, distress and their lived experiences were then overlooked so the person and their behaviour may be poorly understood (Williams & Keating, 2005), including the effects of separations (Cooke & Bailey, 2011). Those who have received a PD diagnosis are likely to have particular difficulty in regulating emotions in relation to perceived social rejection (Dixon-Gordon, Yiu & Chapman, 2013) and then retaliate with violence. Distress at perceived rejection may be an explanation why women, more than men, tend to direct their violence against staff (Nicholls, Brink, Greaves, Lussier & Verdun-Jones, 2009).

6.2. The Relational Needs of Women in Forensic Care

The current empirical knowledge of women's forensic relational needs comes from four small scale British studies employing semi-structured interviews or focus groups (Brunt & Rash, 2007; Carr, 2013; Cooke & Bailey, 2011; Long, Knight, Bradley & Thomas, 2012). Participants spoke of the importance of maintaining pre-existing relationships but particularly emphasised the significance of the personal qualities of care staff to enable inpatients to trust, feel supported, understood and respected. A further quantitative study from Sweden assessed aspects of the ward environment associated with relational needs.

How well relational needs are met has been investigated through three correlational studies (Brunt, 2008; Dickens, Suesse, Snyman & Pichioni, 2014; Long, Langford, Clay, Craig & Hollin, 2011). These studies assessed the social climate and how well the environment was able to provide positive relational needs that were associated with secure relationships with staff and cohesion with peers.

6.2.1. The Most Significant Relational Qualities of Forensic Wards

Particular qualities of care staff were emphasised as determinates of whether positive relationships could develop. Carr's (2013) research was first critiqued in section 6.1.1 in relation to separations. Participants in the study also spoke of the importance of maintaining pre-existing relationships for developing hope for the future. Participating in activities or having meaningful roles gave participants some sense of autonomy and importantly offset problems of restrictive environments. Similarly, the importance of maintaining existing relationships was emphasised in Cooke and Bailey's (2011) research which was also critiqued in section 6.1.1. and participants also spoke of

the importance of stable, dependable relationships with staff so that trust and a secure base could be established.

When Long, Knight, Bradley and Thomas (2012) asked women what was required from the environment to meet their relational needs, their responses were largely focused on the qualities of care staff. A self-selecting group of 19 women, mainly with a diagnosis of PD, volunteered from medium and low-secure units in Britain. They took part in one of two focus groups and data underwent thematic analysis. Participants explained they most valued having good relationships with staff where they felt understood and believed in. Having clear boundaries and feeling there was genuine interest in their progress helped to develop trust. Participants also explained the importance of feeling treated with dignity and for power differentials to be managed sensitively. The researcher provided illustrative quotes to support themes but these were often brief, making it difficult to appraise themes or to have a sense of the experiences through the women's own voices. Nonetheless the connections of themes were clearly presented and there was credibility from inter-rater reliability of coding. This gives confidence that important qualities associated with care giving from staff and meeting women's relational needs have been identified.

Brunt and Rask (2007) completed a cross-sectional survey of forensic inpatients, and their nurses' perceptions of the distinguishing characteristics of ward atmosphere. 35 patients and 104 nurses from a high security psychiatric hospital in Sweden took part, 30% of participants were female, with BPD as the prevalent diagnoses. Participants completed the WAS (Moos, 1989) and then the inpatients completed a questionnaire asking them to rate three distinguishing characteristics of the ward atmosphere which were analysed using content analysis. The findings indicated that both patients and staff experienced the environment as relationally focused. The

majority of statements indicated that interpersonal relationships characterised the ward environment with the overwhelming focus being on the personal qualities of staff and virtually none regarding their peers who were apparently not viewed to contribute as significantly to the ward atmosphere. Patient characteristics were adequately described, although the ratio of nurse to patient participants was not explained. The questionnaire was devised solely for the study and its development is not described but had good inter-rater reliability and findings corresponded to the WAS results. This research is important in highlighting the great emphasis placed upon the experiences with staff in determining the overall experience of the ward by inpatients.

6.2.2. Meeting Women's Relational Needs

Two social climate studies contribute to the understanding of women's relational needs. Dickens, Suesse, Snyman and Picchioni's (2014) longitudinal study of ward environments was critiqued in section 6.1.3. in relation to difficulties women face with peers. This, together with findings from Long, Langford, Clay, Craig and Hollin's (2011) correlational study critiqued in section 6.1.2. have indicated that in lower secure care it was easier for inpatients to form positive relationships with staff and peers, and to experience safety. However, at higher security positive relationships with staff were more easily achieved than with peers. The importance of cohesion was only evident on women's wards and again underlines the gender specific forensic care relational needs.

Women's relational needs with both care staff and peers and how well they were met was also investigated by Brunt (2008), whose study appeared briefly in section 6.1.2. in reference to the impact of the forensic environment on women's distress. It is critiqued here as the greater emphasis of the study concerned women's relational needs.

This was a between groups cross-sectional correlational study to compare the social climate of gender specific wards. 35 inpatients, 50 % women, and 104 nursing staff at a maximum security hospital in Sweden took part. Over 90% of women and 80% of men had a PD diagnosis. Participants completed the WAS (Moos, 1989) and other self-report measures of psychiatric and psychological functioning. Women and their care staff rated their wards as being significantly more relationship-orientated than men and women experienced both staff and peers as supportive. The ward programmes were evaluated as being insight orientated, with a more positive ward atmosphere, including ward involvement. Ward atmosphere is particularly important as it has been shown to relate to clinical outcome (Schalast, Redies, Collins, Stacey & Howells, 2008)

Women appear to use group membership differently to men, placing greater emphasis on relational needs with staff and peers. The findings from these studies are important for illustrating gender specific needs that require addressing during the design and reviewing of services.

6.2.3 Reflection on the Empirical Studies of Women's Relational Needs

Despite the challenges of the forensic environment and the potential for problematic relationships with care staff, research has indicated it can be possible to meet gender specific relational needs in forensic care for women with a PD diagnosis (Dickens, Suese, Snyman & Picchioni, 2014). Maintaining existing relationships is particularly important (Carr, 2013) and maintaining social networks are associated with successful adjustment post discharge (Long & Dolley, 2012). Qualities of care staff in particular were significant including being dependable, boundaried and interested in them and this experience could help inpatients to better cope with distress (Long, Knight, Bradley & Thomas, 2012). Also, having the opportunity to acquire meaningful social roles could offset the effects of the environmental restrictions (Carr, 2013).

The need for relational-orientated forensic environments with both staff and peers appeared more significant for women than for men (Brunt, 2008). This supports Kaplan and Surrey's (1984) theory that women have a more significant need to be part of a peer group. The experiences and qualities of peer relationships also appeared associated with ward environment and in particular the security level. Cohesive peer relationships may be harder to establish in higher security care and Jenkinson's (2011) research identified that women may fear and avoid their peers. This level of complexity within peer relationships highlights the need to further investigate which ward conditions can promote positive relationships and reduce negative effects and under what conditions it is advisable to promote peer cohesion.

6.3. The Therapeutic Nature of Relationships

This clinical group faces particular relational problems when in forensic care such as the susceptibility to being re-traumatised (Carr, 2013) or experiencing stigma due to PD diagnosis (Black, Thornicroft & Murray, 2013). However, despite these problems there is also evidence that women's relational needs can be met in forensic care (Cooke & Bailey, 2011).

As interpersonal difficulties for those who receive a PD diagnosis are particularly distressing and intransigent (Crawford et al., 2006) then it is important to discover if experiencing more positive and hopeful interpersonal contact in forensic care is a significant therapeutic target.

The findings from interviews conducted with women forensic inpatients from three small scale British studies (Carr, 2013; Long, Knight, Bradley & Thomas, 2012; Parkes & Freshwater, 2012) indicated that positive forensic relationships with staff and peers could have a positive therapeutic impact in managing emotions, reducing the effects of stigma, and in coping with the distress of forensic admission. Also undertaking positive roles including supporting peers could help improve self-esteem.

The forensic recovery model has been argued to better meet the needs of forensic inpatients than a purely medical approach to treatment (Drennan & Aldred, 2012). This model emphasises the need to develop inpatients hope for change, for empowerment and personal agency, ability to manage one's illness, develop self-worth and identity outside of illness, improve relationships and to gain socially valued meaningful roles (Alexander, Simpson & Penney, 2011, Drennan & Aldred, 2012). One British (Jenkinson, 2011) and two Canadian studies (Livingston, Nijdam-Jones & Brink, 2012; Nijdam-Jones, Livingston, Verdun-Jones & Brink,

2015) have emphasised relational qualities related to personal recovery and assessed how well the forensic recovery approach matched women's experiences of forensic care and whether it was associated with improved pro-social relational functioning.

6.3.1. How Relationships Help with Making Positive Change

Research findings have suggested that through the development of trusting relationships, women in forensic care can feel better able to manage emotional distress and develop hope for the future.

Participants in Parkes and Freshwater's (2012) study, which was critiqued in section 6.1.2. in relation to environmental problems, also explained that developing clear boundaries and supportive mutual relationships with staff helped women feel safe and had therapeutic effects. Social support coming from either staff or a close friend, or hope of restoring relationships with family, helped women to tolerate distress which reduced destructive behaviours.

Similarly Carr's (2013) study, which was critiqued in section 6.1.1. in relation to problems with separations also highlighted the importance of peer relationships for increasing emotional management. Participants had affection for peers and developing connections helped offset the adverse environmental conditions. They felt they could learn from peers who had been through similar experiences and helping others gave meaning to what they had been through. Participants explained that staff could help with de-stigmatising diagnosis, for example through explanations describing PD traits as being merely extreme examples along a normal continuum. This is important for therapeutic progress as reducing stigma has been identified as an important target before recovery is possible (Drennan & Aldred, 2012).

Women spoke of gaining in other ways through their peer relationships. Long, Knight, Bradley and Thomas's (2012) research focused upon relational needs and was critiqued in section 6.2.1. The research also identified that acting as role models for other patients made participants feel valued and increased their self-worth. However, in research by Livingston, Nijdam-Jones and Brink (2012), to be evaluated in the following section, inpatients explained they did not have access to patient mentors and care staff appeared less positive or encouraging of peer support. Participants in these studies explained they would value having peer support workers and whilst this has yet to be studied within forensic care, peer support workers have proved helpful in other settings as representing a hopeful model of change that has challenged negative stereotypes (Verhaeghe, Bracke & Bruyoghe, 2008) and so warrants investigation in the forensic environment.

6.3.2. The Forensic Recovery Model and the Significance of Relationships

Drennan and Aldred (2012) emphasised that recovery is associated with improving relationships as well as opportunities for empowerment and hope. Jenkinson's (2011) qualitative study exploring women's experiences of forensic care was critiqued in section 6.1.5. which addressed problematic relationships with care staff. The research also focused upon inpatient recovery and highlighted that despite the restrictions and custodial nature of the forensic environment, women inpatients' accounts of their progress and opportunities in forensic care were consistent with the recovery model and suggested it could be successfully applied. The quality of relationships with staff and peers appeared closely associated with recovery. The power of feeling genuinely cared for, heard and understood by staff helped foster hope when struggling to cope, and

relationships with peers provided the opportunity for validation and connections through common experiences. Women were able to engage in meaningful activities in the forensic system that enhanced positive identity.

Livingston, Nijdam-Jones and Brink (2012) conducted a cross-sectional survey to investigate patient-centred care in a forensic hospital in Canada. 30 self-selecting patients, 20% female, with a range of diagnoses including PD, and 28 staff completed self-report measures of patient-centred recovery orientated care and rated the therapeutic milieu using the EssenCES (Schalast et al., 2008). Other measures of personal recovery, engagement, empowerment and internalised stigma were also completed. The findings indicated higher levels of personal recovery were associated with less internalised stigma, and greater empowerment and satisfaction with the therapeutic milieu. There were no significant gender differences and inpatients overall ratings of recovery-orientated care were not associated with overall personal recovery ratings. However, perceiving the hospital helped in developing life goals, and feeling believed in, that care was individualised, connecting with others and desire for further growth were independently associated with greater basic functioning. The research employed measures standardised for this population, although demographic details were limited. Jenkinson's (2011) study indicated that the recovery model was consistent with participants' accounts of positive experiences in forensic care, and the current research substantiates this with empirical evidence that specific aspects including relational ones of forensic recovery orientated care are associated with improved clinical outcome.

In a related study with the same participants in Canada, Nijdam-Jones, Livingston, Verdun-Jones and Brink (2015) interviewed forensic inpatients and assessed if their narratives about recovery reflected concepts of social bonding theory. Social bonding

theory proposes that individuals' attachment to others, belief in social norms, and the commitment and involvement in conventional activities, are key contributors to normative social behaviour. Semi-structured interviews were undertaken and data underwent thematic analysis. The findings indicated that recovery was associated with increasing acceptance and valuing positive social norms. Participants explained how over time, rules felt less provocative and they started to respect them and felt they promoted safety. Support and encouragement of staff was seen as key in recovery but it could be a set back if staff seemed disinterested. Peers could be a source of support, acceptance and camaraderie and could help with self-acceptance of the awfulness of their index offence. Relationships with family and friends were a central concern, but the stigmatising association with the hospital could isolate them from external relationships and increase the need for affective relationships within the hospital. However, many felt lonely and some lost hope when peers were discharged only to be re-admitted. The research underwent credibility checking of coding between authors. The extracts of interviews are sufficient to allow appraisal of the data with the themes and there is integration of findings with the organising theory. This research is significant as the only study to date to apply a social model to forensic recovery and suggests that progress can be associated with internalising attitudes based on social norms. However, in both studies only a small number of women participated and the minority had a PD diagnosis. Future research would be helpful to explore such social theories further with female forensic inpatients diagnosed with a PD.

6.3.3. Reflections on the Therapeutic Potential of Relationships

The research highlighted the particular significance for this clinical group of relationships for coping and managing emotions (Parkes & Freshwater, 2012). Peer relationships can provide normalising experiences, and peers can be a resource for learning new ways to manage distress (Carr, 2013) and having a positive role and being a role model for peers can also increase self-worth (Long, Knight, Bradley & Thomas, 2012). Women stated they would value more opportunities to access peer support workers and opportunities to take on supportive and productive roles.

Despite environmental constraints the forensic recovery relational targets were possible including improving relationships, normalisation, hope, and better coping being enabled through relationships (Jenkinson, 2011). Despite obstacles to forming relationships, the review identified that if women felt safe, understood, respected and had clear boundaries with their care givers they could experience positive relationships with staff (Parkes & Freshwater, 2012). Those who attract a PD diagnosis tend to have difficult attachment relationships (Meyer & Pilkonis, 2005) and Aiyegbusi (2004) believed that it was possible to develop more coherent attachment relationships within forensic care. However, no research to date has attempted to measure attachment change in forensic care and further studies are needed.

6.4. Overall Discussion of the Review in Relation to Broader Theory

In forensic care, women who have received a PD diagnosis are those inpatients most likely to be survivors of abuse, and social disadvantage. The National Mental Health Implementation Unit (2010) emphasised that such women in forensic care require a high level of relational security to recover from trauma and the opportunity to develop social networks. The findings of the literature review indicate that providing this is far from straightforward and there are complex effects of the individual in relation to their physical and social environment. This clinical group experience a range of difficulties in forming relational security, peer cohesion and opportunities for recovery. Women forensic inpatients can experience distress at separations, be re-traumatised, have problems with forensic peers and experience high levels of fear and aggression that lead to social withdrawal, or unmanageable emotions. Also there is a tendency for difficulties with staff to result in women to feel stigmatised which creates a barrier to creating trusting relationships and lowers self-esteem.

Qualities of relationships with staff were identified as having particular significance in determining women's experience of services and positive trusting relationships with staff may help in developing more effective coping with emotional distress (Parkes & Freshwater, 2012). Positive relationships with staff can help to reduce stigma and shame and provide relational safety. However, forensic services operate alongside legal systems with multiple aims; to reduce recidivism, reduce risk to the public as well as the service user, and improve mental health (Knabb, Welsh & Graham-Howard 2011). Thus care staff have to occupy divergent roles from providing ward containment to developing therapeutic relationships. Care staff may also find it distressing and difficult to understand women's complex care-seeking behaviours and may move from a therapeutic to a containment role to defend themselves

emotionally. The over-use of control or distancing can lead to women feeling rejected and misunderstood which can lower their self-worth (Jeffcote & Travers, 2004). Feeling rejected can mirror painful childhood experiences with carers and has also been found to trigger retaliatory violence (Parkers & Freshwater, 2012). Jeffcote and Travers (2004) have emphasised the importance of attachment-based training for care staff. To better understand women's behaviour from a relational developmental perspective is essential otherwise such behaviour may be confusing and misinterpreted. This is especially likely if staff have tended to rely upon understanding this behaviour purely through the lens of medical diagnosis. So there can at times be a challenge in creating these important positive relationships with staff.

Parry-Crooke and Stafford (200) emphasised the importance of developing a relational environment for women in forensic care who have been excluded from normative relational peer development. Kaplan and Surrey (1984) argued that differently to men, women's self-concept and wellbeing are associated with their peer group relationships. However, Jeffcote and Travers (2004) explained that through being placed in forensic care, women have been placed beyond the community of ordinary women and so there is a need to support them to reconnect with this community and with their families. The research indicated that peer relationships could be normalising and make women feel understood and hearing each other's experiences of progress could be a source of hope for the future (Carr, 2013). Drenan and Aldred (2012) emphasised the importance of day-to-day interactions for recovery.

Whilst developing cohesive peer relationships may support women with a PD diagnosis to be more self-accepting and increase self-worth (Long, Knight, Bradley & Thomas, 2012), the complexity of forensic relationships is emphasised by how it may take women longer to form cohesive peer relationships which may be due to fear (Long

et al., 2011) but also joining a group requires some letting go of autonomy (Brabender, 2002) which is likely to be particularly difficult for those already feeling disempowered. This is a challenging environment in which to attempt to form relationships and it may not always be wise to do so. The restrictions of the environment can be re-traumatising for survivors of abuse resulting in difficult to control emotions (Parkes & Freshwater, 2012) and the levels of aggression may result in the environment feeling unsafe (Cooke & Bailey, 2008). Women may not know how long their inpatient admission is likely to be and whether it is wise to invest in relationships that could be very transitory, which could be distressing if they evoke feelings of abandonment. Furthermore, Jeffcote and Watson (2004) theorized that women may enter into abusive relationships and become victims due to a maladaptive interpersonal style and it will be particular important for staff to instead promote opportunities for positive peer relationships. There is a need for care staff to be vigilant and ensure inpatient safety but staff's perception of more subtle forms of aggression appear underestimated (Woods, Reed & Collins, 2004) and women have indicated often feeling ill-equipped to manage the emotional intensity of peer relationships (Mezey, Hassell & Bartlett, 2005). Therefore, there is a need for research to guide practice.

Nonetheless there is evidence to suggest that forming relationships with staff and peers enables women to feel understood and connected which was associated with more effective regulation of their emotions and relationships (Jenkinson, 2011). This highlights the importance of relational qualities to many aspects of forensic recovery.

These findings indicate that it is important to provide greater clarity to service planners regarding under which conditions developing women's peer relationships in forensic care is desirable and most likely to be successful and promote recovery, or when positive effects are less likely and instead the risk of harm is increased.

6.5. Limitations of the Research

There are similar limitations affecting the majority of the studies reviewed. They tend to have small samples and self-selecting participants, thus the range of views of women with BPD in forensic care may not be fully represented as recruited patients tend to have more positive views (Bressington, Stewart, Beer & MacInness, 2011). Only one study contained a power calculation of the number of participants required so associations in other studies may have gone undetected due to being underpowered. Many of the studies come from one of three research sites indicating a need to replicate findings to ascertain if they represent general characteristics of forensic care for women with PD. Research in forensic care has been criticised for not exploring gender differences and several of the studies included here had quite minimal gender analysis.

Many of the instruments utilised in forensic services have only been standardised for male populations (Longan & Blackburn, 2009). Despite still being commonly used in research, the WAS (Moos, 1989) has been criticised for being out-of-date (Schalast et al., 2008) and having problems with validity. Whilst the EssenCES has good reliability and its authors believe it has good face validity they state it is not based on a particular psychological model (Schalast et al., 2008).

There was a lack of testing of psychological models and whilst the study with social bonding theory suggested how positive social behaviour may be developed, and the functional analysis of violence identified behavioural characteristics, there lacked understanding of the emotions provoked by others such as jealousy or envy or the desire for another person to feel their pain (Jeffcote & Travers, 2004). There is a need for an understanding of the types of relationship characteristics in women's wards and what factors influence these. For example in a male secure ward improved personal insight

and coping skills were associated with attracting more positive interactions from others (Van Der Horst, Snijders, Volker & Spreen, 2010). General Systems Theory has developed an understanding of forensic ward norms for men and how individuals take up roles and status within a forensic community (Sijuwade, 2007).

6.6. Conclusion

The research indicated that for women who attract a diagnosis of PD their forensic needs are relationally focused but environments may feel re-traumatising, and such women may fear their peers or feel stigmatised. In contrast, when offered sensitive care they can trust this may be a powerful opportunity for building a more secure attachment. Forming cohesive peer relationships can be normalising and increasing the sense of relating can support recovery but without a model to predict peer interactions it is difficult for staff to advise or mediate peer relationships (Jeffcote & Travers, 2004)

6.7. Implications for Research and Practice

It is proposed that the following areas require future research

- Validity and reliability research to assess the gender sensitivity and appropriateness of assessment tools for women who are in forensic care.
- Longitudinal study of women's relationship types and qualities with both staff and patients during forensic admission.
- Investigation of women's experiences of forensic peer relationships.

References

- Adshead, G. (2011). Same but different: constructions of female violence in forensic mental health. *International Journal of Feminist Approaches to Bioethics*, 4(1), 41-68. DOI:10.1353/ijf.2011.0000
- Agrawal, H. R. , Gunderson, J. , Holmes, B. M. , & Lyons-Ruth, K. (2004). Attachment studies with borderline patients: A review. *Harvard Review of Psychiatry*, 12(2), 94-104. DOI:10.1080/10673220490447218
- Aitken, O., Alberti, G., Amadi, O., Appleby, L., Bewley, S., Bhugra, D. et al. 2010. Responding to violence against women and children – the role of the NHS The report of the Taskforce on the Health Aspects of Violence Against Women and Children Retrieved 28.08.14 from http://www.health.org.uk/media_manager/public/75/external-publications/Responding-to-violence-against-women-and-children%E2%80%93the-role-of-the-NHS.pdf
- Aiyegbusi, A. (2004) Thinking under fire: the challenge for forensic mental health nurses working with women in secure care. In N. Jeffcote, & T. Watson, T. (Eds.). (2004). *Working Therapeutically with Women in Secure Mental Health Settings* (Vol. 27). (pp108-120). London:Jessica Kingsley Publishers
- Alexander, I., Simpson, F. , Penny, S. R. , (2011) Editorial the recovery paradigm forensic mental health services. *Criminal Behaviour and Mental Health*, 21, 299-306. DOI: 10.1002/cbm.823
- American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders 5*. American Psychiatric Association.
- Black, G. , Thornicroft, G. , & Murray, J. (2013). What do people in forensic secure and community settings think of their personality disorder diagnosis? A qualitative study. *Social Psychiatry and Psychiatric Epidemiology*, 48(7), 1161-1168. DOI 10.1007/s00127-012-0616-4
- Blackburn, R. (2006) What is personality disorder? In M. Sampson, R. A. McCubbin, P. Tyrer. *Personality Disorder and Community Mental health Teams. A Practitioner's Guide*. (Pp. 21-40) Chichester: John Wiley and Sons Ltd.
- Blatt, S. J. , & Levy, K. N. (2003). Attachment theory, psychoanalysis, personality development, and psychopathology. *Psychoanalytic Inquiry*, 23(1), 102-150. DOI:10.1080/07351692309349028
- Brabender, V. (2002). *Introduction to group therapy*. Chichester: John Wiley & Sons Inc.
- Brendel, D. H. (2002). The ethics of diagnostic and therapeutic paradigm choice in psychiatry. *Harvard review of psychiatry*, 10(1), 47-50. DOI:10.1080/10673220216205

- Bressington, D. , Stewart, B. , Beer, D. , & MacInnes, D. (2011). Levels of service user satisfaction in secure settings “A survey of the association between perceived social climate, perceived therapeutic relationship and satisfaction with forensic services. *International Journal of Nursing Studies*, 48(11), 1349-1356.
[http://www.journalofnursingstudies.com/article/S0020-7489\(11\)00228-8/abstract](http://www.journalofnursingstudies.com/article/S0020-7489(11)00228-8/abstract)
- Brunt, D. , & Rask, M. (2007). Ward atmosphere-the Scarlet Pimpernel of psychiatric settings?. *Issues in Mental Health Nursing*, 28(6), 639-655. DOI:10.1080/01612840701354513
- Brunt, D. (2008). The ward atmosphere of single-sex wards in a maximum-security forensic psychiatric hospital in Sweden. *Issues in Mental Health Nursing*, 29(3), 221-241. DOI:10.1080/01612840701869858
- Carr, M. (2013). The Process of Adjustment and Coping for Women in Secure Forensic Environments. (Unpublished doctoral dissertation). University of Nottingham: Nottingham.
- Chambers, J. C. , Yiend, J. , Barrett, B. , Burns, T. , Doll, H. , Fazel, S. , . . . & Fitzpatrick, R. (2009). Outcome measures used in forensic mental health research: a structured review. *Criminal Behaviour and Mental Health*, 19(1), 9-27. DOI: 10.1002/cbm. 724.
- Cooke, K. , & Bailey, D. (2011). Women's experience of forensic mental health services: implications for practice. *Journal of Mental Health Training, Education and Practice*, The, 6(4), 186-194. DOI 10.1108/17556221111194527
- Crawford, T. N., Shaver, P. R., Cohen, P., Pilkonis, P. A., Gillath, O., & Kasen, S. (2006). Self-reported attachment, interpersonal aggression, and personality disorder in a prospective community sample of adolescents and adults. *Journal of Personality Disorders*, 20(4), 331-351. DOI: 10.1521/pedi.2006.20.4.331
- Daffern, M., Ferguson, M., Ogloff, J., Thomson, L., & Howells, K. (2007). Appropriate treatment targets or products of a demanding environment? The relationship between aggression in a forensic psychiatric hospital with aggressive behaviour preceding admission and violent recidivism. *Psychology, Crime & Law*, 13(5), 431-441. DOI:10.1080/10683160601060861
- Daffern, M. , Howells, K. , & Ogloff, J. (2007). What's the point? Towards a methodology for assessing the function of psychiatric inpatient aggression. *Behaviour Research and Therapy*, 45(1), 101-111. DOI: 10.1016/j.brat.2006.01.011
- Department of Health (2003) Mainstreaming gender and women's mental health: implementation. Retrieved 30.08.2013.
[guidancehttp://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4072067](http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4072067)

- Dickens, G. L. , Suesse, M. , Snyman, P. & Picchioni, M. (2014) Associations between ward climate and patient characteristics in a secure forensic mental health service. *The Journal of Forensic Psychiatry & Psychology*. 25 (1) pp1-17. DOI:10. 1080/14789949. 2014. 903505
- Dixon-Gordon, K. L. , Yiu, A. , & Chapman, A. L. (2013). Borderline personality features and emotional reactivity: The mediating role of interpersonal vulnerabilities. *Journal of Behavior Therapy and Experimental Psychiatry*, 44(2), 271-278. DOI. org/10. 1016/j. jbtep. 2012. 12. 001
- Dolan, M., & Whitworth, H. (2013). Childhood sexual abuse, adult psychiatric morbidity, and criminal outcomes in women assessed by medium secure forensic service. *Journal of Child Sexual Abuse*, 22(2), 191-208. DOI:10.1080/10538712.2013.751951
- Drennan G, & Aldred, D. (2012) Recovery in forensic mental health settings: from alienation to integration. In G. Drennan, & D. Aldred (Ed.). (2012). *Secure Recovery: Approaches to Recovery in Forensic Mental Health Settings*. Abingdon:Routledge. pp1-23.
- Elliott, R. , Fischer, C. T. , & Rennie, D. L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology* 38, 215-229. DOI: 10. 1348/014466599162782
- Fossati, A. , Madeddu, F. , & Maffei, C. (1999). Borderline personality disorder and childhood sexual abuse: a meta-analytic study. *Journal of Personality Disorders*, 13(3), 268-280. DOI:0. 1521/pedi. 1999. 13. 3. 268
- Gunderson, J. (2007). Disturbed relationships as a phenotype for borderline personality disorder. *American Journal of Psychiatry*, 164(11), 1637-1640. DOI:10. 1176/appi. ajp. 2007. 07071125
- Jeffcote, N. Travers, R. (2004). Thinking about the needs of women in secure settings in N. Jeffcote, T. Watson, (Eds.), *Working Therapeutically with Women in Secure Mental Health Settings*(Vol. 27) (pp. 19-30). London: Jessica Kingsley Publishers.
- Jeffcote, N. , & Watson, T. (Eds.). (2004). *Working Therapeutically with Women in Secure Mental Health Settings*(Vol. 27). Jessica Kingsley Publishers:London
- Jeffcote, N. , Watson, T. , Bragg, A. , and Devereux, S. (2004). A women's group in a medium secure setting. In N. Jeffcote, T. Watson, (Eds.), *Working Therapeutically with Women in Secure Mental Health Settings* (Vol. 27) (pp. 129-142). London: Jessica Kingsley Publishers.
- Jeglic, E. L. , Vanderhoff, H. A. , & Donovanick, P. J. (2005). The function of self-harm behavior in a forensic population. *International Journal of Offender Therapy and Comparative Criminology*, 49(2), 131-142. DOI: 10. 1177/0306624X04271130

- Jenkinson, J. (2011). Exploring Recovery and Women Diagnosed with Personality Disorder in a Secure Setting. (Unpublished doctoral dissertation) Canterbury Christchurch University : Canterbury.
- Johnson, D. M. , Shea, M. T. , Yen, S. , Battle, C. L. , Zlotnick, C. , Sanislow, C. A. , . . . & Zanarini, M. C. (2003). Gender differences in borderline personality disorder: Findings from the Collaborative Longitudinal Personality Disorders Study. *Comprehensive Psychiatry*, 44(4), 284-292. DOI. org/10. 1016/S0010-440X(03)00090-7
- Kaplan, A. G. & Surrey, J. L. (1984). The relational self in women. *Developmental theory and public policy in L. E. Walker, L. E. (1984). Women and Mental Health Policy (Vol. 9). Pp59-94. London:Sage Publications.*
- Katsakou, C. , Marougka, S. , Barnicot, K. , Savill, M. , White, H. , Lockwood, K. , & Priebe, S. (2012). Recovery in Borderline Personality Disorder (BPD): a qualitative study of service users' perspectives. *Public Library of Science*, 7 (5) DOI:10. 1371/journal. pone. 0036517. t002
- Kernberg, O. F. (2006). Change in attachment patterns and reflective function in a randomized control trial of transference-focused psychotherapy for borderline personality disorder. *Journal of Consulting and Clinical Psychology*, 74(6), 1027. DOI: 10. 1037/0022-006X. 74. 6. 1027
- Keulen-de-Vos, M. , Bernstein, D. P. , Clark, L. A. , Arntz, A. , Lucker, T. P. , & de Spa, E. (2011). Patient versus informant reports of personality disorders in forensic patients. *The Journal of Forensic Psychiatry & Psychology*, 22(1), 52-71. DOI:10. 1080/14789949. 2010. 511242
- King, G. (2014). Staff attitudes towards people with borderline personality disorder: Therapeutic optimism can be achieved with the use of specially adapted interventions and sophisticated clinical supervision, says Gemma King. *Mental Health Practice*, 17(5), 30-34. DOI:org/10.7748/mhp2014.02.17.5.30.e803
- Knabb, J. J. , Welsh, R. K. , & Graham-Howard, M. L. (2011). Treatment alternatives for mentally disordered offenders: A literature review. *Psychology*, 2, 122. DOI:10. 4236/psych. 2011. 22020
- Lester, R. J. (2013). Lessons from the borderline: Anthropology, psychiatry, and the risks of being human. *Feminism & Psychology*, 23(1), 70-77. DOI: 10.1177/0959353512467969
- Levy, K. N., Meehan, K. B., Kelly, K. M., Reynoso, J. S., Weber, M., Clarkin, J. F., & Kernberg, O. F. (2006). Change in attachment patterns and reflective function in a randomized control trial of transference-focused psychotherapy for borderline personality disorder. *Journal of Consulting and Clinical Psychology*, 74(6), 1027-1040. www.ncbi.nlm.nih.gov/pubmed/17154733

- Livingston, J. D. , Nijdam-Jones, A. , & Brink, J. (2012). A tale of two cultures: examining patient-centred care in a forensic mental health hospital. *Journal of Forensic Psychiatry & Psychology*, 23(3), 345-360. DOI 10. 1080/14789949. 2012. 668214
- Livingston, J. D. , Rossiter, K. R. , & Verdun-Jones, S. N. (2011). 'Forensic'labelling: An empirical assessment of its effects on self-stigma for people with severe mental illness. *Psychiatry Research*, 188(1), 115-122. DOI:10. 1016/j. psychres. 2011. 01. 018
- Logan, C. , & Blackburn, R. (2009). Mental disorder in violent women in secure settings: potential relevance to risk for future violence. *International Journal of Law and Psychiatry*, 32(1), 31-38. DOI. org/10. 1016/j. ijlp. 2008. 11. 010
- Long, C. G. , Anagnostakis, K. , Fox, E. , Silaule, P. , Somers, J. , West, R. , & Webster, A. (2011). Social climate along the pathway of care in women's secure mental health service: Variation with level of security, patient motivation, therapeutic alliance and level of disturbance. *Criminal Behaviour and Mental Health*, 21(3), 202-214. DOI: 10. 1002/cbm. 791
- Long, C. G. , Banyard, E. , Fox, E. , Somers, J. , Poynter, D. , & Chapman, R. (2012). Barriers to treatment: reasons for non-attendance in women's secure settings. *Advances in Dual Diagnosis*, 5(4), 154-163. DOI. org/10. 1108/17570971211281657
- Long, C. G. , & Dolley, O. (2012). Factors predictive of length of stay for women in medium secure settings. *Journal of Psychiatric and Mental Health Nursing*, 19(10), 870-874. DOI: 10. 1111/j. 1365-2850. 2011. 01866. x
- Long, C. G. , Dolley, O. , & Hollin, C. R. (2011). Women in medium secure care: tracking treatment progress for changes in risk profiles and treatment engagement. *Journal of Psychiatric and Mental Health Nursing*, 18(5), 425-431. DOI: 10. 1111/j. 1365-2850. 2010. 01678. X
- Long, C. G. , Fulton, B. , & Hollin, C. R. (2008). The development of a 'best practice'service for women in a medium-secure psychiatric setting: treatment components and evaluation. *Clinical Psychology & Psychotherapy*, 15(5), 304-319. DOI: 10. 1002/cpp. 591
- Long, C. G. , Knight, C. , Bradley, L. , & Thomas, M. (2012). Effective therapeutic milieus in secure services for women: The service user perspective. *Journal of Mental Health*, 21(6), 567-578. DOI:10. 3109/09638237. 2012. 734649)
- Long, C. G. , Langford, V. , Clay, R. , Craig, L. , & Hollin, C. R. (2011). Architectural change and the effects on the perceptions of the ward environment in a medium secure unit for women. *The British Journal of Forensic Practice*, 13(3), 205-212. DOI 10. 1108/14636641111157850
- Lorenzini, N. , & Fonagy, P. (2013). Attachment and personality disorders: a short review. *The Journal of Lifelong Learning in Psychiatry*, 11(2), 155-166. DOI: 10.1176/appi.focus.11.2.155

- Mann, C. J. (2003) Observational research methods. Research design II: cohort, cross sectional, and case-control studies. *British Medical Journal*. 20 54-60. DOI:10.1136/emj.20.1.54
- Mahmood, S. T. , Tripodi, S. J. , Vaughn, M. G. , Bender, K. A. , & Schwartz, R. D. (2012). Effects of Personality Disorder and Impulsivity on Emotional Adaptations in Prison Among Women Offenders. *Psychiatric Quarterly*, 83(4), 467-480. DOI: 10. 1007/s1126-012-9215-5
- Meyer, B., & Pilkonis, P. A. (2005). An attachment model of personality disorders. In M. F. Lenzenweger & J.F. Clarkin (Eds), *Major Theories of Personality Disorder*, pp, 231-281. New York : Guilford Press.
- Mezey, G. , Hassell, Y. , & Bartlett, A. (2005). Safety of women in mixed-sex and single-sex medium secure units: staff and patient perceptions. *The British Journal of Psychiatry*, 187(6), 579-582. DOI: 10. 1192/bjp. 187. 6. 579.
- Mikulincer, M. , & Shaver, P. R. (2007). *Attachment in Adulthood: Structure, Dynamics, and Change*. London: Guilford Press.
- Moos, R. H. (1989). *Ward Atmosphere Scale. Manual (2nd ed.)*. Palo Alto, CA: Consulting Psychologists Press.
- The National Mental Health Implementation Unit. (2010). *Working Towards Women's Well-Being: Unfinished Business*. Retrieved 30.08.2014. <http://www.hsconsultancy.org.uk/system/resources/2/working-towards-womens-wellbeing-unfinished-business.pdf?1302161290>
- Nedderman, A. B., Underwood, L. A. , & Hardy, V. L. (2010). Spirituality group with female prisoners: Impacting hope. *Journal of Correctional Health Care*, 16(2), 117-132. DOI: 10. 1177/1078345809356526
- Nicholls, T. L. , Brink, J. , Greaves, C. , Lussier, P. , & Verdun-Jones, S. (2009). Forensic psychiatric inpatients and aggression: An exploration of incidence, prevalence, severity, and interventions by gender. *International Journal of Law and Psychiatry*, 32(1), 23-30. DOI: 10. 1016/j. ijlp. 2008. 11. 007.
- Nijdam-Jones, A. , Livingston, J. D. , Verdun-Jones, S. , & Brink, J. (2015 in press) Using Social Bonding Theory to Examine 'Recovery' in a Forensic Mental Health Hospital: A Qualitative Study. *Criminal Behaviour and Mental Health*.
- Parkes, J. H. , & Freshwater, D. S. (2012). The journey from despair to hope: an exploration of the phenomenon of psychological distress in women residing in British secure mental health services. *Journal of Psychiatric and Mental Health Nursing*, 19(7), 618-628. DOI: 10. 1111/j. 1365-2850. 2012. 01909
- Parry-Crooke, G. , & Stafford, P. (2009). *My Life: in Safe Hands? Dedicated Women's Medium Secure Services in England*. London: London Metropolitan University. <http://www.ohrn.nhs.uk/resource/policy/WMSSEvaluationFinalReport.pdf>

- Parrott, F. R. (2010). 'Real Relationships': Sociable Interaction, Material Culture and Imprisonment in a Secure Psychiatric Unit. *Culture, Medicine, and Psychiatry*, 34(4), 555-570. DOI 10. 1007/s11013-010-9188-5
- Pfafflin, F. , & Adshead, G. (2003). *A Matter of Security: The Application of Attachment Theory to Forensic Psychiatry and Psychotherapy* (Vol. 25). Jessica Kingsley Publishers:London
- Rich, P. (2006). From theory to practice: The application of attachment theory to assessment and treatment in forensic mental health services. *Criminal Behaviour and Mental Health*, 16(4), 211-216. Sarkar and Di lustro, (2011 - 65). DOI: 10. 1002/cbm. 629
- Rom, E. , & Mikulincer, M. (2003). Attachment theory and group processes: the association between attachment style and group-related representations, goals, memories, and functioning. *Journal of Personality and Social Psychology*, 84(6), 1220. DOI: 10. 1037/0022-3514. 84. 6. 1220
- Rüsch, N. , Corrigan, P. W. , Wassel, A. , Michaels, P. , Larson, J. E. , Olschewski, M. , . . . & Batia, K. (2009). Self-stigma, group identification, perceived legitimacy of discrimination and mental health service use. *The British Journal of Psychiatry*, 195(6), 551-552. DOI: 10. 1192/bjp. bp. 109. 067157
- Sansone, R. A. , & Sansone, L. A. (2011). Gender patterns in borderline personality disorder. *Innovations in Clinical Neuroscience*, 8(5), 16. Pp 16-20. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3115767>.
- Sarkar, J., & di Lusto, M. (2011). Evolution of secure services for women in England. *Advances in Psychiatric Treatment*, 17(5), 323-331.DOI: 10.1192/apt.bp.109.007773.
- Schalast, N. , Redies, M. , Collins, M. , Stacey, J. , & Howells, K. (2008). EssenCES, a short questionnaire for assessing the social climate of forensic psychiatric wards. *Criminal Behaviour and Mental Health*, 18(1), 49-58. DOI: 10. 1002/cbm. 677
- Shultz, K. F., Altman, D. G. , Moher, D. CONSORT 2010 Statement: updated guidelines for reporting parallel group randomised trials. *British Medical Council Medicine*. 8, 18 pp 1-9. <http://www.biomedcentral.com/content/pdf/1741-7015-8-18.pdf>
- Sijuwade, P. O. (2007). General systems theory and structural analysis of correctional institution social systems. *Journal of Social Sciences*, 2, 163-167. Retrieved from <http://www.krepublishers.com/02-Journals/JSS/JSS-14-0-000-000-2007-Web/JSS-14-2-000-000-2007-Abst-Text/JSS-14-2-163-167-2007-444-Sijuwade-P-O/JSS-14-2-163-167-2007-444-Sijuwade-P-O-Tt.Pdf>
- Stepp, S. D. , Hallquist, M. N. , Morse, J. Q. , & Pilkonis, P. A. (2011). Multi method investigation of interpersonal functioning in borderline personality disorder. *Personality Disorders: Theory, Research, and Treatment*, 2(3), 175. DOI: 10. 1037/a0020572

- Van Der Horst, R. , Snijders, T. , Völker, B. , & Spreen, M. (2010). Social Interaction Related to the Functioning of Forensic Psychiatric Inpatients. *Journal of Forensic Psychology Practice*, 10(4), 339-359. DOI:10. 1080/15228932. 2010. 481238
- Verhaeghe, M. , Bracke, P. , & Bruynooghe, K. (2008). Stigmatization and self-esteem of persons in recovery from mental illness: the role of peer support. *International Journal of Social Psychiatry*, 54(3), 206-218. DOI: 10. 1177/0020764008090422
- Williams, J., & Keating, F. (2005). Social Inequalities and Mental Health—An integrative approach. *Beyond the Water Towers*, 113.http://www.centreformentalhealth.org.uk/pdfs/Beyond_the_water_towers.pdf#page=113
- Woods, P. , Reed, V. , & Collins, M. (2004). Relationships among risk and communication and social skills in a high security forensic setting. *Issues in Mental Health Nursing*, 25(8), 769-782. DOI:10. 1080/01612840490506356.

Richard King BSc (Hons) PGDip MSc

MAJOR RESEARCH PROJECT

SECTION B : THE EMPIRICAL PAPER

Peer Relationships of Women with a Diagnosis of
Borderline Personality Disorder in Forensic Care

Word count 7,990 (2,000)

May 2014

SALOMONS

CANTERBURY CHRIST CHURCH UNIVERSITY

For submission to The Journal of Forensic Psychology Practice

1. Abstract

Women inpatients in forensic services are more likely than men to be victims of abuse both as children and adults and attract a diagnosis of personality disorder (PD), most commonly Borderline Personality Disorder (BPD). Developmental adversity increases the likelihood of relational difficulties and emotional regulation problems. An inpatient forensic admission is likely to cause great relational anxiety through sudden separations and it may be difficult to form relationships with care staff and peers. Improving relationships, social networks and interpersonal skills are important for forensic recovery and women have previously reported both positive and negative effects of peer relationships. This research set out to develop a theoretical model of peer relationships of women with a BPD diagnosis in forensic care using grounded theory methodology (Charmaz, 2006). Twelve women with this diagnosis were interviewed about their experiences in forensic care and a model developed. The model characterised how women's experiences of relating with their peer group depended upon ward characteristics and personal readiness for forming relationships. This determined whether superficial interactions or deeper relating was possible. Some relational processes were found to maintain difficulties but other forms of relating could support recovery through fostering hope, providing encouragement, developing insight and establishing new ways to connect with others. The research highlighted the significance for women of peer communities in personal development and recovery, and the need for care staff to develop more nuanced understandings of peer relationships to optimise the conditions for recovery.

Keywords: social milieu, forensic, borderline personality disorder

2. Introduction

2.1. Forensic Care

In a national review of women's forensic services, Parry-Crooke and Stafford (2009) explained that gender differences in offending, relational needs and psychiatric diagnoses indicated that women had distinct forensic care needs compared to men. However, they argued that women had been disadvantaged by their minority status and services required further development to reduce women's offending, to respond to their specific needs as women, and ensure their safety. Analysis of offending behaviour indicated that women were less likely than men to have committed any form of crime and where one was committed it was more likely to be arson and less likely to be a violent offence. When a violent offence occurred women's victims were more likely to be relationship partners (Sarkar & di Lusco, 2011).

2.2. Women's Relational Needs

In addition to disorder specific needs, Kaplan and Surrey (1984) argued that whilst men's development is characterised by individuation, women's well-being sense of self and continued development is partly in reference to their networks of connections (Sarkar & di Lusco, 2011).

2.3. Diagnostic Labels

Women in secure services are more likely than men to have received a diagnosis of Personality Disorder (PD) in particular Borderline Personality Disorder (BPD) (Keulen-de-Vos et al, 2011). The Diagnostic and Statistical Manual of Mental Disorders (5th Edition), (American Psychiatric Association, 2013) defined PDs as characterised by impairments of identity, sense of self, unstable relationships, poor impulse control and fear of abandonment. These are enduring patterns of cognition, affectivity, interpersonal behaviour and impulse control that are inflexible and lead to distress and social impairment (Blackburn, 2006). However, the concept of PD has been criticised as has the predominance of women attracting the diagnosis of BPD (Lester, 2013). Some have argued the discrepancy reflects a gender difference in the expression of the disorder. However, Brendel (2002) explained that many have questioned the existence of BPD as a category at all. Instead it is suggested women have been wrongly pathologised and the category identifies women as having a disorder when in fact their presentation needs to be understood as response to trauma and social disadvantage. Further problems can be created as PD disorder labels may be seen as blaming of women (King, 2014) and also obscure the significance of women's personal histories and social circumstances in the development and maintenance of their difficulties (Williams & Keating, 2005).

2.4. Attachment

How individuals relate to each other is based partly upon their attachment processes which are first developed through primary care relationships where the child develops a sense of their caregiver's ability to accurately perceive and meet their needs. When this is achieved a secure attachment is developed (Mikulincer & Shaver, 2007) and a positive sense of worth at being able to elicit care develops and the expectation of the appropriateness of offered care. In a secure attachment relationship the child's emotions are contained by the care-giver and fed back which supports the development of the child's sense of self and ability to understand and manage emotions.

Women in forensic services who attract a diagnosis of PD are likely to have been victims of childhood abuse (Keulen-de-Vos et al, 2011), and aversive childhood experiences have been linked to the formation of insecure attachments (Blatt & Levy, 2003; Fossati, Madeddu & Maffei, 1999). Insecure attachment results in difficulty in accurately interpreting the thoughts and feelings of oneself and others and a relational style characterised by both enmeshed and dismissing states of mind (Jeffcote & Travers, 2004). There is a desire for closeness but this is in powerful conflict with a fear of intimacy; of being taken over or rejected (Lorenzini & Fonagy, 2013).

2.5. Forensic Admission

Attachment anxiety is likely to be very high during admission to a forensic ward due to sudden separations and losses and the need to form new relationships (Pfafflin & Adshead, 2003). Forensic patients have little control over their environment (Davies, 2004) and allocation is on the basis of legal and not just clinical judgements so treatment readiness cannot be assumed (Jeffcote & Travers, 2004). Women with a

BPD diagnoses are likely to be fearful of care staff based upon their past experiences of receiving 'care'. When staff attempt to offer care women may also reject staff in a pre-emptive move to protect themselves from expected rejection (Lorenzini & Fonagy, 2013). Without a model of secure relationships women may unconsciously attempt to enact learnt maladaptive relating which whilst abusive is at least predictable and staff may be unaware of the roles they are drawn into (Pfafflin & Adshead, 2003).

2.6. Peer Relationships

Women separated from their existing relationships may have few emotional resources and seek meaning and validation through new relationships (Jeffcote & Travers, 2004). However, maladaptive interpersonal behaviour often results in re-enacting prior abusive relationships (Weldon, 1991) where they can be either victims or perpetrators. In the absence of early attachment developing in a caring relationship, then punitive behaviour by others which at least acknowledge one's existence may represent love to that person (Jeffcote, Watson, Bragg & Devereux, 2004). Violence may be used as an aggressive denial of their own dependence and powerlessness (Jeffcote & Travers, 2004).

However, women in forensic care also frequently show great kindness and acceptance towards each other (Jeffcote & Travers, 2004) and women have referred to their peer relationships as a source of support, acceptance, and camaraderie. (Nijdam-Jones, Livingston, Verdun-Jones & Brink, 2015).

2.7. Peer Relationships and Recovery

Definitions of forensic recovery by Alexander, Simpson and Penney (2011), Drennan and Aldred (2012), and Nedderman, Underwood and Hardy (2010) all emphasise the development of hope for change, developing personal agency and self-worth, and improving relationships. However, developing relationships may be particularly difficult for women who have experienced abusive relationships (Jeffcote & Travers, 2004) and for women who attract a diagnosis of BPD the distress experienced within relationships are often the most intransigent of difficulties (Gunderson, 2007; Stepp, Smith, Morse, Hallquist & Pilkonis, 2012). Peer support can include the sharing of experiences and role modelling to develop hope for change and in community settings has been shown to reduce stigma (Davidson & Rowe, 2008). There had been little research to date in the forensic services (Davison, Rowe, Tondora, & O'Connell, 2008),

2.8. The Value of Group Treatment Settings

Peer interactions can be a vehicle for change and Kilman et al (1999) demonstrated that group therapy helped women with attachment difficulties to improve their interpersonal styles and develop more secure attachments. Yakeley and Wood (2011) reviewed forensic psychotherapy group inpatients who explained that seeing their own difficulties reflected in the accounts of others lead to greater self-acceptance. This identification created tolerance and positive feelings for others and themselves. Jeffcote, Watson, Bragg and Devereux (2004) described a women's group in a medium secure hospital where, once trust was established, women were

able to experience support, raise powerful issues and experience a sense of belonging, normality and identity, but such relating was also often difficult to sustain.

Following BPD group treatment participants explained that sharing with peers helped them to normalise their experiences and was inspiring but they could find their peers' emotional reactions distressing and lead them to drop out (Pipon-Young & Cole, 2012). Jenkinson (2011) found that peers provided support which validated shared experiences, but at times women found it necessary to protect themselves from others' distress.

Therapeutic communities use peer relationships as the vehicle for treatment; as a catalyst for adaptive attachments (Chiesa & Fonagy, 2010) and empowerment through human relations (Haigh, 1999). However, an individual's actions are examined in minutiae and commented on by the whole community and social learning can be emotionally challenging and confronting (Vandeveld, Broekaert, Yates & Kooyman, 2012). In forensic care, admission is usually involuntary and this treatment approach might be considered too intense for the majority of women forensic inpatients (Dr Nikki Jeffcote, Oxleas, Personal communication, 27th July 2012). Women's forensic therapeutic communities have not yet been empirically evaluated but in women's prisons, therapeutic communities have been demonstrated to produce more adaptive change and decreased recidivism than CBT (Sacks, McKendrick, & Hamilton, 2012).

Interestingly, there is evidence of beneficial incidents both within the peer group and outside of formal therapy (Bloch & Crouch, 1999) and behavioural change is most effective when patterns of unhelpful behaviours are identified both within a group and also when they are happening outside of it (Brabender, 2002). However, Jeffcote and Travers (2004) explained that it is unclear the extent to which relational

learning is possible in forensic care. They noted that in women's medium secure care there were potential opportunities for individuals to reflect upon and learn how to resolve conflicts but nursing staff understandably intervened to prevent physical injury although later did not revisit the incident with women which could have provided a learning opportunity. As a result, women are not necessarily provided with the required support to explore the range of interpersonal interactions they experience and explore alternative relational behaviours in more stressful or difficult situations (Jeffcote & Travers, 2004).

Whilst studies have highlighted how peers can provide support both informally (Bloch & Crouch, 1999) and in therapy groups (Yakeley & Wood, 2011) these studies are cross-sectional and do not describe the dynamic nature of relationships or the detail of mechanisms through which relationships may support or hinder recovery.

2.9. Rationale

Women forensic inpatients who attract a diagnosis of BPD are likely to be survivors of childhood abuse and social inequality. Due to developmental adversity they commonly experience distressing attachment relationships and admission to a forensic unit and needing to form relationships with staff and peers is likely to be difficult and provoke anxiety.

In this context, women have little control over their social environment and whilst some have found peer relationships supportive others have been fearful of their peers. Also some women may perpetuate unhelpful patterns of relating as a consequence of insecure attachment; both desiring and fearing intimacy and identify themselves alongside peers in complex ways based upon prior experiences of

relationships (Pfafflin & Adshead, 2003). Currently, there is a lack of theory or research evidence to predict under what conditions forensic peer relationships are likely to be helpful and contribute to recovery or maintain distress and unhelpful ways of relating. This will be important in identifying and minimising potential harm or distress and optimising recovery potential.

2.10. Aim of the Research

The aim of the research was to develop an explanatory model based upon the views of women in forensic care, who have received a diagnosis of BPD, about the role of their peer relationships in their experiences of forensic admission and in their self-defined recovery.

3. Method

3.1. Participants

The inclusion criteria were for participants to be over 18 years and to have had an inpatient forensic admission of a minimum of six months. It was expected that the majority of participants would currently be inpatients. However, the admission could be historical. It was believed that as improving relational style is associated with recovery then reflections upon the meaning and qualities of relationships are likely to hold different significance at different stages of personal recovery. Therefore it was hoped that some participants would be further in their recovery and able to reflect from this standpoint on when they were in forensic care. It was hoped this would strengthen the subsequent analysis and their inclusion would model a wider range of perspectives.

The clinical reality for this group meant that many women have attracted multiple diagnoses across their time within psychiatric services and inclusion was based on the presence of BPD in their case history and co-morbid conditions were allowed. The exclusion criteria were a primary diagnosis of psychosis or schizophrenia and under six months history of inpatient forensic admission.

Participants were twelve self-selecting women with an age range of 27-54 years. The majority had a combination of forensic inpatient stays at different levels of secure care within the service and all but one had been in medium secure care. At the time of interview eight were in low secure, one medium secure and three in the community. All had a current diagnosis of BPD along with co-morbid conditions. (See Appendix 3 for demographic details).

The grounded theory cycle is one of data collection, analysis and further theoretical sampling and recruitment based upon the emergent theoretical categorisation. Dey (1999) explained that sampling continues until theoretical sufficiency is achieved. The emergent theory at this stage is said to have then reached good explanatory power. This was reached after twelve interviews. This concept of sufficiency was preferred to that of theoretical saturation which implies the process has been exhaustive and is unrealistic in this process (Dey, 1999).

Due to the depth of analysis required for grounded theory the sample size of twelve was found to be typical for such research in this area. Similar studies interviewing forensic inpatients about their experiences and recovery had sample sizes of eight (Hinsby & Baker, 2004), thirteen (Laithwaite, & Gumley, 2007), ten (Mezey, Kavuma, Turton, Demetriou, & Wright, 2010), six (Sainsbury, Krishnan, & Evans, 2004), and twelve (Wynn, 2004).

3.2. Sampling Strategy

Three sites within one English NHS trust were chosen that represented different stages in forensic care; medium, low, and community services. This was to gain a broad range of experiences at different stages of women's recovery.

The researcher visited morning meetings at the sites over a period of three months and spoke with women about the research and left information leaflets which detailed the aims of the study and the involvement required by participants (Appendix 7). The researcher also displayed posters and met with nursing teams to promote the research. Inpatients and community patients were also identified by care staff as potential participants and if they met the inclusion criteria they were

approached by the key worker and given an information sheet. They were later approached by their key worker to ascertain if they would be interested in participating. On the day of the interview participants were asked to confirm and provide written consent.

3.3. Ethics

The study was granted ethics approval by the NHS Research Ethics Committee (Appendix 3) and the participating trusts Research and Development committee (Appendix 4). The study adhered to the Health and Care Professions Council (2008) and British Psychological Society code of ethics and conduct.

3.4. Design

The research employed a qualitative design because this was an under-theorised area and Grounded Theory Methodology (GTM) offered a systematic approach to analysing a social phenomenon and processes grounded in the data (Charmaz, 2006). As such this was appropriate for better understanding the processes involved in peer relationships. Madill et al (2000) argued that the philosophical position when using GTM depends on how the findings are interpreted; the extent to which the findings are considered to be discovered within the data or the result of construction of inter-subjective meanings.

Charmaz's (2006) social constructivist approach was adopted because it acknowledges the role of the researcher and participant in co-constructing the data which will have unique qualities associated with that particular encounter. The data produced will depend upon the participants own understandings and cultural meaning

systems, their experiences of the researcher and the researchers interpretations. The assumption here being that multiple constructions of reality exist, and society privileges certain constructions over others. Women who tend to be in forensic care have experienced multiple social inequalities and social exclusion by admission to forensic care and providing a platform for their experiences to be heard is consistent with this approach. Therefore the aim was not to discover a universal truth but develop a co-constructed understanding of women's peer relationships and an explanatory model from the perspective of the participants.

Semi-structured interviews are consistent with generating data for GTM analysis (Urquhart, 2013), and the methodological design for conducting the interviews was based upon Mills, Bonner and Francis's (2006) criteria for constructivist GTM. Firstly, they urged that as the research is a co-construction the researcher must be mindful of power imbalances that will affect the nature of the data. Their recommendations were followed and in an attempt to redress some of the imbalance the participants were able to make their own choice of interview location and chaperone. Interview questions were designed to be open-ended to give participants control to develop their reflections and responses of what they felt was meaningful. The participants had control over the interview's length and when breaks were taken.

Mills, Bonner and Francis (2006) recommended that the researcher invests personally in the research and so for a 6 consecutive weeks the researcher visited each ward once a week for 3 weeks and twice a week for a further 3 weeks from 9am-5pm, including attendance of the morning meeting to promote the research, so that staff and inpatients had the opportunity to get to know the researcher and vice versa.

Mills, Bonner and Francis (2006) also emphasized the role of reflection in constructivist GTM for raising personal awareness of one's own filters through which data is generated and analysed and is addressed in section 3.8. Memoing was undertaken and an effort made to keep the voice of the participant through the use of their language and quotations in the analysis and write up.

3.5. Materials

A draft interview schedule was designed through consultation with the literature and experts in the field. The researcher then met with three service users who gave comments about the nature of the study and the question areas they believed were most salient. The service users then helped to design the questions and checked the accessibility of language and that the questions would be unlikely to cause distress. (See Appendix 12 for the interview schedule). For community participants they were asked to reflect upon their prior forensic admission. The researcher used the same interview schedule but asked questions in the past tense.

3.6. Procedure

Potential participants were given an information sheet and asked to sign a consent form prior to interview. Participants took part in a one-off interview which was conducted with a female chaperone in a quiet room on the patient's unit, or for community patients, at their day services. At the start of interviews participants were reminded they were free to end the interview without any explanation or repercussions to their care. Interviews took between 45 and 80 minutes. At the end of the interview the participant was debriefed and offered an individual session with their key worker.

There were two stages to the procedure. Once the first six interviews had been completed, the initial analysis was undertaken. Certain themes were identified and to gain further depth and clarification of their significance, a further six interviews were completed based upon theoretical sampling (Charmaz, 2006). Two forms of theoretical sampling are identified whereby particular participants are selected because they are the ones likely to be able to provide more information on a particular topic. However, in this case all potential participants who met the inclusion criteria would be expected to be able to comment on these themes. Therefore the interview schedule was adapted to include further focus upon these themes which were about competition between inpatients, status, coercion and bullying.

Following data analysis the participants were asked to complete participant verification of the categories and the model that was generated. Eight participants were able to do this. (Appendix 15; participant feedback form).

3.7. Data Analysis

Audio recordings were made of the interviews and then transcribed verbatim with any identifying information removed. A sample of transcripts were made by a person employed to do so who signed a confidentiality form (Appendix 10).

Following this the transcripts were analysed using Charmaz and Bryant's (2011) GTM protocol. Once the first six interviews had been completed then line by line coding was undertaken which enables the researcher to become immersed in the data and identify active codes related to actions and meanings. During this and all subsequent processes memos were used to identify how concepts related to the emerging theory.

The next stage was to code at the next conceptual level which was to construct the focus codes from the most frequent codes. During this and all subsequent stages constant comparison was made between data, and all the levels of abstraction. Whilst retaining constant comparison between the focus codes and memos the theoretical codes were established of the relationships between codes. This process also involved diagramming of the codes.

Theoretical sampling then continued to expand and gather more data of the focus codes and theoretical codes and refine provisional categories. The remaining six interviews were analysed with the focus codes and memos and constant comparison until no new codes were generated.

3.8. Quality Assurance

The social constructionist approach to GTM acknowledges the role of the researcher in the production of data from interviews and in the subsequent analysis. The following quality assurance steps were taken to ensure reflexivity and transparency.

The significance of the role of the researcher was acknowledged through bracketing interviews conducted with a research peer before and after the data collection phase to raise self-awareness and sensitivity to the researcher's beliefs, influence of the researcher, biases, assumptions, interests and approach to the research and data produced which will all influence the data collection and analysis. This aided awareness of the impact of such assumptions upon the data collection and analysis.

Self-reflection was supplemented by using a reflective diary throughout the research project to raise awareness of the researcher's biases and reactions to the data (Appendix 16) and examples are presented. This provides readers with some opportunity to see the thought process and track the development of the analysis and appraise the impact of this upon how the researcher presented the findings.

To demonstrate how the categories were grounded in the data there was extensive use of quotes in the results, and in Appendix 14. Quotes were used extensively to exemplify the categories and increase credibility and the opportunity for others to assess the quality of the categories (Hill et al. 2005).

During the research process, the coding was cross checked with research supervisors. Also within a peer research group, members were consulted at each

stage regarding the researcher's approach to the data and analysis. A sample of focus coding was checked by a peer researcher and where there was lack of clarity this was discussed until an agreement was made. During the analysis the researcher actively looked for dis-confirming cases to ensure that the researcher stayed open-minded to the possibilities of the data. Respondent validation was completed with a summary of the model to assess how closely it corresponded to the participant's experience of the phenomena. (Appendix 15).

4. Results

4.1. Overview of the Model

Figure 1 outlines the constructed model of peer relationships of women with a BPD diagnosis in forensic care and the potential for relationships to promote recovery. The analysis produced nine major categories. These categories, sub-categories and focused codes are presented in Appendix 13.

This model has two overarching ways in which peers engage with each other. This can either place an emphasis on survival and coping or upon more deeply relating to their peers. In this model the engagement style was determined by a combination of the ward and personal conditions of the individual. The relating mode may lead to negative experiences or maintain unhelpful ways of relating but positive relating had the potential for developing recovery.

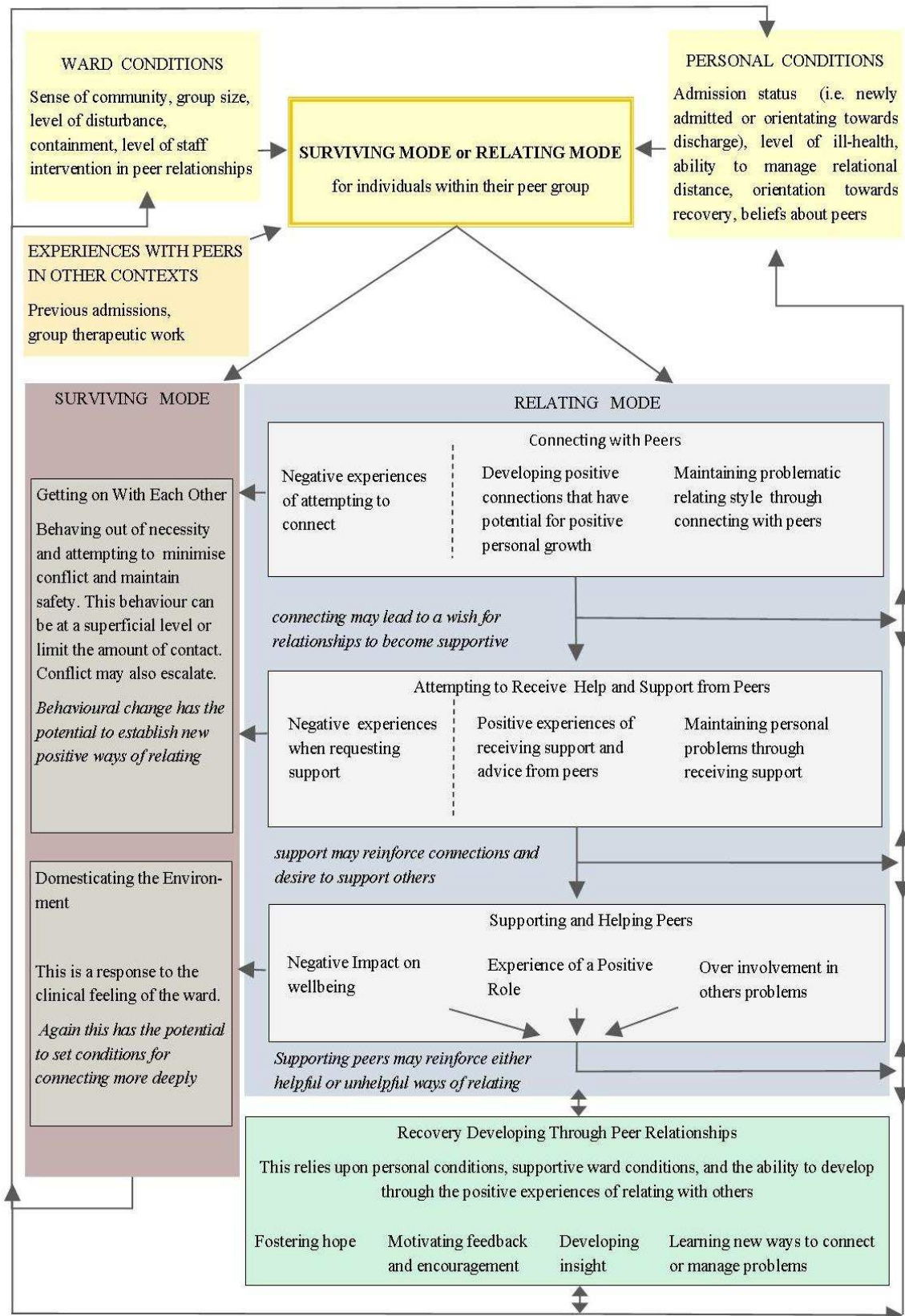


Figure 1. Peer relationships of women diagnosed with borderline personality disorder in forensic care and the implications for recovery

The model and relationships between categories and sub-categories are now explored. Unless otherwise stated all headings in bold typeface refer to categories and sub-categories are in bold with italics.

4.2. Interactions that Set the Functioning Mode for Interpersonal Peer

Behaviour

At the centre of the model is the mode of interpersonal functioning which directs an individual's expectations and behaviour. The mode is determined by the dynamic relationship between the ward and personal conditions which are mediated further for some participants by knowledge of peers in other contexts.

4.2.1. The Ward Conditions

This represents participants' experiences of action or identity at a group level. Positive group identity was developed through shared experiences of survival and created a sense of unity.

“the fact that we’ve been through tough times and that’s brought us ... closer together.” (Participant 3, Line 219)

Ward atmosphere variables that could negatively influence the mode were related to increased size of the inpatient group and levels of disturbance which could be re-traumatising and lead to withdrawal from the group.

“Yeah, a lot of banging or shouting or people um being restrained... I would feel absolutely terrified ... it brought things back” (Participant 2, Line 262)

The subsequent loss of unity and community spirit could be frightening to women and further negatively influence the mode of relating.

“When there is less sense of a shared community then you feel more vulnerable and anxiety and it’s highly stressful... it’s a very detrimental effect to recovery” (Participant 1. Line 514)

4.2.2. Personal Conditions

The individual’s personal conditions contributed to the mode of interpersonal behaviour. Personal conditions such as wellness impacted upon interpersonal communication.

“I became very ill and I used to shout a lot... they didn’t want to know and it wasn’t really their fault” (Participant 7, Lines 94-96).

The admission status influenced whether an individual was starting to get to know their peers, deepening relationships or looking towards discharge and focused upon reconnecting with external relationships.

“I go out a lot more ... I’m less involved in the ward activities or what’s going on here and I think I’d be more involved with the other women here if I wasn’t moving on.” (Participant 4, Lines 249-258).

4.2.3. Experiences with Peers in Other Contexts

Experiences in other contexts moderated the effects of the ward and personal conditions. Knowing other women from previous admissions could help to reduce anxiety when first admitted.

“There was quite a few of us came at the same time ...so it wasn’t too bad”

(Participant 4, line 14)

Experiences from other contexts such as group therapies were largely seen as positive. However, when trust was broken there was a withdrawal to the surviving mode. Nonetheless when this was more positive this could provide experiences or skills to promote a deeper connection between peers

“Being in a group made me more able to interact with people, and you feel in more contact with them after the group and understand them.”(Participant 3. Lines 644-646).

“I’ve learnt to do it quite gingerly to bring up tricky things. I’ve said to [xxxx] before in a group, you know, about her hitting a member of staff, and she said she had no idea that it affected us that way. So it was good to have her feedback. After the group we were fine and I think she found it helpful as well. I think its good you get a deeper understanding of where you stand with each other” (Participant 6 Lines 938-943).

4.3. The Surviving Mode

The balance between ward characteristics and personal characteristics direct the type of mode. The surviving mode is an orientation towards coping with the difficulties of living on a forensic ward. Apprehension about engaging with peers lead to minimising the risk of conflict and maintaining safety, which is likely to keep relationships superficial. Depending upon the potential transitory nature of relationships and likelihood of harm through relationships then the surviving mode may be adaptive. Coping responses included social withdrawal but these strategies were not always successful and conflict could escalate.

“I never state my view because I am fearful *and it's another way in which I protect myself, because that's how arguments and disagreements [start]*”

(Participant 1 Line 214)

4.3.1. Getting On with Each Other

A forensic admission meant that women were in close proximity for much longer than on other wards. The participants reported it was an imperative to get on with each other which had the potential for women to employ pro-social behaviour they would not normally use. If this was successful and the behaviour positively reinforced this may influence the mode changing to the relating mode and ultimately lead to promoting recovery.

“I'd never done it before but learning here to apologise made me stronger, I think err because I could apologise and not let things get, drag me down. I'm now quite happy to say sorry because I got my friends back”

(Participant 8, Line 142-144).

4.3.2. Domesticating the Social Environment

Through being a community of women, and using familial ways of communicating to each other that reflected valued or desired family bonds this helped with coping with the clinical harshness of the environment.

“when it’s just women you become, I don’t know what the word is, but you become closer, like a family if you’re like all women, because we look after each other like sisters”(Participant 8. Line 214).

“They try and make you like a sister, or if you’ve got a mother at home, they try and make you like a mother and say “oh, you’re like a mother to me”, they try to make characters out of the people.... It helps I’ve done it. I have said to people “you’re like a mum to me”(Participant 7, Lines 456-461).

Doing everyday activities or just ‘hanging out’ was valued as a way to normalize their day. These experiences could improve well-being, peer closeness and ward conditions, and result in a change to the relating mode.

“Doing normal little things together is important there’s a sense of you not being so disconnected from the real world, and you get closer ”
(Participant 1, Line 476).

4.4. The Relating Mode

The following provides an overview of the relating mode which is then followed by a detailed analysis of the categories.

Positive experiences with peers, improved ward characteristics, or personal well-being all may contribute to changing to the relating mode which allowed a deep level of peer interaction.

The relating mode was comprised of three categories. The first was connecting with peers. If connections were perceived by the individual as being positive, even ones that may perpetuate unhelpful ways of relating, then the person was more likely to try to develop relationships including requests for support from their peers. If receiving help was experienced as positive by that person then they wished to take on a helping role with others. Perceived negative experiences at any stage may feedback and influence a return to the surviving mode.

Perceived positive peer relationships of developing connections and reciprocal support then provided the opportunity to move from the relating mode to promoting recovery. However, at each stage unhelpful ways of relating may alternatively maintain the person's difficulties despite their continued efforts at developing connections.

The mode state remains dynamic with the ward and personal states and if ward conditions no longer support the relating mode, personal conditions change, or relating with peers is experienced negatively, there will be a movement back towards the surviving mode.

However, in circumstances where the individual is developing relationships that maintain unhelpful ways of relating, or they are being exploited, this will continue in the relating mode if not perceived by the individual as negative.

4.4.1. Connecting with Peers

Attempting to form a deeper level of connecting in the relating mode may draw upon positive skills learnt in the surviving mode. Participants spoke of their wish for meaningful relationships with peers. The context also provided more opportunity for developing connections with peers due to the length of admission, being cut off from pre-existing relationships, and the common difficulties experienced in their personal histories.

There were three sub-categories associated with connecting with peers and each had characteristic behaviour, types of experience, and interpersonal consequences. They determined whether or not connecting was experienced positively and whether unhelpful relating was maintained or conditions developed that could promote recovery.

Negative Experiences Through Attempting to Connect with Peers

Participants' spoke of the consequence of feeling their trust had been betrayed, the over-intrusiveness of peers, or feeling rejected which all led back to the surviving mode.

"I now tend to keep things to myself... I told someone [about my symptoms] who then took the piss and I burst into tears, and I had to take something [sedating medication]" (Participant 8. Line 629-640)

'Othering' could inhibit relationships developing but also instability in relationships was common. Even positive expressions of friendship could be experienced with fear.

“Well then I really worried [after someone gave her toiletries] oh gosh, I’ll have to get them something back, and why did they do that but later I realised they were just doing it altruistically” (Participant 2. Line 32-33)

Participants’ wellbeing could be affected by worrying about a peer or a sense of lost hope if friends were re-admitted. But there was also a sense of loss when friends were discharged.

“When one gets discharged, [it’s] like you’re losing someone” (Participant 8. Line 222)

Developing Positive Connections That Have Potential for Personal Growth

Relating could produce positive interpersonal changes. Over time participants could find in their shared experiences, a deep mutual understanding and connection with peers and learn to trust.

“friendships ..., have formed over years of being in hospital with the same people, it’s got a lot deeper level of trust and the understanding and caring and friendship” (Participant 2. Lines 395-401)

Feeling accepted and connected were powerful new experiences for many participants and there could be a determination for relationships to continue following discharge developing a hopeful image of a future away from services.

“I used to feel alone but then found it’s reassuring to know that you are not an isolated case and you will go on together” (Participant 6. Lines 371-372)

Maintaining a Problematic Relational Style

Participants explained that some types of closer relationships had negative consequences which they may not be aware of at the time as interpersonal difficulties such as idealising others or becoming over involved could prevent recovery.

“We ended up very close friends and of course if she kicks off and staff went to grab her then, ... I would go and help free her, and it ended up that we both ended up kicking off” (Participant 12. Lines 300-302).

Negative feeling of jealousy, competition, holding grudges or peer pressure could undermine progress and relationships.

“yeah I’ve done it to new people [purposefully being overly intrusive] and It’s difficult because it feels like you’re interrogating them but it’s expected that we do it” (Participant 8, Line 701).

Competing could be used to establish dominance.

“When you’ve got someone trying to be at the top, they can be very intimidating. It depends on what sort of people you have in the unit ...whether there is competition for top dog. Sometimes it can be the whole group fighting to be top” (Participant 12 Line 930-932).

4.4.2. Attempting to Receive Help and Support from Peers

If connections had been developed with peers this prompted relationships to develop where support and help were sought. There were three types of outcome with associated consequence for peer relating.

Negative Experiences When Requesting Support

There may be rejection for requests for help or sense of guilt for asking. These would reduce the likelihood of developing supportive relationships and could lead back to the surviving mode.

“I do sometimes tell other women when I'm not coping or going to self-harm, but sometimes it upsets them and then they go to staff because they're upset, and then I feel guilty, I want to go to them [peers] but now I go to staff and don't say so much [to peers] (Participant 8. Line 338-340).

Positive Experiences of Receiving Support from Peers

Receiving help and support could deepen connections and trust. The sense of being worthy of support and kindness from a peer was different to that from a staff member who was being paid to provide care. As well as the particular characteristics of the help received there was a deep meaning associated with receiving support from one's peer and this reinforced connectedness. It could also normalise problems and such experiences promoted reciprocal relationships and created the conditions for peer relationships to foster recovery. Peers demonstrated great insight and ability to emotionally reach others in distress.

“A lot of these women, they're very sensitive to what is needed and how to get through to someone that's on their bed and is just struggling. Like they remind [them] of things that um that they had a laugh about at another time or they'll call them a little nickname and connect” (Participant 2, Line 203-205).

Maintaining personal problems through seeking supportive relationships

However, the successfulness of helping relationships was moderated by the appropriateness of expectations and the quality of support. Inappropriate requests or unhelpful support may perpetuate relational difficulties.

“I was very lively with self-harming and stuff, and you um you tend to expect more of people. I expected them to communicate with staff for me, or keep it quiet if they know I’d self-harmed, and not to tell anyone. But you can’t put that on people but [I] didn’t realise it at the time and felt sort of betrayed, I suppose and other women when I asked for help would egg me on to do stuff and that kept me back”. (Participant 10, lines 770-774).

4.4.3. Supporting and Helping Peers

Developing connections with peers and receiving support could lead to the desire to adopt a supportive role towards others. This was a valued role and revealed great compassion and the wish to reduce another's suffering. There were three alternatives identified that could either reinforce both helpful and unhelpful relational patterns or reduce contact. If supporting others developed a mutual supportiveness this had the potential to positively influence peer cohesion and ward conditions. Both accessing and giving support were closely connected to the ability for relationships to continue successfully and could set conditions for peer relationships to support recovery.

Negative Impact upon Personal Wellbeing in Giving Care

Providing care may affect one's wellbeing so there was a need for balance in care giving which could be difficult and present a dilemma of when to involve care staff.

“it's hard work because obviously I want to help her, and I can see her failing and that's upsetting, but on the other hand I've got to try and look after myself as well” (Participant 12, Lines 381-385).

It could also be difficult to know how best to help

“It's hard gauging when and who is right to go and approach that person and check on them (Participant 2. Line 199-201).

Experience of a Positive Role

Giving care could feel positive and strengthen the sense of connectedness.

“we have gone through the same stuff and knowing I can be of support is good and realising we *know what we’re talking about when we give advice*”

(Participant 8, Line 655)

Over Involvement in Peers Problems

However, difficulties with regulating emotional distance with peers may result in feeling rejected, maintaining relational problems.

“it could be frustrating when you’re trying to help someone and they’re just totally pushing you away. I could become quite depressed and angry with myself if I couldn’t help someone or they wouldn’t let me. But I understand now and it’s not like that now” (Participant 12. Lines 422- 425)

4.5. Recovery Developing Through Peer Relationships

Experiences of peer relating could improve sense of self and wellbeing as well as develop interpersonal skills and capacity for self-reflection. This could support both internal and relational recovery but was dependent upon personal conditions including wellness and readiness to accept feedback. This was also related to the credibility of peers, ward conditions and how engaged the participant was with positive change.

There were distinct types of action through relating with peers that supported recovery. These were the fostering of hope, motivation, developing personal insight, learning new ways to connect positively with others and learning ways to manage problems.

Fostering Hope

Testaments from peers had particular power due to authenticity and credibility.

“one thing that really stuck in my minds, that someone told me once, “life is worth living, and no matter what you’ve been through you can always come out of it”. I think that really stuck with me because of all she had been through” (Participant 12, Lines 693-695).

Due to shared experiences then the recovery of one’s peers could foster hope for one’s own progress.

“she wasn’t very well...now she’s just doing so well she sees her daughter. Being a real mum, and that’s what I want to be with my daughter... I want to be more hands on when I get out. ” (Participant 6, lines 535-520)

Motivating Feedback and Encouragement

Praise from valued peers and their positive responses to the person's more adaptive relating, reinforced pro-social behaviour.

"I've tried not to be as in their face and keep it a bit more to myself and they've been lovely and have more time for me." (Participant 7, Lines 170-172).

"I was told I was putting XXXX on a pedestal and I took it well really, I took it well and I felt I had to deal with it and they said I did well" (Participant 6, Line 681)

Insight through Feedback from Peers

Developing insight could lead to change and was dependent upon peer group cohesion and valuing credible peers.

"these girls are great and they see things in you that you don't see in yourself. I learn how others see me. ... you do look at yourself and it means that you can grow." (Participant 7, Lines 170-174)

Learning New Ways of Connecting with Others

In forensic care, connections with peers had been developed over long periods of time. Through peer cohesion, recovery could develop through learning ways to develop and maintain meaningful relationships.

“I’ve learnt through being in secure hospitals how to form friendships, how to feel affection, how to sort of like reach out to people, how to show caring and listen to them and understand them and be a shoulder for them to cry on if they need to, and just basically how to sort of engage in a friendship with another human being and when I leave hospital that will carry on and go into all my relationships” (Participant 2, Lines 455-460)

Learning New Ways of Managing Problems

Receiving non-judgemental advice from peers who had overcome similar difficulties was seen as very helpful.

“Well when you self-harm the people you know from life in the community would be like “you’re so stupid. Why would you do that?” and people in hospital were like “yeah, I understand why you do that, but why don’t you try this?... and it works” (Participant 12 Lines 796-799)

Feeling more competent at talking through difficulties with peers resulted in women's communicational skills developing and them feeling better able to discuss difficulties and resolve their distress rather than resort to less helpful behaviour.

"If I had a problem with someone, well it was negative thinking that's not very good. I'd end up like thinking badly of myself for too long, I ended up self-harming...I talk to the other women now if I feel I have a grudge and try and resolve it. " (Participant 6, Lines 196-200).

Seeing peers with similar difficulties to themselves resolve problems could be a template for progress.

"I've learnt through seeing amazing examples of women resolving conflicts. It has taught me and I'm still learning, seeing how they handle it"
(Participant 2, Line 561).

This included being able to learn through relationships with peers how to recognise and resist getting stuck, and instead focus upon recovery.

"I've learnt from the others so when XXXX says to me " I don't want you to [be discharged], I want you to stay here with me", part of me still says yeah blow it, stay here, but now the other half says you want to be like XXXX and you want to be with your daughter " (Participant 6, Lines 768-773).

5. Discussion

5.1. The Significance of Women's Peer Relationships in Forensic Care

Using grounded theory methodology this study was successful in inductively generating a model which highlighted the significance of women's peer group relationships in the clinical outcomes of their forensic care. It is consistent with previous findings that women are intrinsically motivated to connect with others (Nedderman, Underwood & Hardy, 2010) and the importance of women's social networks on their wellbeing (Jeffcote & Watson, 2004). The findings underline policy that stated the need for women's forensic services to promote a relational focus and support women to re-establish a sense of peer community (Parry-Crooke & Stafford, 2009).

Whilst recent policy recognised the importance of peer relationships, how this was to be achieved was not explained and Long, Fulton and Hollin (2008) believed little was known about how to address women's relational needs with peers. Long et al. (2011) suggested there may be specific challenges to forming relationships with peers as they took longer to achieve than with care staff. The model helps explain the differing effects of peer relationships and indicates the need for more nuanced thinking about them. Personal and ward conditions determine women's interpersonal mode of behaviour which can be superficial to maintain safety and survival, or progress to deeper peer group identification and relating. The current findings suggest that peer relationships play a central role in recovery as there are wide ranging effects including improved self-esteem and emotional regulation.

5.2. Interpersonal Difficulties and Coping Strategies

The National Mental Health Implementation Unit (2010) stated that women in forensic care required a high level of relational security and need to recover from trauma and develop social networks. However, Sarkar and diLustro (2011) warned that services often fail to recognise the impact of women's development on their current functioning. In this case, participants were women who had attracted a BPD diagnosis and there is concern this label obscures the effects of women's personal histories (Brendel, 2002). Relating was found to be complex and the model highlights how developmental trauma and attachment difficulties may maintain unhelpful relational styles and women will still seek meaning and validation through relationships even if detrimental to them (Jeffcote and Travers, 2004).

The current research had similar findings to Mezy, Hassell and Bartlett (2005) who highlighted how women can feel unsupported by staff to develop their relationships and ill equipped to manage the emotional intensity of women's wards. In the current research, participants described feeling fearful of others and, at times, re-traumatised which created a barrier to accessing the peer group relational environment.

In this model, personal conditions contributed to the type of interpersonal mode and this is consistent with a stage model of readiness for recovery (Andresen, Caputi & Oades, 2006). The combined effects of ward characteristics, such as inpatient numbers, level of disturbances and individual conditions (including level of distress), determine the conditions under which peer cohesion and relating are harder to achieve. This can result in more superficial "survival mode" interactions and a reduced sense of community. The complexity of peer relationships is highlighted in that at any one time whether survival or relational mode is currently the most

adaptive depending upon a number of factors. Admission to forensic wards may be transitory and so investment in relationships and then the sense of abandonment once they ended could be highly distressing. The findings of the study indicate that participants at times experienced aversive effects of peer relationships or sense of rejection at unsuccessful attempts to develop relationships when unwell there may be risks in attempts to relate to others. In the result in section 4.2.2 participants explained that behaviour when unwell led to them feeling rejected by peers. Also in section 4.4.1 participants explained the problems in entering into relationships that perpetuated problematic relational styles. Thus appropriately employing the surviving or relating mode may optimise the experience of forensic care. In section 4.2.3. participants indicated that relationships often were not transitory and would be re-acquainted as they progressed through different forensic wards.

Participants also described domesticating the forensic environment. This relates to research suggesting that more homely forensic environments improve wellbeing and reduce anxiety for women (Long, Langford & Clay, 2011). In the current study, this included relating to peers using normalising familial roles to offset the clinical environment. It also may serve to define roles and organise women's relationships. However, it may be that offers of "mothering" come from women who have suffered great losses but may not necessarily be able to successfully provide this role. Alternatively, Motz (2004) has identified that the ward staff tend to give familial names to these women in an attempt to feel less fearful of them. It is possible that similar processes are occurring for the women in their peer relationships and it is important to further identify the function and consequences of this behaviour.

Forensic wards are distinct from many inpatient environments in that peer relationships develop over long periods of time and often in isolation from other

systems. Participants described developing more positive ways of behaving out of necessity, which were then positively reinforced. This is consistent with social bonding theory associating pro-social behaviour with recovery (Nijdam-Jones, Livingston, Verddun-Jones & Brink, 2015). In the current model this can lead to the “relating mode” which then has the potential for recovery.

5.3. Recovery Through Peer Relationships

British forensic services increasingly apply the secure recovery model (e.g. Drennan & Aldred, 2012). Slade (2010) described relationships as being central to recovery and Scon, Denhov and Topor (2009) emphasised that recovery is a social and relational process. Personal recovery involves developing one’s identity and sense of self outside of illness, understanding the experience of illness and transition from clinical management to self-management. This is also dependent upon a relational focus for developing socially valued meaningful roles and relationships (Slade, 2010). In the current study peer relationships were instrumental in developing hope, motivation, insight, new ways to connect and feel understood, and to manage problems. The power of informal peer relationships to promote recovery is consistent with findings that much improvement and learning comes outside of formal therapy groups (Block & Crouch, 1999) and is important for generalising learning from group work (Barbender, 2002). In the current study the reciprocal nature of understandings formed between therapy groups and ward life were emphasised and day to day interactions are thought to be particularly important for recovery (Drennan & Aldred, 2012).

The strengths and resources within the peer group are evident and whilst individuals cannot at first see it in themselves, they see it in their peers. Many

participants described the importance of the shared experiences with peers; feeling understood and their own experiences validated and similar to group therapy findings (Yarkley & Wood, 2010). Medical diagnosis can leave women feeling stigmatised and overlooks their adaptive processes (Brendel, 2002). Through “holding a mirror” to their experiences, participants in the current study felt able to choose new ways of expressing their distress; similar to findings by Long Fulton and Hollin (2008). Women learnt to trust and communicate in more helpful ways and use relationships to regulate emotions, which suggest that some form of change has occurred within their internal working models and there has been progression towards a more secure attachment. This is despite relational problems being thought to be the most intransigent of difficulties for this clinical group (Stepp, Smith, Morse, Hallquist & Pilkonis, 2012).

Differing functioning of formal and informal modes of recovery are emphasised by Davidson and Rowe’s (2008) model of peer relating where informal relationships offer only support whilst the current research indicates broader effects including recovery. The participants in this study described an intrinsic motivation for receiving help and for helping their peers. Experiencing being worthy of support and also being able to help their peers could both be ways to increase self-esteem. This is one of the few productive roles available within forensic settings and developing positive self-roles are important for identity and recovery (Slade, 2010). Long, Knight, Bradley and Thomas (2012) also found in other settings becoming a role model increased self-worth and recovery and a similar role is developed within therapeutic community participation (Sacks, McKendrick & Hamilton, 2012).

Participants emphasised the different quality of receiving help from peers, than from staff. Peers could show great insight and offer support altruistically which

conveyed a deep sense of acceptance which is significant for women who have been placed beyond typical communities of women.

By reconnecting with a community of women via the ward environment this helped develop a sense of belonging, normality, identity and validation and similar to previous findings of the therapeutic nature of women's forensic relationships (Carr, 2013, Parkes & Freshwater, 2012). However, women in the current study explained they could also find relationships too intense, resulting in a move back to the surviving mode.

5.4. Methodological Quality and Research Limitations

This research exclusively focused on women's peer relationships as this was an under-studied area but means it is not possible to compare these effects to pre-existing relationships or relationships with staff. It is possible that these all inter-relate in dynamic ways such as more negative relationships with staff may encourage peer cohesion or vice versa. However, this is speculative and would require further investigation.

The model is a co-construction between the participants and the researcher and not objective. Whilst it represents these participants' experiences further research will be needed to establish the usefulness of the model. The completeness of the research is subjective but adopted a recognised approach to judge sufficiency of data (Dey, 1999). The researcher discussed the development of the themes with supervisors to judge when these were adequately covered by the data which determined sample size. The sample size was similar to previous similar studies. There may be a self-selection bias as more satisfied people tend to volunteer for research and so some experiences may not be

represented (Miles & Huberman, 1994). Bias was likely through the sampling strategy as staff encouraged certain individuals to participate. However, the researcher's frequent visits resulted in other women eventually expressing an interest and participating.

The role of the researcher is acknowledged with the aim to produce transparency. The researcher was a man and whilst gender is likely to have had an impact the exact consequence may be difficult to predict. The researcher's own professional background and interests were identified as was the researcher's admiration for the participants which may have created a desire to focus more on their positive accounts, who themselves may have wished to be portrayed in a positive light (Miles & Huberman, 1994). However, some women did in fact share accounts of their own anti-social behaviour. The use of a reflective diary, peer study group and reflection with supervisors were particularly important for bracketing assumptions and being aware of biases. It was felt that these techniques were successful in acknowledging the potential biases and their effects on the research, in particular with the approach to interviews and analysis. However, had there been an opportunity for a further bracketing interview following the completion of the model this would have aided any revisions to the model and supported the report write up. The reflective diary was frequently returned to during analysis to reflect upon the researcher's feelings immediately before and after an interview which highlighted particular themes or concerns that otherwise may have been lost. The peer study group was invaluable for comparing experiences of the process as the research progressed. Common challenges were shared which gave an opportunity to reflect upon one's own approach to conducting research. A level of self-awareness was developed that successfully allowed alternate interpretations to be considered during the analysis. Whilst looking for disconfirming cases were

undertaken this was quite difficult in practice and would have been helpful to ask the peer researcher to also attempt this with the data. Peer support in checking the analysis was helpful and highlighted the researcher's particular style of analysis but may have been strengthened had it been used after the first three interviews rather than later in analysis.

It was hoped that the analysis would be grounded in the participants' own language and they would see their experiences reflected in the model. Keeping to direct quotes worked well for checking that the development of categories were still grounded in the data, and for evaluating the themes of memos. It was especially important when exploring the usefulness of organising categories around types of relational models. During the process the use of memos became more refined. Early memos were later found to be too long and later a style of capturing concepts more succinctly and clearly allowed them to be held in mind better whilst comparing to other ones. Participant validation was undertaken by eight women to test this and ensure methodological rigour. There was generally high agreement with all categories of the model (Appendix 16). However, the complexity of the participant feedback form meant it was read to them by the researcher and participants may also have wished to please the researcher although some disagreements were registered. A simpler form would have been beneficial which participants could have completed themselves.

Some participants were not currently forensic inpatients and this was a purposive decision to gain retrospective understandings of this phenomenon. Reflections may lack detail, although this did not appear to be the case. A longitudinal study would be more sensitive to capturing the dynamic, changing phenomena of relationship trajectories. Whilst participant homogeneity was reduced in this study Charmaz (2006) indicated that diversity is appropriate for GTM.

Participants were able to describe their relationships but some process including unconscious aspects of attachment would be unavailable to reflection. Observational data collection may have been helpful to broaden the understandings of the phenomena and introduce methodological triangulation but was thought too intrusive.

5.5. Future Research

The findings indicate the importance of speaking directly to women about their experiences to adequately understand complex phenomena but this research focus has been limited in women's forensic services. Prior research has focused upon using rating scales to measure ward type but the complexity of peer relationships shown here suggests that future research requires more nuanced measurement based upon psychological models. There is a need to further examine these interactions to find optimal environmental conditions for cohesive relationships and an evaluation of the formal and informal methods of peer support in forensic care, and effects of roles including familial type relationships and offering and receiving care.

The research is consistent with a resource oriented approach and Priebe, Omer, Giacco and Slade's (2014) treatment review explained that such therapeutic models which focus upon the person's personal and social resources are showing promising results and warrant further attention. These approaches include peer support, self-help groups and therapeutic communities. They explained these models focus upon identifying strengths rather than medical symptom reduction so are likely to be more consistent with the empowerment aims of the recovery approach. They also concluded that the active use of social relationships were central to all such approaches. This supports the findings of the current research, which suggest the

importance of forensic research focusing on developing and evaluating theory of recovery through personal strengths and relationships. This would involve the evaluation of the model in the current study and could also include focusing on women's roles and positions taken up in forensic wards and the consequences for relating and recovery.

5.6. Clinical implications

The research emphasised a need to re-focus forensic care on recovery within relational contexts which is consistent with Zanarini, Frankenburg, Reich and Fitzmaurice's (2010) conclusion that treatment has been too focused upon symptom reduction and instead should focus on relational needs based upon personal histories. Slade (2010) warned against disempowerment of personal recovery through its professionalization by clinical staff taking a lead, and this study places recovery back within women's peer groups.

The move towards peer role models and the therapeutic nature of informal feedback suggest this can include more therapeutic community approaches. This could help to maximise the therapeutic potential and total experience of formal and informal interpersonal contexts.

Services need to be designed with women inpatients to best identify their needs and incorporate recovery and therapeutic community principles. This calls for a resources and strengths based model and a move away from the medical model and recovery from the consequence of personal histories and placing peer relating at the centre. Care staff training needs to recognise that women's recovery is a social process and can happen outside of formal contexts. It will be important that staff are aware of ward and

personal factors that determine survival or relating mode and so that relating environments are maintained. This may include providing appropriate groups and reflective spaces for women to maximise peer relating.

Similarly to therapeutic communities interpersonal disputes can be thought of as learning opportunities and women in this study expressed learning a great deal through such discussion and understanding peers' motivations better. Difficulties will need space to be discussed and worked through so that interpersonal interactions do not create a retreat to the surviving mode but continued relating as a peer group leading to personal growth.

It is concerning that despite efforts to address women's environments, women spoke of feeling re-traumatised. There continues to be the need to transform clinical spaces into nurturing environments including making them feel more homely. It is also important to assess suitability for ward admission and to rate this alongside the mix of presentations and the number of inpatients.

6. Conclusion

The findings indicate the potential for peer relationships to promote recovery. However, for women survivors of trauma and relational difficulties there are obstacles for this to be achieved and difficulties in forming peer cohesion. This resources-based model is able to make predictions of which factors in combination are likely to be most important in determining this. This is an area that requires further investigation including the testing of this model and staff training to develop protocols to maximise the positive potential and reduce chances of harm.

References:

- Alexander, I., Simpson, F. , Penny, S. R. , (2011) Editorial the recovery paradigm forensic mental health services. *Criminal Behaviour and Mental Health*, 21, 299-306. DOI: 10. 1002/cbm. 823
- American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders (5th Edition)*, Washington D. C. : American Psychiatric Association.
- Andresen, R., Oades, L., & Caputi, P. (2003). The experience of recovery from schizophrenia: towards an empirically validated stage model. *Australasian Psychiatry*, 37(5), 586-594.<http://informahealthcare.com/doi/abs/10.1046/j.1440-1614.2003.01234.x>
- Anthony, W. A. (1993). Recovery from mental illness: the guiding vision of the mental health service system in the 1990's. *Psychosocial Rehabilitation Journal*, 16, 11-23. DOI: 10. 1037/h0095655
- Blackburn, R. (2006). What is personality disorder? In M. Sampson, R. A. McCubbin, P Tyrer. *Personality Disorder and Community Mental health Teams. A Practitioner's Guide*. (Pp. 21-40) Chichester: John Wiley and Sons Ltd.
- Blatt, S. J. , & Levy, K. N. (2003). Attachment theory, psychoanalysis, personality development, and psychopathology. *Psychoanalytic Inquiry*, 23, 102-150. DOI:10. 1080/07351692309349028
- Bloch, S., & Crouch, S. (1999). *Therapeutic Factors in Group Psychotherapy*. Oxford: Oxford University Press.
- Brabender, V. (2002). *Introduction to group therapy*. Chichester : John Wiley & Sons Inc.
- Brendel, D. H. (2002). The ethics of diagnostic and therapeutic paradigm choice in psychiatry. *Harvard review of psychiatry*, 10(1), 47-50. DOI:10.1080/10673220216205
- Bressington, D. , Stewart, B. , Beer, D. , MacInnes, D. (2011). Levels of service user satisfaction in secure settings – a survey of the association between perceived social climate, perceived therapeutic relationship and satisfaction with forensic services. *International Journal of Nursing studies*, 48, 1349–1356. [http://www.journalofnursingstudies.com/article/S0020-7489\(11\)00228-8/abstract](http://www.journalofnursingstudies.com/article/S0020-7489(11)00228-8/abstract)
- British Psychological Society (BPS) (2010) *Code of Human Research Ethics* <http://www.bps.org.uk/about/rules5.cfm>.
- Carr, M. (2013). *The Process of Adjustment and Coping for Women in Secure Forensic Environments*. (Unpublished doctoral dissertation). University of Nottingham: Nottingham.

- Charmaz, K. (2006) *Constructing Grounded Theory. A Practical Guide Through Qualitative Analysis*. London:Sage.
- Charmaz, K. Bryant, A. (2011) *Grounded theory and credibility*. In D. Silverman Ed. *Qualitative Research*. 3rd Edition. Pp. 291-309. Sage: London.
- Chiesa, M., Fonagy, P. (2010). Scientific research, the therapeutic community and psychodynamic psychotherapy. *Clinical Neuropsychiatry*, 7 (6), 173-180. http://www.clinicalneuropsychiatry.org/pdf/01_chiesa.pdf
- Cooke, K. , & Bailey, D. (2011). Women's experience of forensic mental health services: implications for practice. *Journal of Mental Health Training, Education and Practice*, The, 6(4), 186-194. DOI 10. 1108/17556221111194527
- Davidson, L., & Rowe, M. (2008). Peer Support within Criminal Justice Settings: The Role of Forensic Peer Specialists. The CMHS National GAINS Centre. Retrieved July 1, 2011.
- Davidson, L., Rowe, M. , Tondora, J. , & O'Connell, M. J. (2008). *A Practical Guide to Recovery-Orientated Practice: Tools for Transforming Mental Health Care*. Oxford: Oxford University Press.
- Davies, S. (2004). Secure psychiatric services. In P. Campling, S. Davies, G. Farquharson, (Eds.), *From Toxic Institutions to Therapeutic Environments. Residential Settings in Mental health Service*. Pp. 233-244. London: Gaskell.
- Department of Health. (2008). *Real Involvement: Working With People to Improve Services*. London: The Stationary Office Limited.
- Dey, I. (1999). *Grounding Grounded Theory*. San Diego, CA: Academic Press.
- Dickens, G. L., Suesse, M., Snyman, P. & Picchioni, M. (2014) Associations between ward climate and patient characteristics in a secure forensic mental health service. *The Journal of Forensic Psychiatry & Psychology*. 25 (1) pp1-17. DOI: 10. 1080/14789949. 2014. 903505
- Drennan G, & Aldred, D. (2012) Recovery in forensic mental health settings: from alienation to integration. In G. Drennan, & D. Aldred (Ed.). (2012). *Secure Recovery: Approaches to Recovery in Forensic Mental Health Settings*. Abingdon:Routledge. pp1-23.
- Fossati, A., Madeddu, F. , Maffei, C. (1999). Borderline personality disorder and childhood sexual abuse: a meta-analytic study. *Journal of Personality Disorders*,13 (3), 268-280. DOI:0. 1521/pedi. 1999. 13. 3. 268
- Gunderson, J. (2007). Disturbed relationships as a phenotype for borderline personality disorder. *American Journal of Psychiatry*, 164(11), 1637-1640. DOI:10. 1176/appi. ajp. 2007. 07071125

- Haigh, R. (1999). Psychotherapy for severe personality disorder: Evolution is part of the therapeutic process of therapeutic communities. *British Medical Journal*, 319(7211), 709.
- Health Professions Council (2008) Standards of Conduct, Performance and Ethics. Retrieved from <http://www.hpc-uk.org/assets/documents/10002367FINALcopyofSCPEJuly2008.pdf>.
- Hinsby, K., & Baker, M. (2004). Patient and nurse accounts of violent incidents in a medium secure unit. *Journal of Psychiatric and Mental Health Nursing*, 11(3), 341-347. DOI: 10.1111/j.1365-2850.2004.00736.x
- Jeffcote, N. Travers, R. (2004). Thinking about the needs of women in secure settings. In N. Jeffcote, T. Watson, (Eds.), *Working Therapeutically with Women in Secure Mental Health Settings* (pp. 19-30). London: Jessica Kingsley Publishers.
- Jeffcote, N., & Watson, T. (Eds.). (2004). *Working therapeutically with women in secure mental health settings* (Vol. 27). Jessica Kingsley Publishers:London
- Jeffcote, N. , Watson, T. , Bragg, A. , and Devereux, S. (2004). A women's group in a medium secure setting. In N. Jeffcote, T. Watson, (Eds.), *Working Therapeutically with Women in Secure Mental Health Settings* (pp. 129-142). London: Jessica Kingsley Publishers.
- Jenkinson, J. (2011). *Exploring Recovery and Women Diagnosed with Personality Disorder in a Secure Setting*. (Unpublished doctoral dissertation) Canterbury Christ Church University, Canterbury.
- Kaplan, A. G. & Surrey, J. L. (1984). The relational self in women. *Developmental theory and public policy in L. E. Walker, L. E. (1984). Women and mental health policy* (Vol. 9). London:Sage Publications. pp59-94.
- Keulen-de-Vos, M. , Bernstein, D. P. , Clark, L. A. , Arntz, A. , Lucker, T. P. C., De Spa, E. (2011). Patient versus informant reports of personality disorders in forensic patients. *Journal of Forensic Psychiatry and Psychology*, 22, 1, 52-71. DOI:10. 1080/14789949. 2010. 511242
- Kilmann, P. R., Laughlin, J. E., Carranza, L. V., Downer, J. T., Major, S., & Parnell, M. M. (1999). Effects of an attachment-focused group preventive intervention on insecure women. *Group Dynamics: Theory, Research, and Practice*, 3(2), 138.
- King, G. (2014). Staff attitudes towards people with borderline personality disorder: Therapeutic optimism can be achieved with the use of specially adapted interventions and sophisticated clinical supervision, says Gemma King. *Mental Health Practice*, 17(5), 30-34. DOI:org/10.7748/mhp2014.02.17.5.30.e803

- Laithwaite, H., & Gumley, A. (2007). Sense of self, adaptation and recovery in patients with psychosis in a forensic NHS setting. *Clinical Psychology & Psychotherapy*, 14(4), 302-316. DOI: 10.1002/cpp.538
- Lees, J. Manning, N. , Rawlings, B. 2004. A culture of enquiry: research evidence and the therapeutic community. *Psychiatric Quarterly*, 75 (3) 279- 293. DOI10.1023/B:PSAQ.0000031797.74295.f8
- Lester, R. J. (2013). Lessons from the borderline: Anthropology, psychiatry, and the risks of being human. *Feminism & Psychology*, 23(1), 70-77. DOI: 10.1177/0959353512467969
- Long, C. G. , Anagnostakis, K. , Fox, E. , Silaule, P. , Somers, J. , West, R. , & Webster, A. (2011). Social climate along the pathway of care in women's secure mental health service: Variation with level of security, patient motivation, therapeutic alliance and level of disturbance. *Criminal Behaviour and Mental Health*, 21(3), 202-214. DOI: 10.1002/cbm.791
- Long, C. G. , Fulton, B. , & Hollin, C. R. (2008). The development of a 'best practice' service for women in a medium-secure psychiatric setting: treatment components and evaluation. *Clinical Psychology & Psychotherapy*, 15(5), 304-319. DOI: 10.1002/cpp.591
- Long, C. G. , Dolley, O. , & Hollin, C. R. (2011). Women in medium secure care: tracking treatment progress for changes in risk profiles and treatment engagement. *Journal of Psychiatric and Mental Health Nursing*, 18(5), 425-431. DOI: 10.1111/j.1365-2850.2010.01678.X
- Long, C. G. , Knight, C. , Bradley, L. , & Thomas, M. (2012). Effective therapeutic milieus in secure services for women: The service user perspective. *Journal of Mental Health*, 21(6), 567-578. DOI:10.3109/09638237.2012.734649
- Long, C. G. , Langford, V. , Clay, R. , Craig, L. , & Hollin, C. R. (2011). Architectural change and the effects on the perceptions of the ward environment in a medium secure unit for women. *The British Journal of Forensic Practice*, 13(3), 205-212. DOI 10.1108/14636641111157850
- Lorenzini, N. , & Fonagy, P. (2013). Attachment and personality disorders: a short review. *FOCUS: The Journal of Lifelong Learning in Psychiatry*, 11(2), 155-166. DOI:10.1176/appi.focus.11.2.155
- Madill, A., Jordan, A., & Shirley, C. (2000). Objectivity and reliability in qualitative analysis: Realist, contextualist and radical constructionist epistemologies. *British Journal of Psychology*, 91(1), 1-20. DOI:10.1348/000712600161646/pdf
- Mahmood, S. T. , Tripodi, S. J. , Vaughn, M. G. , Bender, K. A. , & Schwartz, R. D. (2012). Effects of Personality Disorder and Impulsivity on Emotional Adaptations in Prison Among Women Offenders. *Psychiatric quarterly*, 83(4), 467-480. DOI: 10.1007/s11126-012-9215-5

- Mezey, G. , Hassell, Y. , & Bartlett, A. (2005). Safety of women in mixed-sex and single-sex medium secure units: staff and patient perceptions. *The British Journal of Psychiatry*, 187(6), 579-582. DOI: 10. 1192/bjp. 187. 6. 579.
- Miles, M.B., & Huberman, A.M., (1994). *Qualitative Data Analysis: An Expanded Sourcebook*. London: Sage.
- Mills, J., Bonner, A., & Francis, K. (2006). Adopting a constructivist approach to grounded theory: Implications for research design. *International Journal of Nursing Practice*, 12(1), 8-13. DOI: 10.1111/j.1440-172X.2006.00543.x
- Mezey, G. C., Kavuma, M., Turton, P., Demetriou, A., & Wright, C. (2010). Perceptions, experiences and meanings of recovery in forensic psychiatric patients. *The Journal of Forensic Psychiatry & Psychology*, 21(5), 683-696. DOI:10.1080/14789949.2010.489953
- Ministry of Justice. (2011). *Working with Personality Disordered Offenders. A practitioners Guide*. Department of Health.
- Motz, A. (2012). Single-sex units as a defence against anxiety? Pp 116-132. In J. Adlam, A. Aiyegbusi, P. Kleinot, A. Motz, & C. Scanlon. (Eds.) *The Therapeutic Milieu Under Fire: Security and Insecurity in Forensic Mental Health*. Jessica Kingsley Publishers: London
- Nedderman, A. B., Underwood, L. A. , & Hardy, V. L. (2010). Spirituality group with female prisoners: Impacting hope. *Journal of Correctional Health Care*, 16(2), 117-132. DOI: 10. 1177/1078345809356526
- Neville, L., Miller, S., Fritzon, K. (2007) Understanding change in a therapeutic community: an action systems approach. *The Journal of Forensic Psychiatry and Psychology*. 18 (2) 181-203. DOI:10. 1080/14789940601108439
- Nijdam-Jones, A. , Livingston, J. D. , Verdun-Jones, S. , & Brink, J. (2015 in press) Using Social Bonding Theory to Examine ‘Recovery’ in a Forensic Mental Health Hospital: A Qualitative Study. *Criminal Behaviour and Mental Health*.
- Parkes, J. H. , & Freshwater, D. S. (2012). The journey from despair to hope: an exploration of the phenomenon of psychological distress in women residing in British secure mental health services. *Journal of Psychiatric and Mental Health Nursing*, 19(7), 618-628. DOI: 10. 1111/j. 1365-2850. 2012. 01909
- Parry-Crooke, G., & Stafford, P. (2009). *My life: in safe hands?. Summary Report of an Evaluation of Women’s Medium Secure Services*. London Metropolitan University.<http://www.ohrn.nhs.uk/resource/policy/WMSSEvaluationFinalReport.pdf>
- Parrott, F. R. (2010). ‘Real relationships’: sociable interaction, material culture and imprisonment in a secure psychiatric unit. *Culture, Medicine, and Psychiatry*, 34(4), 555-570. DOI 10. 1007/s11013-010-9188-5

- Pfafflin, F., & Adshead, G. (2003). *A Matter of Security: The Application of Attachment Theory to Forensic Psychiatry and Psychotherapy* (Vol. 25). Jessica Kingsley Publishers: London
- Pipon-Young, L. & Cole, S. (2012). A preliminary evaluation of a systems training for emotional predictability and problem solving (STEPPS) group in a women's forensic medium secure unit. *Clinical Psychology Forum*. 239 (November) 35-39. <http://www.sussexpartnership.nhs.uk/component/jdownloads/finish/2276/8506?Itemid=0>
- Priebe, S., Omer, S., Giacco, D., & Slade, M. (2014). Resource-oriented therapeutic models in psychiatry: conceptual review. *The British Journal of Psychiatry*, 204(4), 256-261. DOI: 10.1192/bjp.bp.113.135038
- Sacks, J. Y., McKendrick, K., & Hamilton, Z. (2012). A randomized clinical trial of a therapeutic community treatment for female inmates: Outcomes at 6 and 12 months after prison release. *Journal of addictive diseases*, 31(3), 258-269. DOI:10.1080/10550887.2012.694601
- Sainsbury, L., Krishnan, G., & Evans, C. (2004). Motivating factors for male forensic patients with personality disorder. *Criminal Behaviour and Mental Health*, 14(1), 29-38. DOI: 10.1002/cbm.558
- Sarkar, J., & di Lestro, M. (2011). Evolution of secure services for women in England. *Advances in Psychiatric Treatment*, 17(5), 323-331. DOI: 10.1192/apt.bp.109.007773
- Schmitt, M. T., Branscombe, N. R., Silvia, P. J., Garcia, D. M., Spears, R. (2006). Categorising at the group-level in response to intragroup social comparisons: A self-categorization theory integration of self-evaluation and social identity motives. *European Journal of Social Psychology*. 36, 297-314. DOI: 10.1002/ejsp.306
- Schön, U. K., Denhov, A., & Topor, A. (2009). Social relationships as a decisive factor in recovering from severe mental illness. *The International journal of social psychiatry*, 55(4), 336-347. DOI:10.1177/0020764008093686
- Seidman, I. E. (2006). *Interviewing is qualitative research: a guide to researchers in education and social sciences* (2nd Edition). New York: Teachers College press.
- Slade, M. (2010). Mental illness and well-being: the central importance of positive psychology and recovery approaches. *BMC Health Services Research*, 10(1), 26. doi:10.1186/1472-6963-10-26
- Sperry, L. (2003) *Handbook of Diagnosis and Treatment of DSM-IV-TR Personality Disorders* (2nd Edition). Hove: Brunner-Routledge.

- Stepp, S. D. , Smith, T. D. , Morse, J. Q. , Hallquist, M. N. , & Pilkonis, P. A. (2012). Prospective associations among borderline personality disorder symptoms, interpersonal problems, and aggressive behaviors. *Journal of Interpersonal Violence*, 27(1), 103-124. DOI: 10.1177/0886260511416468
- Stepp, S. D. , Hallquist, M. N. , Morse, J. Q. , & Pilkonis, P. A. (2011). Multi method investigation of interpersonal functioning in borderline personality disorder. *Personality Disorders: Theory, Research, and Treatment*, 2(3), 175. DOI: 10.1037/a0020572
- The National Mental Health Implementation Unit. (2010). Working Towards Women's Well-Being: Unfinished Business. Retrieved 30.08.2014.
<http://www.hsconsultancy.org.uk/system/resources/2/working-towards-womens-wellbeing-unfinished-business.pdf?1302161290>
- Urquhart, C. (2013). *Grounded Theory for Qualitative Research. A Practical Guide*. London:Sage
- Vandavelde, S., Broekaert, E., Yates, R. , Kooyman, M. (2012) The development of the therapeutic community in correctional establishments: a comparative retrospective account of the 'democratic' Maxwell jones therapeutic community and the hierarchical concept-based therapeutic community in prison. *International Journal of Social Psychiatry*. 50 (1) 66-79. DOI: 10.1177/0020764004040954
- Williams, J., & Keating, F. (2005). Social Inequalities and Mental Health—An integrative approach. *Beyond the Water Towers*, 113.
http://www.centreformentalhealth.org.uk/pdfs/Beyond_the_water_towers.pdf#page=113
- Wood, J. V., Wilson, A. E. (2003). How important is social comparison? In M. R. Leary, & J. P. Tangney (Eds.), *Handbook of self and identity* (344-366). New York: Guildford.
- Wynn, R. (2004). Psychiatric inpatients' experiences with restraint. *Journal of Forensic Psychiatry & Psychology*, 15(1), 124-144. DOI:10.1080/14789940410001655187
- Yakeley, J., & Wood, H. (2011). Patients' experiences of forensic psychotherapy. *Psychoanalytic Psychotherapy*, 25(01), 105-114. DOI:10.1080/02668734.2010.519160
- Zanarini, M. C., Frankenburg, F. R., Reich, D. B., & Fitzmaurice, G. (2010). Time to attainment of recovery from borderline personality disorder and stability of recovery: a 10-year prospective follow-up study. *American Journal of Psychiatry*, 167(6), 663-667. doi:10.1176/appi.ajp.2009.09081130

Richard King BSc (Hons)PGDip MSc

MAJOR RESEARCH PROJECT

SECTION C :APPENDICES

May 2014

SALOMONS

CANTERBURY CHRIST CHURCH UNIVERSITY

Appendix 1. Literature Search Methodology

The following data bases were searched Cochrane Database of Systematic Reviews (2005-present), Google Scholar, MEDLINE (1946-present), Psycinfo (1806-present), and Social Policy and Practice. Cinhal, Web of Knowledge, and Zetoc data bases.

No time limit was used in the initial search due to limited extant literature. Searches took place between July 2013 up until April 2014.

The following search terms were used:

social milieu
and
forensic/ prison,

forensic/ secure services
and
women,

peer
and
forensic

personality disorder
and
forensic
and
women/ female

forensic
and
recovery

Inclusion/ Exclusion Criteria for Research Papers

The study included only women over the age of 18 years. The current study sought research that examined the experiences of women with personality disorder and their needs in forensic care given the specificity of this any study that incorporated this sample was included. Therefore, studies that used a mixed male and female sample, or had co-morbidity of disorders were included, or if the participant sample included both women with a personality disorder diagnosis and others with other primary disorders.

Exclusion criteria were studies where no participants had a diagnosis of personality disorder, where there were only male participants, where there was no gender analysis in mixed gender studies, where participants were under the age of 18 years.

Study Abstraction

The search outlined above yielded 240 studies. The studies titles and abstracts were screened to assess whether they met inclusion criteria and contributed to an understanding of women's needs in secure care. When our study met the inclusion criteria, then the full article was obtained.

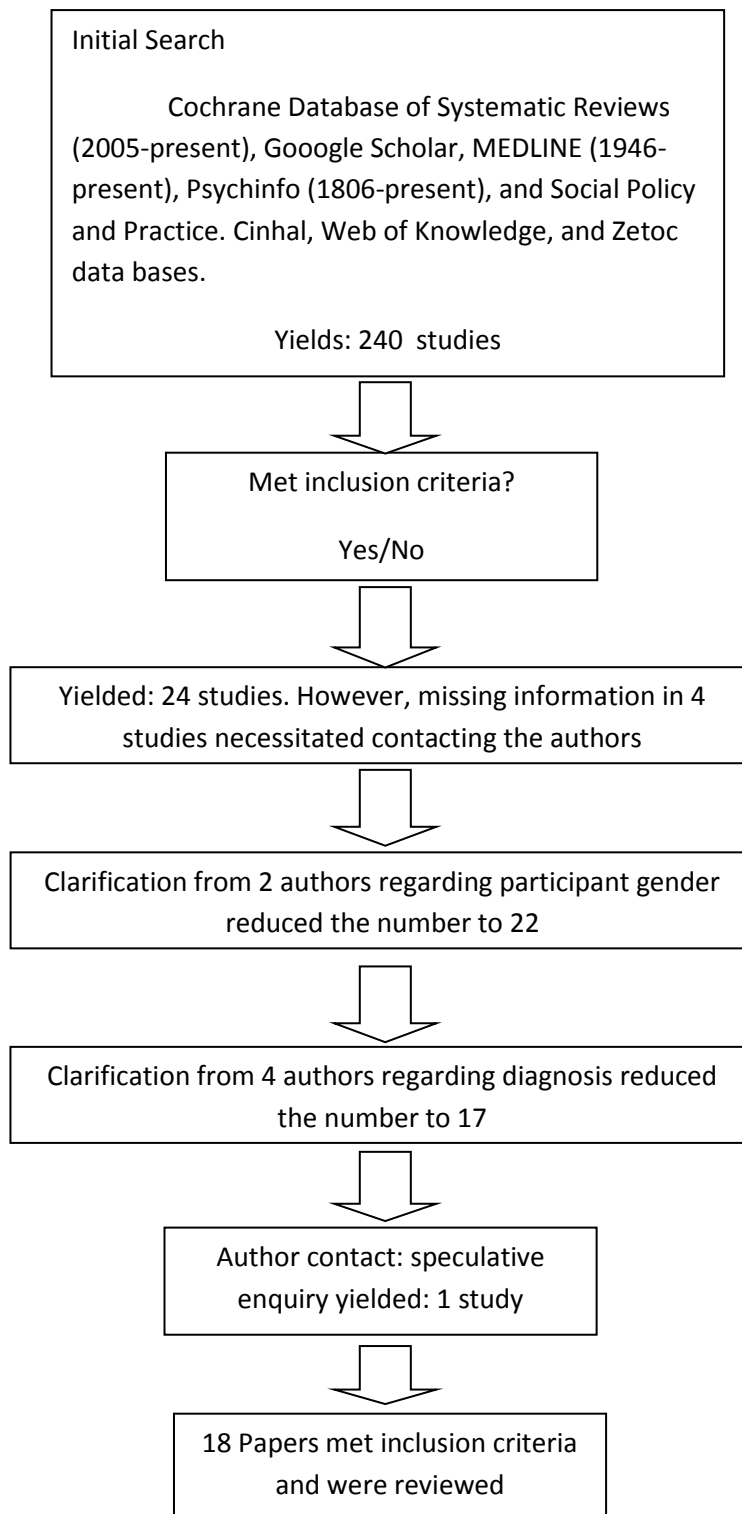
Where studies did not state gender of participants (two studies) or diagnosis of participants (one study) the author was emailed for clarification. This resulted in one paper meeting the inclusion criteria. Key authors that have emerged from initial search were also searched. Where authors have produced three or more relevant studies they were e-mailed with a request for any further advice or relevant research. This produced seven additional papers however none met the inclusion criteria.

The full text references were read and all those that met inclusion criteria were included in the review. This yielded 20 studies.

Study Categorisation

The included studies were categorised in terms of dominant themes and approach to the issue of women's needs in forensic care. This resulted in themes concerned with women's relational needs from care staff, ability of the ward to provide cohesion between women inpatients, women's violence, and women's experiences of stigma.

Search Procedure and Results



Appendix 2. Summary of Reviewed Papers

Authors, Country & Study Title	Aims	Sample & Setting	Design & Analysis	Measures	Main Findings
Black, Thornicroft, Murray, 2012. UK. What do people in forensic secure and community settings think are there personality disorder diagnosis?	The aim of the study was to explore the experience of having a personality disorder diagnosis within the context of forensic secure and community services.	Eight men and two women who had personality disorder diagnosis. Medium secure and community forensic.	Qualitative interpretative phenomenological analysis.	Semi-structured interviews	Participants felt defined by the offence irrespective of setting and some participants appeared to have internalised the negative meanings of the personality disorder and offending. Participants saw themselves and their peer group as different from everybody else, worthless, and felt the diagnosis created a barrier between them and others and they felt identified by their diagnosis. Participants described the process of trying to present oneself as 'normal'. No gender differences were found. Hospital admission increased the sense of stigma with diagnosis. Participants held similar stigmatising views to the general public.
Brunt and Rask 2007. Sweden. Ward Atmosphere- the scarlet pimpernel of	To gain patient and staff perceptions of forensic ward atmosphere.	35 men and women, 30% women. BPD prevalent diagnosis. High secure.	Quantitative and Qualitative	WAS and rating of distinguishing features of the ward	For women inpatients both patients and staff rated the ward as relational focused. However, for men there was no consensus of the ward having a particular relational type. Women reported personal qualities of staff as key as determinates of ward atmosphere. Staff gave similar reports to women except staff rated staff control as being

psychiatric settings?					lower.
Brunt, 2008. Sweden. The Ward atmosphere of single sex wards in a maximum security forensics psychiatric hospital in Sweden	Exploratory study to investigate how the physical, organisational, patient, and staff characteristics impact on the social climate of the ward.	12 women and 23 men and 104 nursing staff. Over 90% of female patients had PD diagnosis. High secure.	Quantitative correlation study	Ward Atmosphere Scale self-rating instrument	Women's wards were rated as being similar to relationship orientated programmes in terms of involvement and spontaneity but with a lower level of support. They were rated as similar to an insight orientated program on the personal growth dimensions with a focus on personal problems and expressing anger and aggression. Also a lower level of autonomy and moderate levels of self-maintenance. Ward atmosphere and social climate on women's wards appeared to be more homogeneous and more favourable than men's wards. There was strong agreement from staff ratings with the exception that staff rated patient autonomy as significantly higher than rated by women inpatients.
Carr, 2013. UK. The Process of Adjustment and Coping for women in secure forensic environments	To gain an understanding from women's own perspective of the process of adjustment to forensic care	6 Women inpatients, all with diagnosis BPD. Low secure.	Qualitative. Focus groups.	IPA	Restrictive environments and repetitive routine were particularly distressing for women and could trigger self-harming behaviour. The relationship with staff and developing relationships with peers were important aspects of adjustment. Helping peers was rewarding but participants often felt ill equipped for developing relationships. The restrictive environment could be re-traumatising and trigger painful childhood memories of abuse.

Forensic Care Needs of Women Diagnosed with a Personality Disorder

Cooke & Bailey.2011 UK Women's experiences of forensic mental health services: implications for practice.	To explore women's experiences of forensic mental health care	Seven women; Four of whom diagnosed with a PD and three schizophrenia . Medium secure.	Qualitative interviews analysed by content analysis to identify commonalities and differences	Semi structured interviews	Themes identified were: women's experiences of different settings and treatments, relationships with staff, impact of placement on social contacts. Respondents spoke about being away from their families and children. The importance and difficulty of maintaining prior social contacts once an inpatient There were mixed views about being in the mixed or woman only environment. Participants spoke of fearing their peers when first admitted which reduced once they got to know them.
Daffern, Howells and Ogloff. 2007. Australia. The interaction between individual characteristics and the function of aggression in forensics.	The aim was to examine the function of aggression and its relationship to individual characteristics.	204 inpatients in a secure hospital 56% women. Main diagnosis were either PD or schizophrenia .	Quantitative. Functional analysis of aggressive behaviours recorded as incidents and individual assessment.	Semi-structured interview and self-report psychological tests.	Patients who did not have the psychotic illness were more likely to be aggressive to avoid demands and more likely to be aggressive to reduce tension. Men and women used aggression to satisfy different functions. Women were more likely to use aggression for a wide range of functions. Women were more likely than men to be aggressive to force compliance, to reduce tension, to obtain tangibles and to reduce social distance.

Dickens, Lange, Picchioni. 2011. UK. Labelling of people who are resident in a secure forensic mental health service: user views.	To establish the preference of terminology among inpatients in secure services.	100 participants in medium secure.30% women. Majority diagnosis; schizophrenia or personality disorder.	Cross-sectional survey design with random sampling	Questionnaire designed for the study.	The term patient was preferred by 50% of women sampled which was not significantly different to men's responses. Many viewed themselves as being treated for a medical disorder. However, they felt diagnosis created a barrier with relationships with staff and felt stigmatised.
Dickens, Suesse, Synman & Picchioni. 2014. UK. Associations between ward climate and patient characteristics in a secure forensic mental health service.	To determine the relationship between level of security, ward characteristics and gender.	63% of the sample were women. 35% had PD diagnosis. Low medium and high secure	Quantitative Longitudinal	EssenCES to measure ward climate	Women experienced greater cohesion and felt safer. Ward climate was stable over time. Higher security inversely proportional to peer cohesion and safety and therapeutic hold

Forensic Care Needs of Women Diagnosed with a Personality Disorder

Jenkinson (2011). UK Exploring Recovery of women diagnosed with PD in a secure setting	Recovery in women diagnosed with PD.	6 women with diagnosis of PD in medium secure care.	Qualitative	Semi-structured interviews	Relationships with care staff were essential for recovery but poor relationships could impeded communication and trust. However, some felt that staff held stigmatising views of them based upon their diagnosis. Feeling invalidated or fear mirrored negative childhood experiences and was very distressing. Nonetheless when feeling cared for by staff this fostered hope. Peers could provide a source of validation. However, they could be stressful, and distressing when others were aggressive or self-harmed.
Livingston, Nijdam-jones & Brink. 2012. Canada. 2012. The Tale of Two Cultures: Examining Patient Centred Care in a Forensic Mental Health Hospital.	To examine the extent to which practices of patient centred care including recovery principles and creating a therapeutic milieu, were achievable in forensic mental health hospitals.	10 women and 20 men in medium secure care. Schizophrenia was the major diagnoses, also PD.	Quantitative correlational study of ward environment and recovery principles.	EssenCES to measure the therapeutic milieu, personal recovery was assessed using the Mental Health Recovery Measure. Engagement and Empowerment self-report measures. Descriptive statistical analysis.	Characteristics of patient centred care may be found within the forensic mental health service. Higher levels of personal recovery among patients were related to greater empowerment. Personal recovery, empowerment, and internalise stigma were unrelated to patients overall perceptions of recovery oriented care but overall perceptions of recovery orientated care were associated with greater service engagement and positive ratings of the therapeutic milieu. Forensic mental health and recovery paradigms are compatible.

Long Anagnostakis, Fox, Silaule, Somers, West & Webster. 2011. UK. Social climate along the pathway of care in women's secure services	The aim was to assess social climate in women secure wards and its variation by level of security and ward type. Also to investigate how social climate correlated with other markers linked to therapeutic progress.	80 staff and 65 women patients in the two medium security wards and two low security wards took part. Disorders included PD.	Quantitative. Cross-sectional survey, between groups design.	The Essen climate evaluation schema, Californian Psychotherapy Alliance scale, Patient Motivation Inventory. Staff assessed levels of disturbed behaviour and treatment engagement.	Social climate varied according to ward type and level of security. Positive social climate was associated with lower levels of security. Low security was also associated with lower behavioural disturbance and with higher levels of motivation, treatment engagement and therapeutic alliance. Therapeutic hold which did not differentiate between medium security and low security wards.
Long, Knight Bradley & Thomas, 2012. UK. Effective therapeutic milieus in secure services for women: service user perspective.	The aim was to identify service user views of the constituents of an effective therapeutic milieu for women in secure settings including women's gender specific needs.	19 women with dual diagnosis, with PD from medium and low secure	Qualitative	Two focus groups with service users from low and medium secure settings. Data underwent thematic analysis.	Themes covered interpersonal relationships; treatment programming; service user empowerment, the ward as a place of safety, and hope for the future, participants did not highlight gender specific issues. In particular good interpersonal relationships with staff were highlighted, being listened to being trustworthy, mutual respect, acknowledgement of the power differences with the sensitive approach.

Long, Langford, Clay, Craig and Hollin, 2011. UK Architectural change and the effects of the perceptions of the ward environment in a medium secure unit.	The aim was to compare patients and staff experiences on a Victorian style ward with their experiences when moved to a new purpose-built unit.	9 transferring women; 8 with PD diagnosis, of which 6 had a BPD diagnosis. 16 staff.	Quantitative pre-and post-design. Between subjects design	Self-report questionnaires; the architectural checklist, Ward Atmosphere Scale, inpatient satisfaction questionnaire, and the brief psychiatric rating scale.	The new accommodation was associated with increased patient satisfaction, particularly with the physical environment. The new ward design allowed observation to be done more remotely. Patient's reported feeling less stressed as a consequence of feeling less under constant observation. There was also reduction in overall symptoms, anxiety and guilt The lower emphasis on staff control
---	--	--	---	---	---

Nicholls, Brink, Greaves, Lussier, Verdun-Jones. 2009. Canada. Forensic psychiatric inpatients and aggression.	The aim was to gain a gender analysis of e risk and needs profile of forensic in-patients.	30% female sample. Most common diagnosis was schizophrenia or PD. High secure.	Quantitative comparison between male and females	Analysis of questionnaires. Mixture of standardised and non-standardised assessments. Retrospective analysis of patient files and incident reports.	Women's aggression was more likely to occur subsequent to attacks of self-harm. Sedating medication was twice more likely to be given to men in contrast women were more likely to be placed in seclusion. Women were significantly more likely to target staff than other patients and more so than for men. Precipitants for aggression were different with women more likely to be aggressive while being escorted to their room or seclusion room, or making a request.
Nijdam-Jones, Livingston, Verdum-Jones & Brink. 2015. Canada. Forensic Recovery and Social Bonding Theory.	The aim was to examine whether forensic mental health inpatients narratives about change and recovery reflect concepts of social bonding theory.	6 women and 24 men forensic inpatients. 60% diagnosed with schizophrenia , also patients diagnosed with PD. Over half had alcohol or substance. abuse	Mixed methods. Standardised quantitative measures and Thematic analysis. Plus open-ended questions. Medium Secure.	Recovery Self-Assessment Measure, EssenCES, Mental Health Recovery Measure, Level of Engagement Scale, Plus semi-structured questions.	Participants' narratives of recovery coincided with components of the social bonding theory. The following themes: involvement in programs, belief in the rules and social norms, attachment to support individuals, commitment to work-related activities and length of stay in hospital. Narratives underscored the benefits of respecting others and internalising social norms in their recovery several participants commented on the importance of rules that keep people safe in the forensic hospital. They identified social relationships with staff friends and family. Some participant's referred to their relationships with co-patients as being a source of support, acceptance, and camaraderie. For some patients the stigma and isolation associated with the hospital created significant challenges to relationships with others outside of the hospital. They

		histories			emphasised the importance of forming and maintaining close affection all relationships within the hospital, which were perceived as being vital for counteracting the long periods of confinement.
Parkes, and Freshwater. 2012. UK. The journey from despair to hope: an exploration of psychological distress in women forensic services.	The aim was to create a general description of the phenomena of psychological distress as expressed by women in the secure care	11 women. Seven from high secure hospital and for medium secure unit. 9 had PD five of which had bpd	Qualitative thematic analysis	Semi-structured interviews	Women felt powerless in forensic wards which could be a trigger for re-traumatising experiences. Preceding destructive acts women wrestled with uncontrollable emotions and re-directing impulses to hurt others towards themselves. The function could also be to release emotions or to communicate to others extreme feelings of unhappiness.
Parrott, 2010. UK. Real Cultures: sociable interaction, material culture and imprisonment in a secure	The aim was to understand how inpatients view their pre-existing and current peer relationships	19 inpatients; twelve men and seven women, diagnosis included PD and schizophrenia Medium	Qualitative Thematic analysis	Semi-structured interviews and observation	For both men and women seemingly sociable activities engaged in by inpatients may actually be done in parallel and patients may not be integrating with peers but more focused upon vicariously focusing upon pre-existing relationships which may include spending time alone looking at photographs and findings this a source of support.

Forensic Care Needs of Women Diagnosed with a Personality Disorder

unit.		Secure.			
Woods, Reed, Collins (2004). UK Relationships among risk, and communication and social skills in high security forensics setting.	To assess the relationship between violence, insight communication and social skills.	500 inpatients 40 % Women. Major diagnosis included schizophrenia and P.D. High, medium and low secure.	Repeated measures design Over a period of 12 months. Patients were assessed at 12 weekly intervals by primary nurses	Insight correlations, factor analysis, and differences among independent groups of patients.	For both men and women the individual level of violence significantly positively correlated with the communication and social skills. It was related to deficits in managing social distance, turn taking, listening effectively to others, controlling emotions, relationship with others, and deferring to others.

Appendix 3: Participant Demographic Data

Participant	Age	Ethnicity	Primary Diagnosis	Co-morbidity; mental health, substance etc.	Intellectual Disability Y/N	Index offence	Prison Y/N	Highest Level of Secure Care H/M/L	Children and care arrangements and status
1	43	White British	Borderline Personality Disorder Asperger's Syndrome	Disordered eating	N	G.B.H with intent	Y	M	No Children
2	46	WB	Borderline Personality Disorder	Substance misuse	Not known	Arson	N	M	None
3	46	White British	Borderline Personality Disorder, asperger's syndrome	Not known	N	Unlawful harassment and arson	Y	M	Not known
4	48	White British	Borderline Personality	Not known	N	Arson	Y	H	Not known

Forensic Care Needs of Women Diagnosed with a Personality Disorder

			Disorder Emotionally unstable personality disorder						
5	54	White British	Borderline personality disorder	Recurrent depressive disorder with psychotic symptoms	N	Arson	Y	M	Has 4 children but no contact
6	41	WB	Borderline Personality Disorder	Substance misuse	Not known	Arson	Y	M	2 children
7	51	White British	Borderline Personality Disorder Bipolar Affective Disorder	Substance abuse in past	N	arson	Y	M	Yes, care arrangements unknown
8	25	White British	Borderline personality disorder.	Not known	Queried LD	No specific offence, history of	N	L	None

Forensic Care Needs of Women Diagnosed with a Personality Disorder

			Recurrent Depressive disorder			violence and threats to harm			
9	27	White British	Borderline personality disorder	Not known	N	Arson (Significant previous history of other offences)	Y	M	Not known
10	36	White British	Borderline Personality Disorder	Substance misuse		Arson (significant previous history of other offences)	Y	M	1 child, does not have custody but in contact
11	34	WB	Borderline Personality Disorder , Asperger's Syndrome.	Previous substance misuse	Not known	Arson	Y	M	None
12	24	WB	Borderline personality disorder,	Substance misuse	Not known	Assaults, criminal damage, carrying a weapon, threats to kill.	N	M	None

Appendix 4. NHS Ethics Approval Letter

This has been removed from the electronic copy

Appendix 5. Research and Development Approval letter

This has been removed from the electronic copy

Appendix 6. Research Advert



What is it like to live in a Secure Unit?

Hello my name is and I am a Trainee Clinical Psychologist Conducting Research

Many women who are in medium secure care attract a diagnosis of personality disorder but little is known about their experiences including what it is like to live with other women in a secure unit.

By finding out more about those experiences I hope this knowledge can improve women's in-patient experiences and help their recovery.

If you would like to know more about taking part in the research please ask a member of staff.

I will be attending morning meetings over the coming weeks and will be on the ward so please feel free to come up to me and ask me more about the research.

Thank you

Appendix 7. Participant Information Sheet



Participant Information Sheet

Women's Experiences of Living with Other Women in Secure Care:

What are these relationships like for Women who have received a Diagnosis of 'Personality Disorder'?

Hello, my name is [REDACTED] 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. Before you decide it is important that you understand why the research is being done and what it would involve for you.

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.

Part 1 of the information sheet

What is the purpose of the study?

Women in Secure Units have said how their relationships with other women in the unit can be very supportive but can also be difficult. This study aims to gain a clearer picture of the ways in which women experience their relationships with other women in the unit so that we can learn how we can help make these as positive as possible. Many women who are in secure care attract a diagnosis of so called 'personality disorder' but the experiences of women who get this diagnosis do not attract a lot of attention and I think it is important to know more about these experiences. I will not be judging or asking about the diagnosis itself but about women's experiences with the other women inpatients.

Why have I been invited?

You have been invited because you have lived for at least 3 months in a secure unit and have received the diagnosis of so called 'personality disorder' at some point in your past.

Do I have to take part?

It is up to you to decide to join the study. If you agree to take part, I will then ask you to sign a consent form. You are free to withdraw at any time, even after signing the form, without giving a reason. This would not affect anything about the care you receive.

What will happen to me if I take part?

You will meet with me and a female staff member for one interview to talk about your experiences of being with other women on the unit. The interview will take place at your regular place of care. In the interview you do not have to mention any names and if you do they will be made anonymous when the interview is written up.

Before starting the interview I will check that you still feel able to participate. I hope the interview will feel like a conversation and there will be some questions to guide the discussion. I will ask questions including “What is it like living with the other women here” and “What do the other women mean to you?” You will be free to ask me to explain anything at any point.

The interview will be recorded by Dictaphone. This recording will be stored anonymously with no identifying details, in a locked filing cabinet. Within a month of the interview I will send you an outline of the themes we discussed and ask you to comment upon the accuracy of these themes. That will be the end of your participation.

What you tell me will be confidential. However, if during the conversation it emerges that there is a risk to yourself or anyone else, neglect or abuse by staff, or any previously unreported criminal activity is mentioned, then that would be the only reason that I would break confidentiality. If I were to break confidentiality then I would explain this to you first and about the process I would take of disclosing to a member of staff to either your or, if relevant, the other person’s ward.

What will I have to do?

If you choose to take part then you will sign a consent form, agree to meet for an interview and to comment on the themes the researcher has written up of the interview. The interview is likely to take somewhere between 60 – 90 minutes. Participants can say no to commenting upon the researcher’s initial interpretations of the interview.

What are the possible disadvantages and risks of taking part?

You may find that thinking about some of your relationships in the unit could make you feel distressed. The researcher will check during the interview that you feel able to continue and will respect your wellbeing and right to not answer. You can also end the interview at any point should you need to do so. If, at the end of the interview, you require support then the researcher will let a member of staff know immediately.

What are the possible benefits of taking part?

I hope you will find it an interesting experience taking part and the information from the study will help with making the social environment as helpful as possible for recovery

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 my taking part in the study be kept confidential?

Yes. We will follow ethical and legal practice and all information about you will be handled in confidence. The details are included in Part 2.

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?

If you decide to withdraw from the study the data collected will be destroyed within 24 hours and this decision will not affect your care in any way.

What if there is a problem?

You may discuss any problems with the researcher if you feel comfortable to do so (contact number at the end of this information sheet) or with the Research Director (see complaints section below).

Complaints

If you have a concern about any aspect of this study, you should ask to speak to me and I will do my best to answer your questions. If you remain unhappy and wish to complain formally, you can do this through the Research Director

[REDACTED]

Canterbury Christ Church University

Salomons Campus

Broomhill Road

Royal Tunbridge Wells

KENT

TN3 0TG

Telephone: [REDACTED]

More about confidentiality

All information which is collected about you during the course of the research will be kept strictly confidential. The interview will be recorded with no identifying details and kept in a locked filing cabinet. It will be used to identify themes in the conversation. Only the researcher and person transcribing the interviews will have access to listen to the recordings. The person transcribing will be bound by a confidentiality agreement not to share any information. The only person who will be notified about your participation is your care coordinator, but they will not be given any details of what you said. The only time I would break confidentiality is if I thought there was a risk of serious harm to either yourself or anyone else or if criminal activity was referred to. If this should happen then I would tell the participant of what I was going to do and I would follow [REDACTED] NHS trust procedure. I would disclose to a member of the participant's care team. However, if the disclosure referred to neglect or care then I would follow Sussex Partnership policies and procedures regarding safeguarding vulnerable children and adults, or the 'whistle blowing' policy regarding poor, abusive or neglectful treatment.

This research is being completed as part of a Doctorate in Clinical Psychology and transcripts and audio recordings of interviews will be kept securely locked and stored for 10 years at Canterbury Christ Church University.

What will happen to the results of the research study?

The study will be submitted for publication and the findings will be presented locally to the Forensic Service. Any quotes that may appear will be anonymous with any potentially identifying information changed.

Who is organising and funding the research?

Canterbury Christ Church University is funding the research.

Who has reviewed the study?

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

You will receive a copy and a signed consent form to keep.

Further information and contact details

For specific information about this research project then please contact me. My contact number is at the end of this information sheet.

If you need advice as to whether you should participate then please speak with your care co-ordinator or Doctor.

If you are unhappy with the study than please let your care co-ordinator know. You may also contact [REDACTED] trust on the details listed in the complaints section.

If you would like to speak to me and find out more about the study, or have questions about it answered, you can leave a message for me on a 24-hour voicemail phone line at [REDACTED]. Please say that the message is for me [REDACTED], and leave a contact number so that I can get back to you.

Thank you very much for taking the time to consider taking part

Appendix 8. Participant Consent Form

Version 5 11/04/13 13/LO



Salomons Campus at Tunbridge Wells

Centre Number:

Study Number:

Patient Identification Number for this trial:

CONSENT FORM

Title of Project: Peer Relationships of Women with a diagnosis of Personality Disorder in Medium Secure Care

Name of Researcher: [REDACTED]

Please initial all
boxes

1. I confirm that I have read and understand the information sheet dated 11/04/13 (version 5) 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 without giving any reason, without my medical care or legal rights being affected. ☐
3. I consent to the interview being recorded by digital recorder. ☐

4. I consent for a secretary who is bound by a confidentiality agreement to make a written version of the interviews from the recordings. This version will be made anonymous with no identifying information. ☐
5. I understand that once made anonymous and any identifying information removed; the data collected during this study may be looked at by the lead supervisor [REDACTED], Clinical Psychologist. I give permission for her to have access to a written copy of the interview with all my personal details removed. ☐
6. I agree to my care co-ordinator being informed of my participation in the study. ☐
7. I agree that anonymous quotes from my interview can be used in the published report. Identifying information would be changed to protect anonymity. However, I maintain the right to change my mind and decline permission for quotes to be published. ☐
8. I have been made aware that the interview is confidential. However, confidentiality would be broken if the interviewer believes there is a serious risk of harm to the interviewee or anyone else, if reference was made to previously undisclosed criminal behaviour, or to neglect from staff. ☐
9. I agree to take part in the above study. ☐

Name of Participant

Date

Signature

Name of Person
taking consent.

Date

Signature

Appendix 9. Information to Care Co-ordinators

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
Tel: [REDACTED]

[REDACTED]
Trainee Clinical Psychologist
Department of Applied Psychology
Canterbury Christchurch University
Broomhill Road
Tunbridge Wells
TN3 OTG
01892515152

Date

Dear

I write to inform you as care co-ordinator that XXXXXX D.O.B. has consented to take part in the following research project.

The research title is “Peer Relationships of Women with Personality Disorder in Medium Secure Care”. The background for the research is that poor interpersonal functioning is a central part of dysfunction in personality disorder but currently the published theory and evidence do not fully guide us how people experience their peer relationships in forensic care and what impact such relationships have upon recovery. The aim of the research is to develop an explanatory model for the role that peer relationships take in personal recovery for women in forensic care. The participation is detailed in the enclosed information for participants, and consent sheet, and will involve the participant in engaging in a one off interview about their peer relationships whilst in forensic care.

The interview will be by myself and last between 60-90 minutes and take place in the person’s usual care environment. A female chaperone known to the participant will also present throughout the interview. Following the interview I will analyse the interview and

send a copy to the participant for their comments, and this will be the end of their participation. At the end of the research I will meet with participants 1:1 to give an overview of the findings. Participants are aware that they are free to withdraw from the study at any point without giving a reason and that their care will not be affected in any way. Further details are in the attached participant information and consent forms.

The research is supervised by Dr [REDACTED] at Canterbury Christchurch University, at the above address and clinically at [REDACTED] Trust by Dr [REDACTED]

Please contact me, or either of the above supervisors on the above numbers if you have any questions or concerns. I will contact you with the date of the interview. On the day of the interview I will seek confirmation from the nursing team directly involved that day with the participants' care that it is suitable to continue with the interview that day.

Yours sincerely,

[REDACTED]

Trainee Clinical Psychologist

Canterbury Christ Church University

Appendix 10. Protocol for the Use of Digital Recorder

Protocol for the Use of Digital Recorder Olympus DM-650 on [REDACTED]

1. Justification for Bringing a Dictaphone onto [REDACTED]

1.1 The qualitative semi structured interview procedure requires rigorous analysis of transcripts of interviews. As such it is vital that interviews are audio recorded and then transcribed before analysis.

[REDACTED] Length of Time Digital Recorder Will Be On [REDACTED]

2.1 The Dictaphone will be kept on the person of the researcher/interviewer [REDACTED] at all times.

2.2 It will only be taken from the entry point of the ward to and from the interview room.

2.3 It will only enter the ward for the start of an interview and will leave the ward at the end of the interview. Interviews will take up to one hour.

[REDACTED] Number of Times the Digital Recorder Will be Taken Onto [REDACTED]

3.1 It will be necessary to conduct between 4-8 interviews.

4. Risks

4.1 Risk of digital recorder being taken by an inpatient and used to send or receive messages.

5. Minimisation of Risk

5.1 Ward Security will be informed prior to the researcher entering the ward for an interview.

5.2 The Dictaphone will be signed in and out at the nurses' station when entering and leaving the ward.

5.3 The researcher will keep the digital recorder in their pocket at all times and have a loop attached to a belt when travelling between the ward entry point and the interview room.

5.4 During the interview the Dictaphone will be placed in clear sight of the researcher and at the end of the interview it will immediately be attached to a belt and placed in a pocket before leaving the interview room.

5.5 The researcher will only be in contact with the ward staff and one in-participant whilst on the ward.

6. In the Event of the Digital Recorder Being Taken

6.1 Ward security would be immediately informed.

6.2 As the digital recorder will always be upon the researcher's person or in clear sight during the interview then the researcher would know immediately if the recorder had been taken and then notify security

Appendix 11. Confidentiality Form for Transcriber

Confidentiality Statement for Persons Undertaking Transcription of Research Project Interviews

Project title-Peer Relationships of Women with Personality Disorder in Forensics

Researcher's name _____

The digital recordings you are transcribing have been created as part of a research project. These recordings may contain information of a very personal nature, which should be kept confidential and not disclosed to others. Maintaining this confidentiality is of utmost importance to the University. Signing this form means you agree not to disclose any information you may hear on the recording to others, and not to reveal any identifying names, place-names or other information on the recording to any person other than the researcher named above. You agree to keep the recording in a secure place, to not make further digital copies of the recordings and only use the password protected version given to you by the researcher. You agree that the recordings will be held so that they cannot be accessed or heard by other people, and to show your transcription only to the relevant individual who is involved in the research project, i.e. the researcher named above.

You will also follow any instructions given to you by the researcher about how to disguise the names of people and places talked about on any recordings as you transcribe them, so that the written transcript will not contain such names of people and places.

Following completion of the transcription work you will not retain any recordings or transcript material, in any form. You will pass all the password protected digital files back to the researcher and erase any material remaining on your computer hard drive or other electronic medium on which it has been held.

You agree that if you find that anyone speaking on a recording is known to you, you will stop transcription work on that recording immediately and pass it back to the researcher.

Declaration

Please initial all
boxes

I agree that:

1. I will discuss the content of the recordings only with the researcher named on the previous page.
2. I will keep all recordings in a secure place where they cannot be found or heard by others.
3. I will treat the transcripts of the recordings as confidential information.
4. I will agree with the researcher how to disguise names of people and places on the recordings.
5. I will not retain any material following completion of transcription.
6. If the person being interviewed on a recording is known to me I will undertake no further transcription work on the recording and will return it to the researcher as soon as is possible.

☐☐☐☐☐☐

I agree to act according to the above constraints

Your name _____

Signature _____

Date _____

Occasionally, the conversations on recordings can be distressing to hear. If you should find it upsetting, please speak to the researcher.

Appendix 12. Interview Schedule

Peer Relationships of Women with a Diagnosis of Personality Disorder in Medium Secure Care

Interview Schedule

Please note that for community participants, the questions were phrased in the past tense.

Introduction to the Interview Questions

This interview is about women's relationships with other inpatients whilst in a medium secure unit. The word relationship is very broad and can be about anyone from someone you know to a friend or partner. It can be about people you get on with and about people you do not get on well with.

During this interview I am going to ask you 12 questions around your experiences of living with other women in secure care. Please ask me if any of these questions are not clear and I can help explain them.

I would like to remind you that it is fine to take a break or decide to end the interview at any point and that this would not affect your care in any way.

Do you have any questions before we begin?

Questions with prompts

Qu.1. What was it like meeting with the other women when you were first admitted?

Prompts – what comes to mind when you think to back then?

Qu.2. What are the different types of relationships you have with the other women here?

Prompts - What sorts of things made you see them this way?

Qu.3. How closely do you connect with the other women here?

Prompts – Are they similar to you? Have they got similar strengths and difficulties? Have you always felt that way?

Qu.4. What do the other women mean to you, and does that change sometimes?

Prompt- Do you value them? and why? Does that change sometimes? When do you most/ least value them? Have you felt bonded

Qu.5. Are there good and bad things about living with each other?

Qu. 6. Are there any difficulties living in a group and how do they come about and do they get resolved?

Prompt – how do people go about resolving problems

Qu.7. Has the way you see your relationships with the other women changed at different times since you've been here?

Prompts - What sort of things, or people have affected this? What has this meant to you? If there has been a change has this had an effect on you?

Qu. 8. Do you see the relationships continuing after discharge?

Qu.9. Have your relationships here ever made you feel like making changes in your life?

Prompts – can other people be role models and encourage you or can people make you feel stuck, worse or feel like giving up?

Qu.10. Have any of the women here helped with your recovery or been a role model?

Prompts – Have they caused you to view things in a different way that has helped you? Have they done the opposite or got in the way? Have your views changed because of them? Do these relationships help you ever make sense of your own problems?

Qu.11. Can you tell me what it is like living with the other women here?

Prompts – What is it like on a day to day basis? What is it like when other women are admitted or discharged?

Qu.12. What is it about a medium secure unit that helps or doesn't help relationships with the other women here?

Prompts - Do you think your relationships would have been different if you had been on a general inpatient ward? Or met as community patients? or met socially and outside of services? Are there specific things about being in the medium secure unit that makes it harder or easier? Are there things that make these relationships closer or more distant?

Qu.13. What is it like to be in therapy groups or meetings with the same women that you live with?

Prompts – What is it like to be in therapy groups, ward meetings, and living with the same people? Do experiences of being, say in a reflective group then have an impact on social time later on? or the other way around?

Qu.14. Do you think other women here have similar experiences to you and if not why?

Prompts – do you think your experiences have a lot in common with other people here, or are there some things that make yours very different? Is there something about you that is different in how you are in relationships? Do you think other women in the medium secure unit see things the same way as you? Do you think about relationships differently to other women here? Have you come from similar backgrounds?

Qu.15. Is there anything else about your relationships with the other women inpatients in medium secure care that you would like to add?

End of Questions. Thank you very much for participating and we have now reached the end of the interview.

Offer of de-brief as per protocol.

Appendix 13. Interview Transcript

This has been removed from the electronic copy

Appendix 14. Categories, sub-categories, focused codes and quotes

Categories	Sub-categories	Focused Codes	Quotes
GROUP CONDITIONS	Empowering a positive group identity	Sharing tough experiences and commonality	<i>“Um caring. Quite deep. Deep. Quite a large extent to what we’ve been through together. You know the fact that we’ve been through tough times and that’s brought us closer, closer together.”</i> Participant, Line 219
		Experiencing empowerment from the group	<i>“Well when there is the sense of the group being together you’re less anxious, you feel more stable, you feel stronger in yourself”</i> Participant 1, Line 579
		Bonding and group identity	<i>“Yes, it is. Yeah. To have a feeling of unity, you know of common value”</i> (Participant 1, Line 554).
	Causes and consequences of lack of unity	Level of Disturbances relate to group identity	<p><i>“And the more disruption that unity is diluted and lost”</i> (Participant 1, Line 558).</p> <p><i>“it did make people less close together when the ward was unsettled”</i> (Participant 5, Line 170)</p> <p><i>“Well they don’t want to get involved on what’s going on the ward and keep to themselves”</i> Participant 8, Line 165)</p> <p><i>“when the ward was unsettled it made them all angry and sometimes it made me angry too when the ward was all unsettled”</i> Participant 5, Line 165-166)</p> <p><i>“And things are settled down now, so we can actually breathe and sort of you know make more of a relationships”</i> (Participant 2, line 111)</p>

		Inpatient numbers determining ability for group unity	<p><i>"It gets a bit clicky if you've got a big, you know, if there's lots of people but before it was sort of homely-ish in a way with just six"</i> (Participant 4, Line 72)</p> <p><i>"Um it gets a bit clicky, when there are more people you know, there's like certain people with certain people and more chance for conflict".</i> (Participant 4, Line 237).</p> <p><i>"because the unit was small and only 6 beds you've got more close knit and there was just more more interaction and more, and the friendships were maybe deeper"</i> (Participant 2, Line 287)</p> <p><i>"having more women means there's more disruption or distraction"</i> (Participant 1, line 503)</p>
	Impact of Lacking sense of Group Identity	Loosing sense of community support	<p><i>"When there is less sense of a shared community then you feel more vulnerable and anxiety and its highly stressful, there's a higher, yes, it's a very detrimental effect to recovery"</i> (Participant 1. Line 514.)</p> <p><i>"You can lose the support when the ward drifts apart"</i> (Participant 8, Line 167)</p>
	Disturbing behaviour and group identity Ward Behaviour and impact on individuals	Attacking Peers Increasing sense of Fear of	<p><i>"Um the grumpiness, the bitchiness. Cat fights. It's just normal what, normally what you would get in with a group of women really. Mind games. Yeah. It's like when you're ever out with a women they're all just like, they use, they use your weakest points to hit you with"</i> Interview 6 Lines 150-151.</p> <p><i>"when there are more disturbances, you don't know"</i></p>

		Escalation	<p><i>what's going to happen next or who's going to kick off next or if someone would hurt themselves really badly. Because when it kicks off, it kicks off, it's not like a little kick off, it's a big kick off"</i> (Participant 8, Line 184-185)</p> <p><i>"Well it stressed everyone out, so everyone was sort of, not everyone, but certain people here were rubbing each other up the wrong way"</i> (Participant 2, Line 115)</p> <p><i>"Well, I think, you know when violence occurs that's also very scary"</i> (Participant 2, Line 614)</p>
		Peer Pressure	<p><i>"yeah I've done it to new people and It's difficult because it feels like you're interrogating them but its expected that we do it".</i> (Participant 8, Line 701)</p>
		Re-traumatising Environment	<p><i>"the general noise level can make me fearful and anxious"</i> (Participant 2, line 262)</p> <p><i>"Yeah, a lot of banging or shouting or people um being restrained, and you know that that's, would get my heart racing at a terrific pace and I would feel absolutely terrified cos I had fear and it brought things back"</i> (Participant 2, Line 262)</p>
		Claustrophobic Environment	
		W	<p><i>"when people self-harm, and other people just withdraw</i></p>

		withdrawing due to others disturbing behaviour	<i>themselves</i> ” (Participant 12, Line 371)
Personal Conditions		Alienating other people	<i>“I became very ill and I used to shout a lot. That’s what I would do, If I’m upset or something, and it upset them [peers] um and so they didn’t want to know and it wasn’t really their fault”</i> (Participant 7, Lines 94-96.)
		Managing social distance	<i>“Not so much thinking about them, but not getting involved now so much in their, not their conversations, but in to their problems like before”</i> (Participant 11. Line 883).
		Timing of receiving advice and ability to use it	<i>“I was told I was putting XXXX on a pedestal and I took it well really, I took it well and I felt I had to deal with it”</i> (Participant 6, Line 681) <i>“I think they helped me in the long run but at the time no I didn’t accept what they said but then the more time I thought about it, I thought “you know what, you are right”. I got better self-understanding and self-awareness because of growing up a bit and maturing and realising human beings aren’t perfect”</i> (Participant 6, Lines 706- 710).
		Prioritising of Relational focus	<i>“I think I’d be more involved with the other women here if I wasn’t moving on. Um in the normal things, like chatting and talking to them a lot and everything. But it’s because I’m ready to move on I spend most of the time in my room and not involved in what’s going on here in the ward, you just hear some things sometimes”</i> (Participant 4, Lines 257-260)

			<p><i>“Um I go out a lot more here than I did in the medium secure unit and so um I’m sort of meeting more of the public, sort of thing and so I’m, it’s, I’m less involved in in the ward activities. as going out more I’m less involved in what’s going on here or sort of arguments or whatever it’s different now with the others, there’s just a couple of people I get on with really well, and the rest of the people are sort of just acquaintances, sort of thing because I’m going out more and moving on”.</i> (Participant 4, Lines 239-242)</p> <p><i>“I’m very driven, I’m very self-dependant, including my recovery. I’m very focused ”</i> (Participant 1, Line 224-225)</p>
inter-relating of contexts of knowing peers		<p>Confidentiality between group and communal living space</p> <p>Improving understanding and relating to peers through group work</p> <p>Transferring learning</p>	<p><i>“I think it it can cause problems outside of the group if people have shared things in the group in some instances between certain patients”.</i> (Participant 1, Line 1068)</p> <p><i>“Being in a group made me more able to interact with people, and you feel in more contact with them after the group and understand them. “</i> Participant 3. Lines 644-646.</p> <p><i>“Um it makes relationships better in some ways, having heard in the activity group what people have gone through, just knowing somebody else has been through the same similar thing to you”</i> (Participant 4, Lines 312-313).</p> <p><i>“I’ve learnt to do it quite gingerly to bring up tricky things.</i></p>

			<p><i>Yeah, I've said to xxxx before in a group, you know, about her hitting a, er a member of staff, and she said she had no idea that it affected us that way. So it was kind of like it was good to have her feedback on it as well. After the group we were fine and I think she found it helpful as well. I think it's good you get an understanding of where you stand with each other"</i></p> <p>(Participant 6 Lines 938 -943)</p> <p><i>"We continue to talk about it after the group and you get different tips off different er patients. You get different tips off, quite helpful ones that."</i></p> <p>(Participant 8, Line 580)</p> <p><i>"Um, well it didn't really affect relationships outside of the group. Obviously with this one person, she used to do everyone's head in though"</i> (Participant 12 Line 1111)</p> <p><i>"Um, well she's gone now, but um yeah it made it easier [already knowing someone] at the time when I was admitted"</i> (Participant 4, line 12)</p> <p><i>"There was quite a few of us came at the same time, sort of, you know, together, so it wasn't too bad"</i> (Participant 4, line 14)</p>
Getting on		Knowing peers from prior admissions	Settling in with
			<i>"It was just getting on with the</i>

with each other		the other women	other women, I suppose helped me to get used to the place” (Participant 4, Line 221)
		Having to get on due to close proximity and length of contact with peers	<p><i>“Everyone’s like stuck in this together and it’s all claustrophobic because it’s such a small area that it’s more difficult to get out of the situation, we have to get on”.</i> (Participant 8. Line 459-460).</p> <p><i>“Probably more need to resolve problems in secure services as living together for a long time“</i> (Participant 2, line 545)</p> <p><i>“Very, you have to by the nature of it there are high emotions, you you have to sort of like not hold grudges”</i> (Participant 2, Line 559).</p> <p><i>“I’d never done it before but learning here to apologise made me stronger, I think er because I could apologise and not let things get, drag me down. I’m now quite happy to say sorry because I got my friends back”</i> (Participant 8, Line 142-144).</p>
		Capacity for getting on	<p><i>“So I think it’s interesting, it shows you how people, the extent to which people can get on if they’re in a situation when it’s in their best interests to get on”</i> (Participant 1 Line 1111-1113.)</p> <p><i>“They’re all at different stages in their lives but through all that we can connect, that’s the thing”</i> (Participant 2, line 489-491).</p>
		Keeping Safe – coping with fear	<p><i>“Um I’m aware of that I never state my view because I don’t think that’s particularly useful and it’s another way in which I protect myself by not stating</i></p>

			<i>subjective views, because that's how arguments and disagreements"</i> (Participant 1 Line 214)
		Fear and protective behaviour	<p><i>"But it was, er I sort of stayed in my room, tended to sort of isolate myself a bit, when I first came in. I did that because I was so highly um sensitive to you know expressions on other people's faces, or just body language etc that it was easier for me to stay in my room"</i> (Participant 2, Lines 22-24)</p> <p><i>"just, I I was frightened of the other women when they kicked off and I was in my room shaking, you know until a member of staff came in and and sort of said we've got a handle on it"</i> (Participant 2, line 64)</p> <p><i>"you don't know whether they're going to hurt you or whether they're going to be supporting of you"</i> (Participant 12, Line 1148)</p>
		Being suspicious	<i>"Well then I worried [after someone gave her toiletries when she had none] oh gosh, I'll have to get them something back, and why did they do that but later I realise they weren't after that. They were just doing it um you know altruistically really"</i> (Participant 2, Line 32-33)
Domesticating the social environment		Creating familial type bonds	<p>Women frequently described peers as being like a mother, big sister or little sister.</p> <p><i>"when its just women you become, I don't know what the word is, but you become closer, like a family if you're like all women, because we look after each other as like sisters"</i> (Participant 8 Line 214)</p> <p><i>"I did get mothered quite a lot"</i> (Participant 12 Line 48)</p>

			<p>“It was nice because obviously I grew up in care so I’ve never had that sort of experience. And it was nice to have someone like there for you mothering you. So, yeah, it was really nice” (Participant 12, line 52-54)</p> <p><i>“I was like a big sister to her. She always called me her big sister. But she was only about 3/4 years younger than me”</i> (Participant 12 Line 462)</p> <p><i>“They try and make you like a sister, or if you’ve got a mother at home, they try and make you like a mother and say “oh, you’re like a mother to me”, “You’re my step mum or second mum”. And they try to make characters out of the people at home in the building. It helps I’ve done it. I have said to people “you’re like a mum to me”. I do have someone in my life who’s like a mum to me but she’s not my mum. And I love my mum Er I’ve said to people “you’re like a sister to me”. But, no, no in the depth that the girls do here. There are different roles. Er one woman said that I’m like a mum”</i> (Participant 7. Lines 456 -461)</p>
		Sharing homely activities together	<p><i>“Um the thing that was nice on XXXX ward was doing lots of cooking and things. We had a weekly meal and things like that, and I liked doing that. Just everybody, well not everybody, but people that could go in the kitchen were sort of um good fun, sort of thing, if you know what I mean. It was sort of a bit of a laugh because we all had things to do but um everybody sort of um pitched in, sort of thing, if you know what I mean”</i> (Participant 4 line 101-104).</p>

			<p><i>“Doing normal little things together is important there’s a sense of you know of not being so disconnected from the real world” (Participant 1, Line 476).</i></p>
		<p>Spending time together/ hanging out?</p>	<p><i>“Well it feels really good to have a close friendship in a place like this because it means that you can just hang out or do things together” (Participant 9, Line 109.)</i></p> <p><i>“I’d lost my home life being put here. It was important to just to talk to people about everyday life things and how the day had been” (Participant 3, Lines 188-190)</i></p>
		<p>Creating a welcoming environment</p>	<p>The participants frequently spoke of the importance of creating this for new admissions onto the ward.</p> <p><i>“Well because everyone seems to be so friendly and welcoming and that, so it feels homely” (Participant 5. Line 158).</i></p>
		<p>Combatting the clinical environment</p>	<p><i>“Um it was very clinical and that was hard but um the ladies were lovely and made you feel more yourself” (Participant 12. Line 23)</i></p> <p><i>“[being] here its so clinical I have to just try and hold on to the person who I am” (participant 1, Line 1046)</i></p>
<p>Connecting with peers</p>	<p>Negative and Experiences and Distance and impact on Attempting to connect</p>	<p>Feeling Betrayed</p>	<p><i>“I tend to keep them to myself about the things of my diagnosis because I’m too embarrassed to say anything because I have said anything and someone took the piss out of me because of it. I’ve got borderline personality disorder and post-traumatic</i></p>

			stress disorder and depression I can get, hear voices and I said to the the <i>patient that I'm hearing</i> voices, so she started to take the <i>piss and was like "who's that?"</i> , like pretending, and making her eyes boggle. That was a friend and I burst in to tears, and I had <i>to take PRN because of it"</i> (Participant 8. Line 629-640)
		Feeling let down and rejected by friends	<i>"When I was in medium secure I made some friends, but they rejected me when they left the hospital they didn't keep in touch. They promised to keep in touch and they didn't. It made me feel bad."</i> Participant 3. Lines 159-161.
		Fluctuating between friendship and rejection	<i>"its gone through phases and stuff like that where one minute she liked me and the next minute don't, and then they're alright and they just ignore and they just mind their own business. But the slightest thing she and other people can pick on. Like my hair, someone yesterday was saying my hair is greasy, and it isn't greasy. Um, you feel down."</i> (Participant 7, lines 685-691)
		Peers behaviour affecting own wellbeing	Um after her suicide attempt I was obviously, I was very worried about my friend (Participant 12, line 338)
		Othering	<i>"I don't really want to be friends with somebody that's severely self-harming themselves. So that might sound a bit out of order. Um it's it's, I think it's, a lot of it's just so much attention seeking that um I don't want to be involved in it, and I don't want to be asking somebody all the time "how have you hurt yourself? How have you hurt yourself? How have you hurt</i>

			<p><i>yourself? ”, and it’s pretty obvious how they’ve done it” (Participant 9. Lines 187-190)</i></p> <p><i>“They are like when they talk about their index offence you get, and it’s mainly from the self-harmers they see it, they treat it when they’re presented as either a joke or as some kind of badge of honour” (Participant 1, Line 992.)</i></p>
		Feelings of loss by discharges	<p><i>“When one gets discharged, like you’re losing someone” (Participant 8, Line 222)</i></p> <p><i>“Well I’ll always tell the girls, it’s hard but you know, um we’ve all got to move on some time or the other really” (Participant 5, Line 302)</i></p> <p><i>“It makes it harder when people are on the point of leaving , it does make it hard. I get lonely. Um I sometimes get a bit depressed.” (5, Lines 299)</i></p> <p><i>“a few of my friends are moving on soon and I wish that was, that was me.” (Participant 5. Line 295)</i></p>
		Being Rejected	<p><i>“Quite upset, when I don’t know how they are going to be with me because I want to get close to them Because I want to get to know them better and Yeah, because it feels like they’re abandoning me It makes me quite angry and like really hurt”. (Participant 8. Line 72-72).</i></p>
	Developing positive connections that have potential for positive personal growth	Feeling mutual understanding	<p><i>“You do have that kind of common understanding that you’re all going through the same thing” (Participant 1. Line 108).</i></p> <p><i>“Because people, most women go through the same things as</i></p>

			<p>other women and they can solve – <i>what’s the word? I can’t</i> remember what the word is. They can sympathise with you. They <i>can, they’ll, if you’ve had such-and-such</i> done and you can sympathise with them and they <i>can sympathise with you</i>” (Participant 11. Line 899-901)</p> <p><i>“It felt good, I’ve not been judged and It makes me feel understood”</i> (Participant 12, Line 812)</p>
		Developing trusting relationships	<p><i>“I’ll always be friends with xxxx because we, we you know we, I understand xxxx, I trust xxxx, and xxxx understands and trusts me”.</i> (Participant 1. Line 864)</p>
		Emotional connection	<p><i>“since I’ve been in the secure hospitals that friendships have have formed over years of being in hospital with the same people, you know, because it’s such a er much longer than acute and it’s got a lot deeper level of trust and the understanding and caring and friendship really”</i> (Participant 2, Lines 395-401)</p>
		Reassurance from not feeling alone	<p><i>“I used to feel alone but then found it’s reassuring to know that you are not an isolated case, you know, that there are others who have struggled and come through it”</i> (Participant 2. Lines 371-372)</p>
		Depth of approaching peers /Approach/ avoidance/ balancing	<p><i>“There’s no one that I won’t try to talk to. You know maybe they’re a little bit unwell or you know they’re sort of like difficult to talk to, so I will just say the odd word here and there”.</i> (Participant 2. Lines 255-256)</p>
	maintaing problematic relational behaving style	Friends escalating each others unhelpful behaviour	<p><i>“We ended up very close friends and and of course if if she kicks off and staff went to grab her and things, then – and whatever possessed me, I don’t know – but</i></p>

		Pressuring peers and impeding progress	<p>I would go an help free her, and it ended up that we both ended up <i>kicking off</i>". Participant 12. (Lines 300-302)</p> <p><i>"Um there was another patient there who 's now in high secure, but um whenever I used to have a moment, like kick off and things, she would do it at the same time and I think it became very, it was more like a competition to see who could the worst. And then I wanted to outdo her and competing, well it didn't get me anywhere, it got me moved up into a medium secure."</i>(Participant 12, Lines 267-270).</p> <p><i>"xxxx says to me " I don't want you to go to xxx, I want you to stay here with me", and I'm like err, because like a part of me says yeah, no, blow it, stay here with xxxx, give xxxx what she needs, let xxxx get out before me.</i></p>
		Idealising	<p><i>"Yeah. I used to find myself as well putting people on pedestals and then when they didn't meet the aspirations that I had for them, it was like oh my God, a catastrophe, you know what I mean? But I've grown out of that over the years, so I don't do that anymore. It was like devastating because it's all your hopes and dreams have gone. Because I've realised human beings aren't um perfect. It was the counselling and stuff that helped".</i> (Participant 6 Lines 664-669.)</p>
		Jealousy	<p><i>"I hated the people who did have the privileges I was jealous I'd shout at them, swear at them, moan that they've got this and I haven't"</i> (Participant 12, Line 217-218.)</p>

			<p><i>“There’s a very selfish self-centred competitive element, and you can see an awful lot of jealousy if you move forward and they’re not”</i> (Participant 1, Line 1018)</p> <p><i>“Ok, so like privileges or kind of they’d compare each other to, I’ve thought how come I’m not allowed as much time out as someone else?, that kind of thing?”</i> (Participant 4. Line 402-403).</p>
		Competing	<p>Because if they’re they’re not getting enough attention they kick off or start beating their door or head-butting the walls or cutting themselves to get the attention I’ve done it because if your not getting attention and because I don’t know what to do because I ask for one-to-one’s and they’re like “yeah, in a minute. In a minute. In a minute”, and you’re waiting there an hour later, and you knock on the door again, “when am I having my one-to-one?”, “in a minute”. So you’re getting frustrated every time you keep asking you’re getting frustrated and that. But if someone’s kicking off, they get the attention straight away. If you’re calm and placid, you don’t get the attention. So I see it that if I kick off, I’m going to get the attention, and it’s going to be negative attention. But I’m still going to get it so I kick off. (Participant 8. Lines 735 -752).</p> <p><i>“Um I think it’s like someone stops eating for a week or so, and someone comes up and goes “yeah, I can do better than you”, and they stop eating for 8 days, that their power’s better than</i></p>

			<p><i>theirs. I think as it's more just like a power rush.</i>" (Participant 12 line 886-890)</p> <p><i>"When you've got someone trying to be at the top, they can be very intimidating. It depends on how, what sort of people you have in the unit at a er a certain time whether there is competition for being top dog. Sometimes it can be the whole group fighting to be top"</i> (Participant 12 Line 930-932)</p> <p><i>"competing Well it didn't get me anywhere, it got me moved up into a medium secure"</i> (Participant 12 Line 891)</p>
		Holding grudges	<p><i>"I wasn't aware of it at the time, but, yeah, I can hold grudges. I've been known to, because like you think afterwards like, you know, what I mean, oh I'll get you, this isn't the end of it, and like things like that. It's stupid, holding grudges really. It is. It don't get you anywhere apart from a nasty temper and peeing someone else off. It was negative thinking's not very good. I'd end up like thinking badly of myself for too long, I end up self-harming. Staff helped me think differently and I talk to other women now if I feel I have a grudge and try and resolve it."</i> (Participant 6, Lines 196-200).</p>
		Behaving to set progress back	<p><i>"I've deliberately messed up to be sent back to be with my ex-girlfriend"</i> (Participant 6, Line 818.)</p>
accessing peers for support	Maintaining personal problems through supportive relationships	Acting on Bad Advice	<p><i>"sometimes they'd be like telling me to be a bit rebellious and kick off and do this or do that. Sometimes at the time I thought it was good advice to kick off"</i> Participant 11, Lines 462-463).</p>

		Making unrealistic demands on others	<p><i>"I was very lively when I was first in. Very lively. Like with self-harming and stuff, and you um you tend to expect more of people um. I expected them to communicate with staff for me, um or to keep it quiet if they know I'd self-harmed, and not to tell anyone. But it's, you know, you can't put that on people but did n't realise it at the time and felt sort of betrayed, I suppose".</i></p> <p>(Participant 10, lines 770-774)</p>
	Negative Experiences requesting support	Worrying about response when seeking support Requests for support being denied	<p><i>"I do sometimes tell other women when I'm not coping or going to self-harm, but sometimes it upsets them and then they go to staff because they're upset, and then I feel guilty, then I go to staff and try and explain to them the situation and what happened"</i></p> <p>(Participant 8, Line 338-340)</p> <p><i>"Yeah, you do sometimes ask how they made that made progress. It depends on the individual really, because like sometimes they don't want to talk about it"</i> (Participant 12, Line 689)</p>
	Positive experiences of receiving support and learning from peers	Choosing source of support	<p><i>"I talk to the other women but I think some people are more reliant on the staff and other people are more reliant on themselves and the patients and so that changes who you would go to for support. But I think most people would look towards each other."</i> (Participant 12 Lines 537-539)</p>
		Being comforted	<p><i>"I see it every day, every day I see the women supporting each</i></p>

			<p>other. they can go in and talk to someone and stop them stewing” Participant 2. Line 156</p> <p><i>“But like if they’re depressed or, we we do stick stick by each other”</i> Participant 6 Line 316</p> <p><i>“there’s one particular girl who’s really kind to me, and she sees me get upset, she always comes up to me, like yesterday when they started on me and I was crying, and the staff were ignoring me in the the evening, she came up to me and said um “oh xxxx, are you alright, xxxx? Oh, you’re crying. She was kind and it meant a lot to me because it showed there were people that were just not going to allow people to do that. And she wouldn’t take sides. It made me feel warm and comforted and there’s another girl who’s a good friend of mine and she’s so sweet to me.”</i> (Participant 7, Lines 142- 147)</p> <p><i>“They were just really friendly and they were there to comfort and support me. you can go to and the ladies give you a bit of support and that. They gave me cuddles and supporting me through the hard times when I was in tears. It was like when I got in to a situation It was er, I found quite difficult, they were like “come on, we’ll help you through it” and knowing they back me up means I will recover.”</i> (Participant, 8, 443-447)</p>
		Depth of ability to help	<p><i>“A lot of these women you know they’re, they’re very sensitive to what is needed and what to do, how to get through to someone that’s on their bed and that is just</i></p>

			<p>struggling. <i>Like they're reminded of things that um that they had a laugh about at another time Or they'll call them a little nickname</i>" Participant 2, Line CHECK LINE</p> <p><i>"Knowing that people have gone through the same stuff that I've gone through, and can support each other and know that what we're talking about when giving advice"</i> (Participant 8, Line 655)</p>
		Learning by observing peers	<p><i>"I've learnt through seeing amazing examples of women resolving conflicts. It has taught me and I'm still learning, seeing how they handle it"</i> (Participant 2, Line 561)</p> <p><i>"they've shown me to not getting involved in things when someone else is having a barney or something, not to get involved"</i> (Participant 4, Line 407)</p> <p><i>"It made me stronger, I think er because I learnt from them how I could apologise and not let things get, drag me down".</i> (Participant 8. Line 142)</p>
		Learning from Advice Received	<p><i>"Well when you self-harm the people you know from life in the community would be like "you're so stupid. Why would you do that?" and people in hospital were like "yeah, I understand why you do that, but why don't you try this?"</i> (Participant 12 Lines 796- 799)</p> <p><i>"Yeah. They, all they said to me was "keep your head down and work towards the future". And that's what I done, and I'm out now"</i> (Participant 12, Line 812)</p> <p><i>"Um one thing that really stuck in my mind is, that someone</i></p>

			<i>actually told me once, "life is worth living, and no matter what you've been through you can always come out of it". I think that one thing that that person told me, really stuck with me because of all she had been through". (Participant 12, Lines 693-695)</i>
		Feedback from peers improving insight	<i>"at the end of the day some of these girls they see things in you that you don't see in yourself, but they pull it to pieces, but if they do start, I look at myself that day and I think to myself 'what have I done today?' or 'what way have I behaved today to make them behave like that?'. And and that's quite interesting, because you do look at yourself. Because they only start if you do something that they don't like and it means that you can grow." (Participant 7, Lines 170-174)</i>
		Meaning of being given help	<i>"meant quite a lot to have their support. I've never had that before" (Participant, Line 32)</i>
Supporting and Helping peers	Negative impact from helping	Wellbeing reducing from helping peer	<i>"There was one girl who I was really really close to and then she started thinking that she could see aliens and things like that and it really um changed my friendship with her because I went from being really good friends to me looking after her for a couple of months. I missed her as a friend. I'd only do it for people that I really care about that I would. I just missed her company because she wasn't herself. It made me quite down. Um it did affect my mood." (Interview 9 Lines 225-231)</i>
	Experience of a positive role	Choosing who to help	<i>"I'd be more likely to offer help if you know built up more of a relationship to know that someone's not going to hurl a book or a TV at your</i>

			<i>head.</i> "(Participant 2, Line 197)
		Timing offers of help	<i>"It's gauging when who is right to go and approach that person and check on them. Someone who's built up more of a relationship with them, the better". (Participant 2, Line 201)</i>
		Ability for balancing helping others and own needs	<p><i>"Well I don't really tend to keep them friends from wards because they can ask for a lot, if you know what I mean. I tend to just try and move on and forget about it. Um I think, well my best friend now who lives with me, um she's got bipolar and she's very unwell at the moment, and it's just that it's, it's hard work because obviously I want to help her, and I can see her failing and that's upsetting, but on the other half I've got to try and look after myself as well" (Participant 12, Lines 381-383</i></p> <p><i>"And I think it does make it very hard. So I think if I ended up doing that with all the people I've met in hospital, I don't think I'd end up being able to stay well" (Participant 12 Line 391-392)</i></p> <p><i>"she is my best friend and I don't want to let her down or anything like that, but on the other hand I need to look after myself, so it's a bit like "ok, what do I do? Do I help her out or do I" – it's like the other night I was really tired and she ended up having to go, come down to A&E, and it was like "do I go with her or do I go to bed?", and I ended up coming with her. Its hard at the moment" (Participant 11, line 437-440)</i></p> <p><i>"my best friend now who lives with me, um she's got bipolar</i></p>

			<i>and she's very unwell at the moment, and it's just that it's it's hard work because obviously I want to help her, and I can see her failing and that's upsetting, but on the other half I've got to try and look after myself as well. ” (Participant 8, Lines 730-737)</i>
	Over involvement in others problems	Intrusively wishing to help	<i>“Um it could be frustrating when you're trying to help someone and they're just totally pushing you away. In the end I just gave up and let them get on with it. ..Um it made me feel like I'd failed them. it makes you feel quite sad. I could become quite depressed and angry with myself, if I couldn't help someone or they wouldn't let me” (Participant 12. Lines 422- 425)</i>
Recovery Through Peer Relationships		<p>Connections and relating leading to change in self esteem</p> <p>Change in understanding of others</p> <p>Acting positively on Advice leading to positive change</p> <p>Internalising positive and self esteem</p>	
		Recovery Learning	<i>“But but I've learnt through being in secure hospitals how to form friendships, how to feel affection, how to sort of like reach out to people, how how to show caring and listen to them and understand them and be a shoulder for for them to cry on if they need to, and just basically how to how to sort of engage in</i>

			<p>in a friendship with with another <i>human being. And er that's kind of, that that will then, when I leave hospital, when I'm out of hospital, that will then go to all my relationships, my relationships with my family</i>" (Participant 2, Lines 455-460)</p> <p><i>"When they said to me to kick off In the end I was like, I could think what my other friend said and I thought I've got to change, I've really got to change. If I want to get out of hospital, I've got to change I look back and think "God, I can't believe I was like that! Was I really that person?"</i>. It was that sort of – sometimes it surprises me that I could have <i>done something like that, I've hurt people like that. And why did I do it?"</i> (Participant 11, Lines 463-469).</p>
		<p>Inspired by others progress to achieve similar things</p>	<p><i>"Well when we were at xxxx she wasn't very well, and then she came here and she wasn't very well for a couple of weeks she was here, but now she's just doing so well she's got unescorted community leave for 8 hours. She goes out two or three times a week, she sees her daughter. Being a real mum, and that's what I want to be. I want to be like xxxx with my daughter and that. We are, but I want to be more hands on when I get out."</i> (Participant 6, lines 535-520)</p> <p><i>"Um I think some of it's made me more positive. Um I think seeing the women go through all different stages and seeing them progress helps you to progress. I think it's just like if you see someone recover and move on, you see how well they've done</i></p>

			<p>and how it makes them happy to be moving on, so you feel like you should be doing that <i>yourself</i>.” (Participant 12, 1059-1061)</p> <p><i>“There was times that I felt “do you know what? I really can’t be bothered. I just wish I wasn’t here”, and then you think about it and you think “actually, why am I like this? If this person can turn it around, why can’t I?”. So when you get positive things like that, although it is hard to think of them when you’re in a certain place, the more you do think about them the easier it becomes”</i> (Participant 12, Lines 706-710).</p> <p><i>“I think it’s such a relief. It really is a relief, especially when people move on and they’re discharged because it helps everyone feel that there’s life at the end of the tunnel”</i> (Participant 1, lines 458-459)</p>
		But relationships pressuring not to progress	<p><i>“xxxx says to me “ I don’t want you to go to xxx, I want you to stay here with me”, and I’m like err, because like a part of me says yeah, no, blow it, stay here with xxxx, give xxxx what she needs, let xxxx get out before me. But then the other half says to me you want to be with your daughter and you’re not going to be with your daughter if you stay here with xxxx, you know what I mean, so”</i> (Participant 6, lines 768-773)</p>
			<p>Refocusing</p> <p><i>“I haven’t kicked off really, not properly thinking of my daughter now helps me. I can’t stay here for her because my daughter</i></p>

			<p>wants me out there with <i>her</i>.”Participant 6, line 776</p> <p>Motivating feedback from changing behaviour This links to help from others <i>“I know I think if they hear a voice all the time, it must get on their nerves, you know what I mean, and now I’ve tried not to be as in their face and keep it a bit more to myself and they’ve been lovely to me and have more time for me.”</i> (Participant 7, Lines 170-172).</p>
--	--	--	--

Appendix 15. Participant Feedback Form

Peer Relationships of Women in Forensic Care

Overview of the model

Figure 1 outlines the constructed model of peer relationships of women with a diagnosis of borderline personality disorder in forensic care and their potential for promoting recovery. This model has two overarching ways in which peers engage with each other. This can either place an emphasis on survival and coping or upon relating to their peers. In the model this is indicated by the position of the barometer. This is influenced by the conditions of the ward and the personal conditions of the individual. Personal conditions might include health and admission status. Opportunities in the relating mode may either lead to positive or negative relating whereby positive relating has the potential for aiding in personal recovery.

How well does the model represent peer relationships on a forensic ward

Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
5	4	3	2	1
<p>suggestions for any changes to the category</p>				

Surviving or relating barometer

This reflects the dynamic relationship between the ward and personal conditions which is further mediated for some participants by knowledge of peers in other context including prior admissions and through group therapy. This dynamic at any one time guides individual behaviour to be either orientated towards the surviving or relating mode.

How well does the category represent peer relationships on a forensic ward

Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
5	4	3	2	1
<p>suggestions for any changes to the category</p>				

Category 1: Ward group conditions

Whilst experiences of the group can be composed of actions with individuals this category represents participant's experiences of action or identity at a group level. Admissions and discharges impact on the social climate and the sense of ability for progress.

How well does the category represent peer relationships on a forensic ward

Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
5	4	3	2	1
<p>suggestions for any changes to the category</p>				

Category 2: Personal Conditions

Participants' accounts included how personal conditions mediated interactions throughout the system of peer relationships. Wellness impacted on the ability to interact. The admission status influenced whether an individual was starting to get to know their peers, deepening relationships or looking towards discharge and reconnecting with external relationships. Opportunities for ward leave or connecting to external relationships also mediated emphasis on inpatient relationships.

How well does the category represent peer relationships on a forensic ward

Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
5	4	3	2	1
<p>suggestions for any changes to the category</p>				

Category 3: Experiences with peers in other contexts

This category did not apply to all participants as not all had experience of their peers in other contexts apart from the current ward. Other participants spoke of the impact of knowing other women from previous hospital admissions and the moderating effect of easing their initial admission to the ward. Also experiences from other contexts such as group therapy was largely seen as positive and could enable better connecting between peers. However, breaking confidentiality of the group can cause disputes.

How well does the category represent peer relationships on a forensic ward

Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
5	4	3	2	1
<p>suggestions for any changes to the category</p>				

Surviving Mode

Participants spoke of the necessity to “survive” or cope with their illness in a forensic ward. This could include apprehension for engaging with peers.

How well does the category represent peer relationships on a forensic ward

Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
5	4	3	2	1
suggestions for any changes to the category				

Category 4: Getting on with each other

As the ward environment meant that women were in close proximity for much longer than in other types of ward it was an imperative that women get on with each other.

How well does the category represent peer relationships on a forensic ward

Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
5	4	3	2	1
suggestions for any changes to the category				

Category 5: Domesticating the social environment

Through being a community of women, familial ways of communicating to each other that reflected valued or previously desired family bonds helped with coping with the forensic environment. Doing everyday activities or just ‘hanging out’ were valued as ways to normalize their everyday experience.

How well does the category represent peer relationships on a forensic ward

Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
5	4	3	2	1
<p>suggestions for any changes to the category</p>				

Relating Mode

For participants to be able to interact more deeply with their peers required moving from the surviving mode, and was dependent also upon personal characteristics and the ward environment. If conditions became experienced again as threatening then participants moved back to the surviving mode. In the relating mode participants attempted to make deeper connections than those required for surviving. This may be helped by experiences and skills learnt from the surviving mode. Ways of relating with peers feedback into how the participant experienced the ward including the degree of ward cohesion.

How well does the category represent peer relationships on a forensic ward

Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
5	4	3	2	1
<p>suggestions for any changes to the category</p>				

Category 6: Connecting with peers

Participants spoke of their wish for making meaningful relationships with peers and the potential depth of relating due to the length of admission and the common experiences and difficulties in life. However, attempts at connecting could be met with rejection or maintain an unhelpful relational style. The level of connection may be able to support recovery and hope for the future. The level of connection with individual peers is distinct to the overall sense of community but will be influenced by it.

How well does the category represent peer relationships on a forensic ward

Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
5	4	3	2	1
<p>suggestions for any changes to the category</p>				

Category 7: Accessing peers for support

When participants' spoke of deep relationships with peers this was often closely associated with receiving support. As well as the particular characteristics of the help received there was a deep meaning associated with receiving support from one's peer. However, the successfulness of this was moderated by appropriateness of expectations and the quality of support. Both accessing and giving support are closely connected to ability for relationships to continue successfully.

How well does the category represent peer relationships on a forensic ward

Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
5	4	3	2	1
<p>suggestions for any changes to the category</p>				

Category 8: Supporting and helping peers

Supporting others was closely related to receiving support and the mutual nature of giving and receiving help was emphasised and how this then influenced ward conditions. There was a valued role to help others and through empathy a desire to reduce others suffering. The role was also developed behaviour associated with domesticating the environment. However, there was the potential for the care giver's wellbeing to suffer so a need to be able to balance care giving with one's own needs. There was also a dilemma of when to involve staff. There could also be an over-involvement in others care which served to maintain problems in relating to others.

How well does the category represent peer relationships on a forensic ward

Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
5	4	3	2	1
<p>suggestions for any changes to the category</p>				

Appendix 16: Summary of Participant Feedback

Eight participants completed feedback on the elements of the model and rated agreement of how accurate or relevant each was

Element of the model	Mean Agreement Rating. In brackets the number of participants whose rating was the same as the mean	Range of Ratings
Overview of the model	Strongly agree (6)	Agree-Strongly Agree
Surviving or relating barometer	Strongly agree (5)	Agree-Strongly Agree
Ward group conditions	Strongly agree (7)	Undecided -Strongly Agree
Personal Conditions	Strongly agree (7)	Agree-Strongly Agree
Experiences with peers in other contexts	Strongly agree (6)	Agree-Strongly Agree
Surviving Mode	Strongly agree (7)	Agree-Strongly Agree
Getting on with each other	Strongly agree (6)	Agree-Strongly Agree
Domesticating the social environment	Agree (6)	Disagree – Strongly Agree
Relating Mode	Strongly agree (8)	Strongly Agree
Connecting with peers	Strongly agree (6)	Agree-Strongly Agree
Accessing peers for support	Strongly agree (5)	Agree-Strongly Agree
Supporting and helping peers	Agree (5)	Disagree-Strongly Agree
Recovery through peer relationships	Strongly agree (6)	Disagree –Strongly Agree

Appendix 17. Extracts from research diary

Met with John he suggested contacting an external supervisor he worked with previously. She works in the forensic services. I'm quite curious as I have very limited experience in forensic services. But I am interested to know if she would like to do a project around personality disorder. I have spoken with John about some ideas he's not sure about the feasibility of a mother and child study platform mothers with personality disorder. I continue to be interested in thinking about the relational aspect of this disorder.

Meeting with Laura. She is interested in looking at women's issues in the forensic services and is explained there is very little empirical research. We discussed several ideas including looking at arson as this is a higher prevalence for women. I'm keen to look of the relational aspect, and we started talking about the Ward environment and I asked about what predicts relational functioning of people who are very well in a pressurised environment. Laura gave me some reading and therapeutic communities

Therapeutic community workers are interested and I've been trying to get in contact with some of the services to find out how an more about forensic provision. However it sounds very specialist and a lot of people and be able to engage as it say very stressful. Looking at group theory

Not finding much literature to consider the research on which makes me somewhat anxious that the same time excited about the project. I'm wondering what it would be like to go on to forensic Ward

Working on proposal. Still feels somewhat nebulous concept of peer relationships for women with personality disorder, and trying to work out if it's something we can predict without the need of the study.

Proposal accepted the university working on NHS ethics

NHS ethics completed looking at starting sampling. Considering how I may be quite a different interview to the one I did when I did my MSc 10 years ago. Wondering what the impact of my training as CBT therapist is going to have on my interview style. Quite nervous about going onto a forensic unit, and to have been some difficulties in accessing one of my services I'm wondering what women will think about a man coming to ask about their peer relationships. However my the forensic consultants said that often

women's abuses at the hands of another woman and that me being a man will not necessarily be problematic.

May 2013

Completed pilot interview, went well although the participant talked in general terms. interesting to consider the differences in relationship between women and with staff and peers where they ran in the comforting without external power control . I'm wondering how the hell dynamics work within the women's more level hierarchical structure. The unit was a lot nicer than I imagined although I still felt somewhat claustrophobic and it was difficult having to have doors constantly opened for me by staff giving me a very brief insight into what the controlled environment this is to live in

June 2013

completed three more interviews. They all feel very different however I've started to read more from Charmaz and I realise I haven't quite understood grounded theory previously and the idea of looking for actions. I'm wondering if this will mean I can find common actions between participants even though the actual details might be quite different.

July 2013

Completed interview with lots of discussion about self-harm been reading about contagion and wondering about group process might be happening. I'm wondering if observational data collection to be useful or although had spoken to supervisor about this who said that ethically it wouldn't be possible for me to sit round the board observing. However I'm thinking about the limitations of the current approach

September

data collection has been very slow and unconcerned with all get enough participants. Starting today the line by line coding my first six. This very labour-intensive however it is fascinating the detail of information in what at first may seem fairly prosaic material. However this is going to generate an awful lot of data and I'm wondering how the built-up manages. Participant one spoken about relational bonds I'm thinking about attachment theory. Also it's interesting that a lot of terms infantilising women's peers is a caring and I'm wondering what the significance of this may be.

November 2013

continuing with the analysis finding it quite difficult to have a workable number of focus codes as it's well over 100 of the moment but I'm concerned about getting the right level of abstraction. Been working with the peer who also is doing grounded theory and that has given me some confidence in harm proceeding. Also spoken with my supervisor and discussed coding.

I'm aware how difficult it can be for the participants to discuss this subject and have access to talking about relationships which is a core part of the dysfunction of the disorder. I'm wondering how difficult this is for the people and really admire their perseverance and taking part

December 2013

starting to wonder if there will be some kind of phase model, as the differences in participants' explanations often seem based on what phase of the inpatient cycle they are in, whether they are newly admitted or orientating themselves back towards the community thinking of discharge. Latest interview was very frank and the person spoke about her herself bullying others. I'm aware there hasn't been an awful lot of more negative self-presentation and I'm wondering if self-presentation has been occurring during interviews. However now that I look back over the transcripts it appears people have been also telling me about some negative aspects of their style.

January 2014

starting to develop a model seems to be surround modes of either being in survival mode on the Ward 14 on a related note however need to work out how I can make this model predictive seems very difficult to work out how it would look

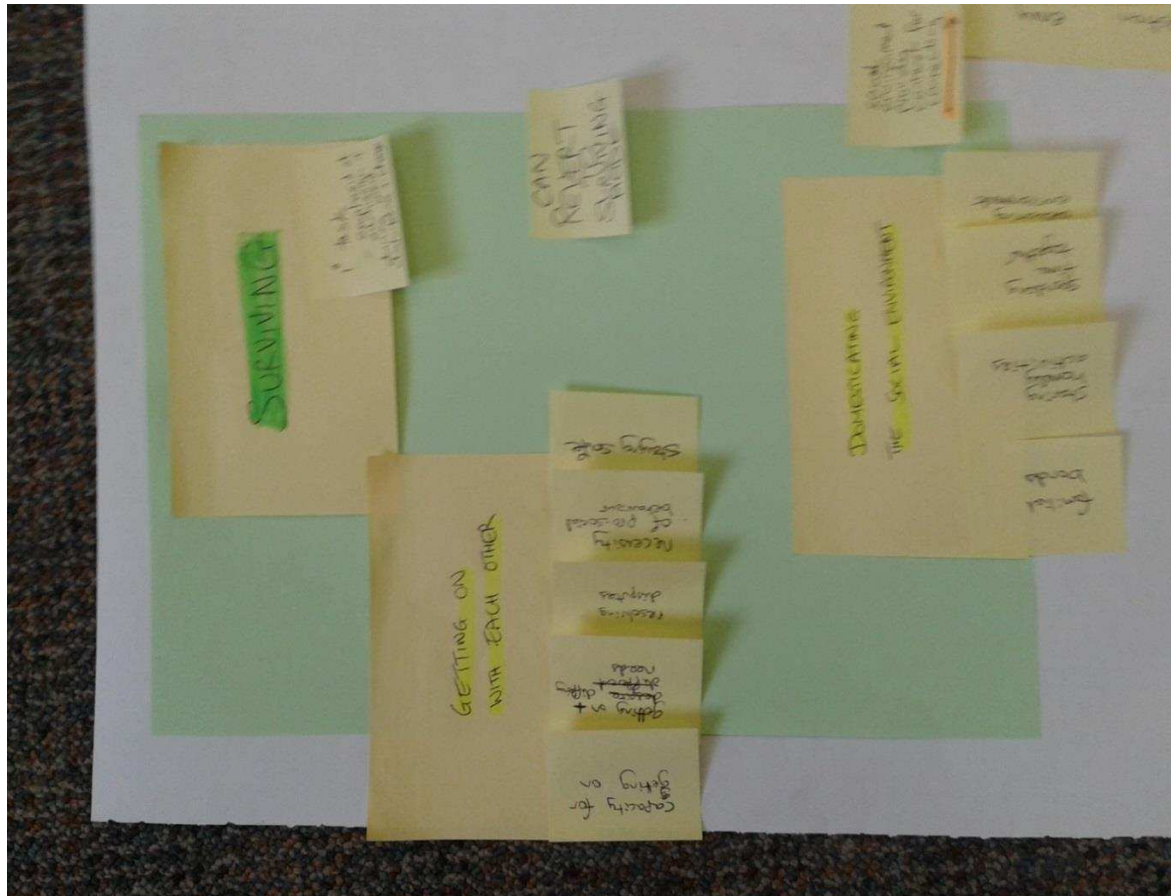
February 2014

seem to have arrived at major categories particularly around 'getting by' 'making it homely' 'recovery through peer relationships'

February 2014

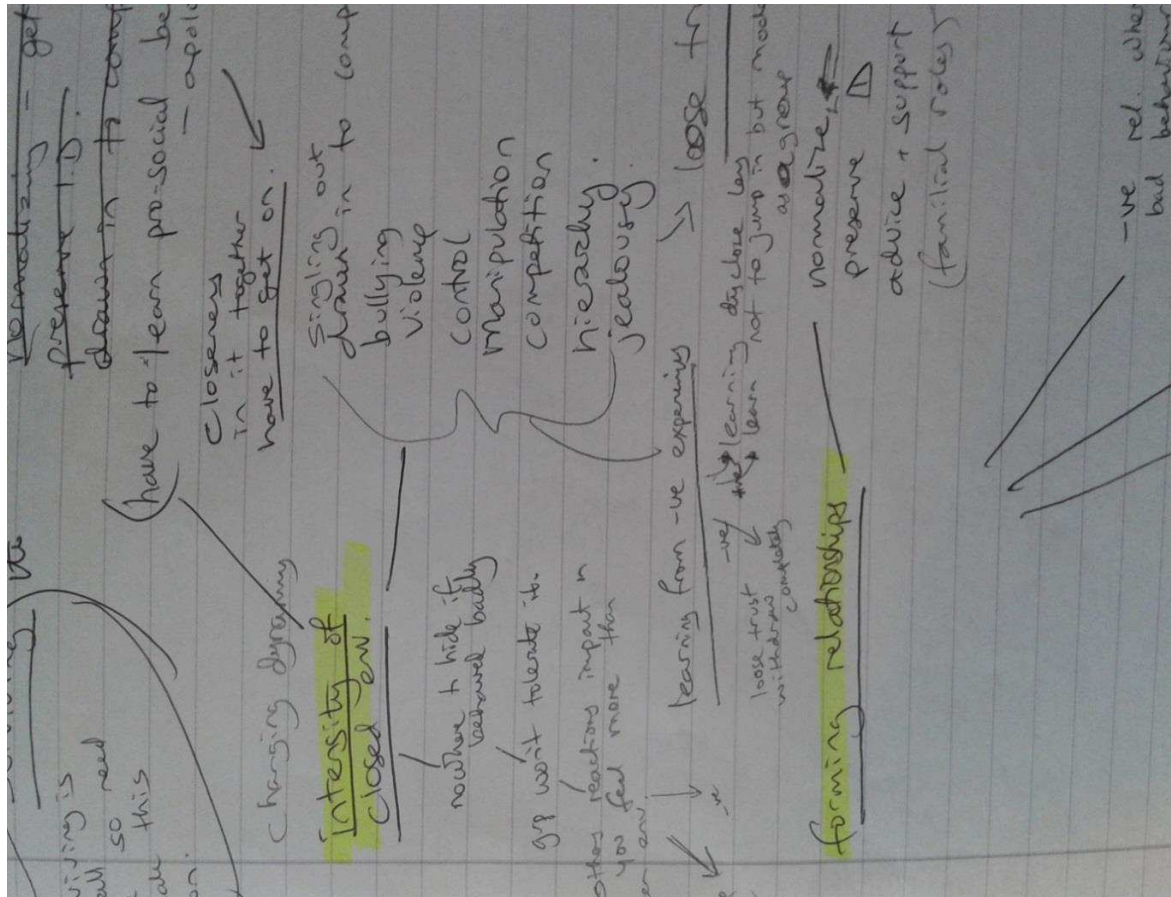
made some changes to the categories. The focus codes seem to be exclusive to those pretty much apart from there is a lot of overlap between positive experiences of relating and aspects of the recovery category. Discussed with John who feels I've arrived at a workable model.

Forensic Care Needs of Women Diagnosed with a Personality Disorder



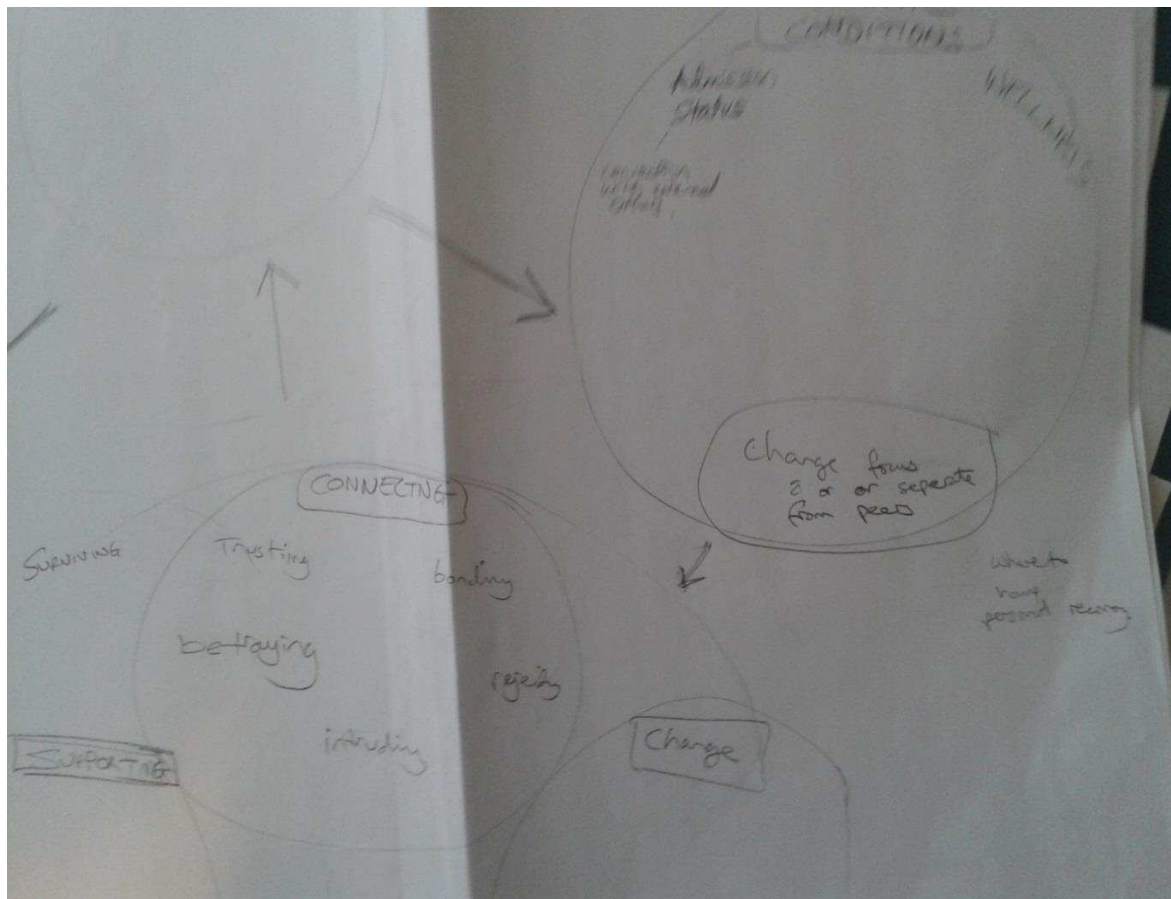
February

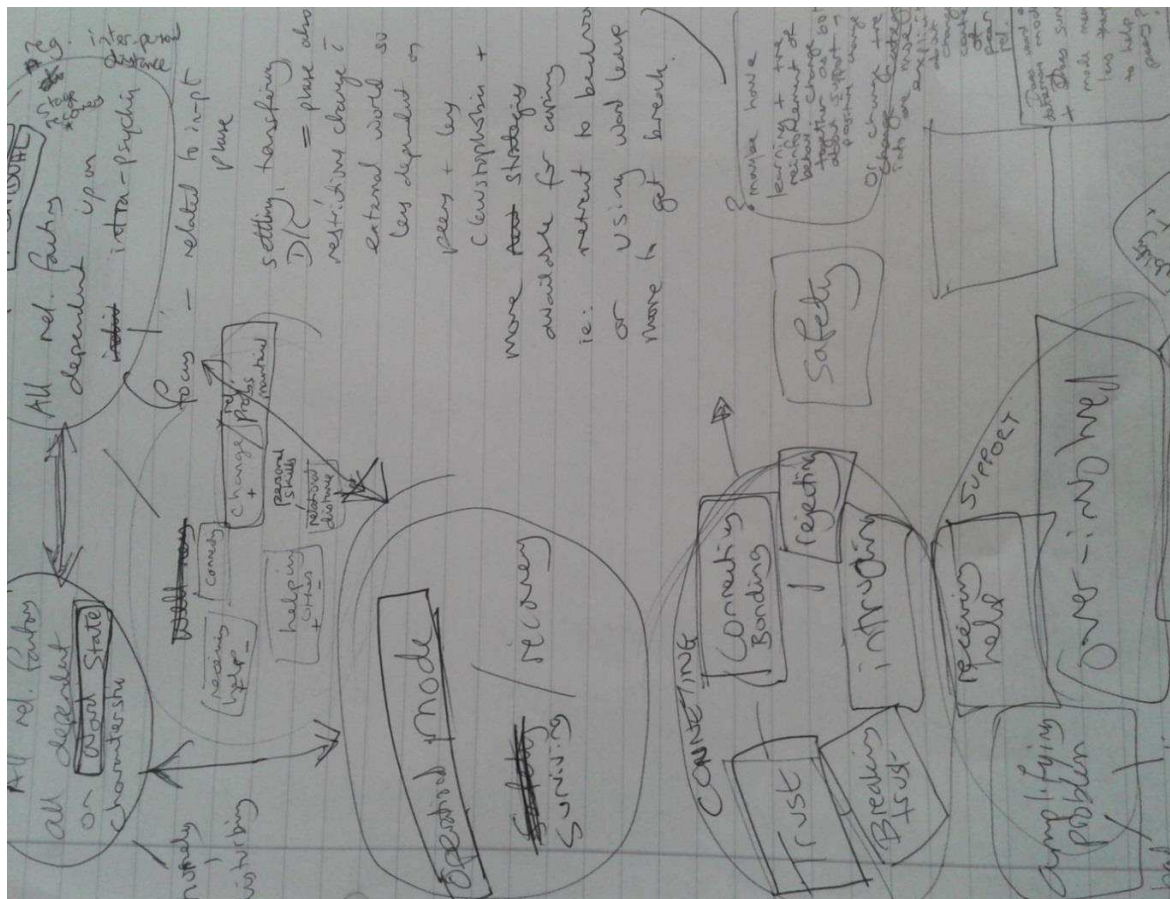
discussed categories with peer who has done some checking of my focus codes again all seems okay however having difficulty in on some of the relationships of categories and also wondering how to represent it in terms of interdependence of categories and mediating factors.



Returned to categories is not sure the model is quite working. Trying to work out how intensity of the closed environment and the forming relationships relate.

March now working on a slightly cool model although the representation doesn't quite work

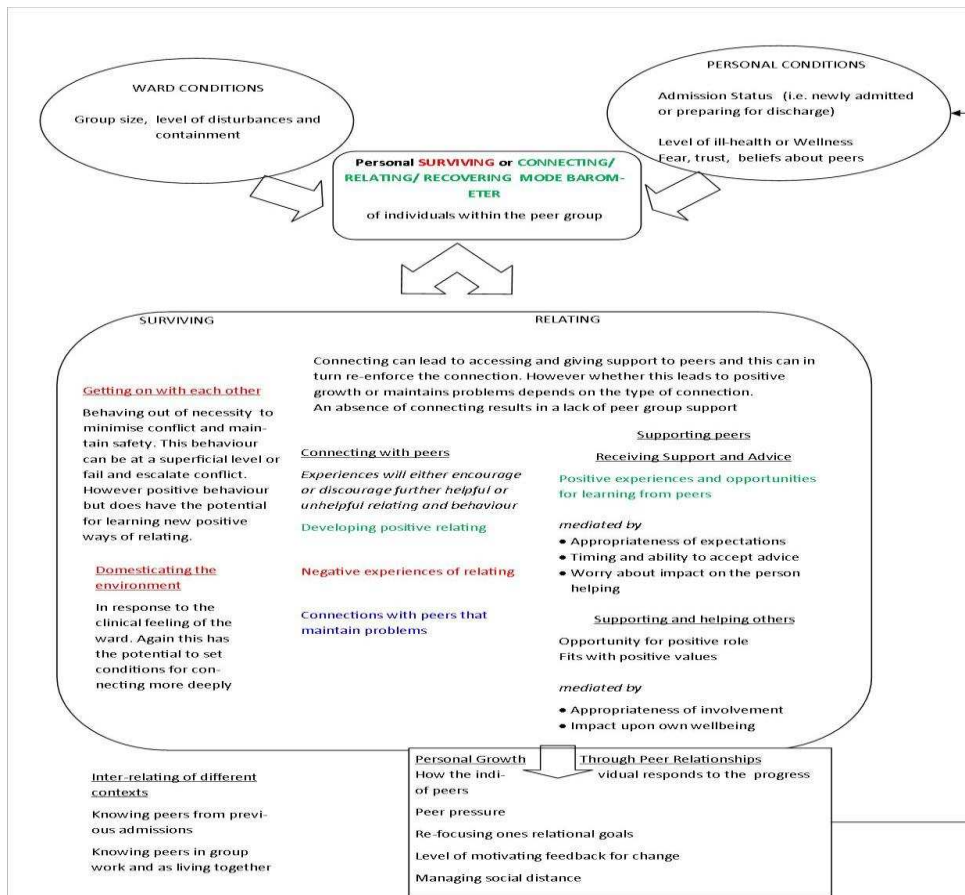




March

using more of a flowchart approached them wonder if I have too many arrows. Spoken with John he says he feels his fine so will decide to stick with this and tested to look for ways in which you may not work

Forensic Care Needs of Women Diagnosed with a Personality Disorder



Appendix 18 End of Study: Summary Report to NHS Panel

XXXX XXXX

Trainee Clinical Psychologist

Department of applied psychology

Canterbury Christ Church University

Broomhill Road

Tunbridge Wells

Kent

TM3 0TG

Study Title:

Peer Relationships of Women Diagnosed with Borderline Personality Disorder in Forensic Care

Dear XXXX,

I write with a summary of my findings for the above research. The study was granted ethical approval in April 2013 and completed in April 2014. The aim of the study was to develop an explanatory model of how the women's peer relationships in forensic care may impact upon their recovery trajectories.

Women in forensic care are more likely than men to be survivors of childhood abuse which is likely to impact upon the development of their relational style with others. Women in forensic care are also more likely than men to have received a diagnosis of Borderline Personality Disorder which is also associated with difficulties in relationships. Current service development guidance has emphasised the need to meet women's relational needs in forensic care. Peer relationships have been described previously as being potentially supportive but they also may be a source of distress. There has been little research to suggest in what ways peer relationships may impact upon recovery in forensic care.

Twelve women who had received a diagnosis of Borderline Personality Disorder and had been a forensic inpatient in secure care took part in interviews to gain an understanding of their perspective on peer relationships. Following a Grounded Theory analysis an explanatory model was developed.

This model had two overarching ways in which peers engaged with each other. This could either place an emphasis on survival and coping with the difficulties of forensic admission or upon more deeply relating with their peers. In this model the engagement style was determined by a combination of the ward conditions such as level of disturbance and group size together with the personal conditions of the individual such as their level of wellbeing and admission status.

If the individual's relational style is one of survival then this limits the opportunity for developing meaningful relationships. However, successful encounters may lead the individual to operate more in a relating mode including entering into roles of seeking help and supporting others. Negative experiences of attempting to more deeply relate to peers may maintain unhelpful relational patterns but positive relating had the potential for aiding in personal recovery and demonstrated unique qualities that peer relationships could offer to support personal recovery. This could support both internal and relational recovery oriented change but was dependent upon personal conditions including wellness and readiness to accept feedback and the ward conditions.

Experiences of peer relating could improve sense of self, personal insight, hope, motivation for change, wellbeing, and learning new skills and ways to connect positively with others or manage relational problems.

The research highlighted the significance for women of peer communities and the complexity of peer relationships and factors that are likely to support or challenge the formation of peer communities that can support recovery. This also indicates a training need for care staff working with this clinical group so as to optimise the environment for positive relating and to maximise the support and learning possible through peer groups. Such training could include familiarisation with the model in this study.

This report is currently being submitted to Canterbury Christ church University as part of a doctorate in clinical psychology. Following completion of the project I intend to disseminate the findings and submit for publication.

Yours sincerely

XXXXXX XXX

Trainee Clinical Psychologist

Canterbury Christ Church University

Appendix 19. Journal Submission Instructions for Authors

Aims and Scope: The Journal of Forensic Psychology Practice is devoted to providing a forum for disseminating timely and practical developments to the forensic psychology practitioner and professional. The Journal promotes original research which examines the impact and effect of new knowledge in the field as it relates to the work of the practicing forensic psychologist and related specialists, mindful of where and how justice and social change are meaningfully advanced. The Journal presents new programs and techniques, analyses existing policies and practice-oriented research and quantitative/qualitative analyses, and single case designs from a broad range of disciplines including forensic psychology, clinical psychology, law, sociology, criminology, clinical social work, and counselling psychology. Case studies and articles dealing with treatment and assessment in police, court, and/or correctional settings are welcome. Research submissions exploring individual, family, adult, and juvenile populations are encouraged. The Journal does not accept books for review.

Please note that The Journal of Forensic Psychology Practice uses [CrossCheck™](#) software to screen papers for unoriginal material. By submitting your paper to The Journal of Forensic Psychology Practice you are agreeing to any necessary originality checks your paper may have to undergo during the peer review and production processes.

Manuscript Submission: Manuscripts should be submitted to the editor, Bruce Arrigo, PhD, Professor, Department of Criminal Justice, University of North Carolina-Charlotte, 9201 University City Boulevard, Charlotte, NC 28223-001. E-mail: barrigo@uncc.edu

Each manuscript must be accompanied by a statement that it has not been published elsewhere and that it has not been submitted simultaneously for publication elsewhere. Authors are responsible for obtaining permission to reproduce copyrighted material from other sources and are required to sign an agreement for the transfer of copyright to the publisher. All accepted manuscripts, artwork, and photographs become property of the publisher.

As an author, you are required to secure permission if you want to reproduce any figure, table, or extract from the text of another source. This applies to direct reproduction as well as "derivative reproduction" (where you have created a new figure or table which derives substantially from a copyrighted source).

Submission Guidelines: Suggested length of the article is 20 to 30 pages, double spaced. Include an abstract including: name, address, telephone number, and e-mail address. Sections of the journal include Articles, Commentary, Practice Update, Case Report, and Ethics, Psychology and Public Policy. Send an electronic copy formatted in Microsoft Word 2000 to the e-mail address above.

Check with the editor about the deadline for submissions. The Editor reserves the right to edit manuscripts received for publication and to reject or return for revision manuscripts that do not adhere to the Submission Guidelines.

Case Report Guidelines:

Protection of Human Subjects and Animals in Research

Manuscripts that describe research with human subjects or animals must explicitly state that the research was conducted in accord with relevant legal and ethical standards. Authors must state the name of the committee (e.g., IRB) that approved and monitored the study. For research with human subjects, authors must include statements indicating that there was a complete discussion of the study with potential participants; that written informed consent was obtained after this discussion (or if a waiver of consent was obtained, an explanation of this); and that the study was conducted in accordance with the Declaration of Helsinki. For research conducted with animals, authors must indicate that institutional and national guidelines for the care and use of animals were followed.

Confidentiality

Participants and patients have a right to privacy that should not be violated without informed consent. Identifying information, including names, initials, or hospital numbers, should not be published in written descriptions, photographs, or pedigrees unless the information is essential for scientific purposes and the patient (or parent or guardian) gives written informed consent for publication. Nonessential identifying details should be omitted. Informed consent should be obtained if there is any doubt that anonymity can be maintained. If identifying characteristics are altered to protect anonymity, such as in genetic pedigrees, authors should provide assurance, and editors should so note that such alterations do not distort scientific meaning.

Formatting: Manuscripts should be highly legible. All parts of the manuscript should be typewritten, double-spaced, with margins of at least one-inch on all sides. Number manuscript pages consecutively throughout the paper.

References: Cite in the text by author and date (Smith, 1983). Prepare reference list in accordance with the APA Publication Manual, 6th ed.

Examples:

Journal : Jacks, J.Z., & Cameron, K.A. (2003). Strategies for resisting persuasion. *Basic and Applied Social Psychology*, 25, 145-161.

Books : Brehm, J.W. (1966). *A Theory of Psychological Reactance*. New York: Academic.
Contribution to a Book: Tajfel, H. & Turner, J.C. (1979). An integrative theory of intergroup conflict. In W. Austin & Worchel (Eds.), *The social psychology of intergroup relations* (pp. 334-47). Monterey, CA: Brooks/Cole.

Illustrations: Illustrations submitted (line drawings, halftones, photos, photomicrographs, etc.) should be clean originals or digital files. Digital files are recommended for highest quality reproduction and should follow these guidelines.

- 300 dpi or higher
- Sized to fit on journal page
- EPS, TIFF, or PSD format only
- Submitted as separate files

Color Reproduction: Color art will be reproduced in color in the online publication at no additional cost to the author. Color illustrations will also be considered for print publication; however, the author will be required to bear the full cost involved in color art reproduction. Please note that color reprints can only be ordered if print reproduction costs are paid. **Print Rates:** \$900 for the first page of color; \$450 per page for the next three pages of color. A custom quote will be provided for articles with more than four pages of color. Art not supplied at a minimum of 300 dpi will not be considered for print.

Proofs: Page proofs are sent to the designated author using Taylor & Francis' Central Article Tracking System (CATS). They must be carefully checked and returned within 48 hours of receipt.

Reprints and Issues: Authors from whom a valid email address is received will be provided an opportunity to purchase reprints of individual articles, or copies of the complete print issue, at the time authors review page proofs. These authors will also be given complimentary access to their final article on *Taylor & Francis Online*. A discount on reprints is available to authors who order before print publication.

Open Access: Taylor & Francis Open Select provides authors or their research sponsors and funders with the option of paying a publishing fee and thereby making an article fully and permanently available for free online access – *open access* – immediately on publication to anyone, anywhere, at any time. This option is made available once an article has been accepted in peer review. [Full details of our Open Access programme](#).

Search Engine Optimization: Search Engine Optimization (SEO) is a means of making your article more visible to anyone who might be looking for it. Please consult our guide [here](#).