**Therapeutic Engagement in Medium-Secure Care: An Interpretative Phenomenological**

**Analysis of Service Users’ Experiences**

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**Abstract**

Service users (SUs) detained in forensic hospitals are usually required to engage in psychological therapies aimed at reducing mental distress and/or for preventing further offending. Poor therapeutic engagement (TE) can lead to adverse clinical outcomes and reoffending, at a cost to the individual, staff, the service provider and the public. To understand what factors influence TE from a SUs’ perspective, the experiences of ten male residents of a medium-secure hospital were explored. Using a service-user informed design, interpretative phenomenological analysis (IPA) of interview data was completed. Four superordinate themes emerged: different worlds; what the individual brings; what the therapy entails; and control. Consideration of how these factors may be of use to professionals working in secure care settings is discussed in relation to existing theory and research.

**Key words:**

Therapeutic engagement, interpretative phenomenological analysis, service-user design, forensic mental health, treatment engagement, offence recidivism.

**Introduction**

There are estimated to be around 6000 service users (SUs) detained in forensic services at any one time in the UK (May 2013; Centre for Mental Health). SUs in secure hospitals are usually engaged in treatments which target mental distress and offence recidivism (Rethink, 2011); however, they generally engage less well than those in the community (McMurran, 2002). For example, Long, Banyard, et al. (2012) found that while psychological therapies and educational sessions were deemed important by service users in secure settings, non-attendance at sessions was frequent, and largely explained by negative evaluations of treatment and treatment outcomes. It is important to understands reasons for non-engagement, as results from a meta-analysis of 16 studies show that re-offending and other damaging effects are higher for those that do not complete treatment than for those who were not offered treatment at all (McMurran & Theodosi, 2007). This indicates that treatment non-completion itself may cause increased risks to the individual and society. A recommended focus for research and practice in offender treatment engagement is for theoretically based, empirically evidenced models of engagement to be produced (McMurran & Ward, 2010). This is in addition to the creation of psychometrically robust assessments and the integration of strategies to improve engagement in treatments (McMurran & Ward, 2010). There have, however, been limited investigations into therapeutic non-engagement in forensic inpatient settings, which have often focussed on understanding internal SU factors for engagement from a professional perspective. Some have found associations between engagement and SUs’ motivation and readiness for treatment (Day et al., 2008; Rosen, Hiller, Webster, Staton, & Leukefeld, 2004). Others have investigated the personal characteristics that lead to treatment drop-out, such as being less rational and more impulsive (McMurran, Huband, & Duggan, 2008); or being embarrassed/scared, having incongruent goals, or having negative understandings of self or therapist efficacy (Sheldon, Howells, & Patel, 2010).

 Studies that have investigated TE from the SU’s perspective have consistently highlighted the importance of external factors on SUs’ ability to be engaged, and likeliness to remain engaged. An exploration of SUs’ experiences of therapeutic change, for example, found an association between therapists’ attributes and engagement (Willmot & McMurran, 2013). Other studies have identified how factors such as trust, relationships and support, having a choice and feeling safe, affected engagement (Frost & Connolly, 2004; Mason & Adler, 2012; Sainsbury, Krishnan, & Evans, 2004; Schafer & Peternelj-Taylor, 2003), and how non-engagement can be related to the ward climate or social milieu (Howells et al., 2009; Milsom et al., 2014).

With few exceptions, however, (for example, the qualitative service user-led participatory research conducted by Long, Knight, et al., 2012), SUs are not routinely involved in the design of studies into TE, or in the delivery and design of forensic services in general (Faulkner & Morris, 2003; National Survivor User Network, 2011; Sainsbury Centre for Mental Health, 2008). However it is obligatory in the United Kingdom for NHS and independent providers to involve SUs in the planning and delivery of services, according to associated guidance (Health and Social Care Act 2008; Health and Social Care Act, 2001; NHS Reform and Health Care Professions Act, 2002). Involving those with direct experience of mental health difficulties, due to their unrivalled expertise and knowledge in a specific field, can be invaluable in sensitively understanding how to investigate phenomena of interest to clinicians (Mental Health Research Network, 2013).

To ensure such ecological validity in the current study, the PI consulted with an ex-service user research group to ensure the type of questions and language used were sensitive for the population and research aims. The group of five, with personal experience of forensic environments, met to establish the questions that they considered were pertinent to TE based on their own experiences. With guidance, the group developed a list of potential questions to investigate the phenomenon. For the purposes of the interviews, this topic guide was used flexibly in accordance with recommendations to use questions that seek to explore the lived experiences of participants (for example, closed questions were rephrased in practice in an open manner; Smith, Flowers & Larkin, 2009). The overarching topics were: relationships with psychologists and other therapeutic staff; the process of being involved in therapeutic work; and the nature of therapeutic activities in forensic settings. Example questions included: Can you tell me about your experience of working with a clinical psychologist? What was your experience of engagement? Can you tell me about someone you have worked with that has made a difference? In what way do you like to do therapy? Although questions were not uniformly phrased or ordered, the overarching topics were covered within and across all interviews.

Guided by this service user involvement, the research question that this study aimed to investigate was: ‘How do SUs experience therapeutic engagement with clinic psychologists and other staff in secure care, and what factors influence this engagement?’ It was hoped this could lead to further understanding of the factors clinicians might consider when planning and delivering treatments, and to optimise the likeliness of successful TE.

**Method**

***Ethical approval***

Peer review and sponsor indemnity were provided by Keele University. Due to the participants being detained for treatment within an NHS hospital, whilst potentially having contact with the criminal justice system, approval from the North Wales research ethics committee required specific guidance from a National Offender Management Service panel representative. Subsequently, the host NHS trust provided research and development approval. Introducing the topic of TE had the potential for vulnerable men to be made more aware of difficulties in their environment and interpersonal relationships. However, due to their incarceration it was considered unlikely they would have the opportunities to remove identified concerns. Part of the agreed proposal therefore was for participants to name a chosen staff member/family member prior to involvement in the research for the principal investigator (PI) to contact should their involvement cause any distress.

***Participants***

Participants were 10 male SUs detained in a medium-secure NHS facility in the [region deleted to maintain integrity of review process]. The participants were aged between 21 and 48 (mean age 27.5 years), and were all subject to hospital orders for detention and treatment relating to index offences which included sexual/violent offending and arson. All participants had active diagnoses of major mental disorder, including schizophrenia; none had a diagnosis of personality disorder (International Classification on Disorders [ICD-10], 2010). Due to the sensitive nature of the secure hospital environment, individual demographic details are not provided, as this was considered highly likely to breach anonymity for some participants.

***Procedure***

Responsible clinicians provided written consent to approach eligible participants. All participants who were able to understand the purpose and nature of the study, and who could to provide informed consent, were included. Those who were considered by their responsible clinician to be acutely unwell and those whose participation may cause an increased risk to themselves or others were not approached. In total, 20 of the service’s 45 residents were approached and provided with study information. Written consent was provided by all participants following a period of at least one day from the study information sheet being issued and verbally presented.

 Of those 20 residents, seven consented to be interviewed but declined to be audio recorded; two did not consent and did not offer reasons for not providing consent (nor were obligated to do so); and one resident did not adequately understand the study information, leaving ten participants. Participants had a right to withdraw their participation until synthesis of data occurred during analysis. No participants requested to withdraw their consent or data. Consent forms and other documentation with identifiable information were kept securely according to National Institute for Health Research Good Practice Guidelines (NIHR, 2011). Staff were informed of the purpose of the study by presentations at multidisciplinary team meetings, and by making the study information available by Email and on noticeboards.

 All audio-recorded interviews were conducted by the PI in private rooms situated on the wards of the participants, at agreed times. The PI was experienced in conducting research interviews in forensic settings, held a postgraduate research qualification, and had undertaken additional postgraduate and professional training courses/workshops in conducting interviews for the qualitative method employed. The mean interview duration was 37 minutes with a range from 17 to 48 minutes. The participant who completed the interview in 17 minutes did not use English as a first language, resulting in comprehension difficulties. Interviews were subsequently transcribed verbatim on site by the PI, with each participant’s name substituted with a pseudonym, and other verbalised names individually coded. To preserve anonymity, specific content or nuances of speech that could potentially identify participants were also re-worded.

**Analysis**

Due to the exploratory nature of engagement experiences of SUs in forensic care, data was investigated using Interpretative Phenomenological Analysis (IPA; Smith, 1996). IPA is an idiographic approach to understanding how groups of individuals make sense of a particular phenomenon. IPA also incorporates a hermeneutic understanding of conducting research, whereby meanings are socially constructed, and interpretation of others’ experience is not possible without the influence of the researcher. Following Smith et al.’s (2009) guidelines, individual transcripts were read whilst listening to the audio files to gain a greater understanding of each participant, and then read again recording initial thoughts about the data (in a reflective diary; described later).

 Following this, line by line initial coding was completed by using an in-text tricolour recording methodology: Descriptive and linguistic codes were commented on separately between data lines, with related conceptual codes recorded on the right-hand margin. Following the initial coding, emergent themes were developed and reported in the left-hand margin. Connections across emergent themes were then established by considering their abstraction, polarisation, contextualisation, function and frequency (Smith et al., 2009). The resultant case themes were conceptualised graphically to aid with understanding their interconnectivity. An iterative process then followed for the remaining cases, before patterns across cases were established leading to synthesis and reorganisation into superordinate themes.

 Adhering to good practice recommendations (Smith et al., 2009; Yin, 1989), transcript inclusion, initial coding, emergent theme production, and super-ordinate theme emergence were regularly checked and independently audited by the research team, and within a host institution IPA research group; further guidance was sought from members of a national IPA group. Participants were not asked to contribute to theme validation due to the potential for confidentiality breaches within an environment where information security is paramount; however, three participants did subsequently comment individually on the overall themes.

***Diary***

Initial thoughts resulting from reading and listening to transcripts were recorded in a reflective diary. The reflections related to general topics that resonated with the PI as being important to the participants. No attempts were made to interpret these reflections; however they were revisited following the super-ordinate theme production to check that the topics which initially appeared important to the participants were covered within the reported themes. It is acknowledged that the process of recording these topics may have influenced future interpretations, despite attempts to separate them from the analysis process.

***Findings***

In total, 496 themes were identified across participants. By reconfiguring the resultant 85 case themes, four super-ordinate themes and eleven sub-themes were identified (Table 1; all themes were present in at least half the cases).

[Table 1 near here].

***Different worlds***

All participants described how being in different worlds affected how they engaged in therapeutic work. Participants reported their own and therapists’ movements between different spatial and environmental positions, which were dependent upon where they and therapists were from, where they were currently located, and where they were going to.

*Coming from different worlds*

Participants often described experiences of how staff coming from different backgrounds and having different realities affected how they wished to be engaged:

*‘…[staff] are not in my world, I am in my world…you’ve got your little world now that you’re in, whereas my world is the real world, what I have been in all my life’* (HAL).

Coming from the same background was reported to be a more pertinent factor for how likely the therapist was to understand the participant’s world than their professional training. Backgrounds were described by participants in terms of “culture” which included the influences of religion, class/social standing, ethnicity, fashion, and social interests/activities:

*‘If someone was from my culture, then I’d find it easier to engage with them because they are quite likely to understand the lives and the situations that you have in my culture every day, so it’s not about what job it is or anything like that, it’s more about the individual and the culture…I can’t really put my finger on it, but it’s just a wavelength, like a way of thinking, and a way of traditions’* (BOB).

For some, regardless of backgrounds, by purposely sharing part of their own world, therapists were able to enter the world of the participants.

*‘It’s just the way they approach you. I suppose they come over when you are talking. Just really friendly and you know they’ll tell you stuff about their own lives’* (KEN).

By putting the participants at ease, participants were able to feel in the same world as the therapist.

*‘I did feel very comfortable. She made me feel very comfortable…just by listening* (ANT).

*Meeting at the same level*

The different worlds that people occupied were often described in terms of hierarchical levels that could or could not be scaled, generally determined by social background, occupation, and educational attainment.

 *‘There’s different levels to different people. Like [Clinical Psychologist] can sit there and use a wide range of vocabulary with me, and I would be ok, but some people can’t really understand what she’s on about’* (ANT).

*‘They are more educated than me, they’re up the ladder compared to my level of life I think, I just categorise them as up there, and me down there you know. I could never say that I am on a par with a psychologist… water finds its own level don’t it?’* (HAL).

When staff revealed similar backgrounds, SUs were more likely to consider them to be on the

same level.

*‘They would be in my shoes, they’d know how it is…they’d have the same perspective of it than me, but a better one because they’d obviously got through it* (DEN)’.

For some, meeting at the same level was a challenge due to having a different sex. Ted highlighted how engaging with women was on a different level.

*‘If it was a man I would do [a preferred social greeting], but if it was a woman, just shake her hand like’.*

Hal highlighted how for some, it was more difficult to engage on a personal level with women in the social world of the ward.

*‘You’ve got female staff coming in and you think “woah, I don’t want to talk about that because this might offend her, and that might offend her”…because if there’s women about, it ain’t the same thing is it?’*

However when engaging in therapeutic work, Hal would find it more appropriate to speak about personal issues with women due to their maternal connotations, than with men because they are not on the same level.

*‘I found talking to her pretty easy…and I laid everything on the table…I felt comfortable telling her everything, but with men…I don’t want to talk about things that happened in my childhood, you know like abuse and any of those things, and I wouldn’t go into detail with a man so much I just felt open like she’s my mother sort of thing’.*

Some participants experienced staff engaging at their level by actively moving into their world, by using professional skills including listening, by being empathic and showing that they are genuinely interested. Ant described how his psychologist could:

*‘… talk to people on their level…she really does listen, and she does take note of everything I say…she knows her stuff and knows how to…connect with people’.*

Others however experienced staff being static and not willing to move towards the participants’ worlds.

 *‘The doctors sit there, they’re timid...I don’t know what it is with the doctors, some doctors speak and the rest of them, you look around the room and they daren’t even look at you…as if they can’t be arsed (DEN).’*

*Abnormal home environment*

The secure ward itself was considered to be one of the worlds in which the participants resided, both literally (‘I’ve got to live in this environment’ (HAL)), and in comparison to the normal/outside/real world. Despite being their home, usually associated with a place of comfort and safety, the environment was considered unstimulating, hostile, and scary to the participants, who felt they were under continual surveillance. For some however, this had now become their reality.

*‘I have been here a while now, so it’s, this is normality I suppose’* (KEN).

As well as being under surveillance themselves, the participants were also engaged in observing others, and regulating perceived threats within their home environment. For example, some participants explained how despite the hospital being their home, they lived with a fear of others who lived there, and used strategies such as creating alternative identities to manage their concerns.

*‘With everyone, you know, you have to be careful in this place with who you try to speak [to]. You know, so if somebody new [comes in], [at] first [you] watch him, you know, and if he is not friendly, [you] just don’t speak with him’* (FIN).

*‘I say I’ve done a different thing…I’ve got to, they’ll lynch me’* (TED).

***What the individual brings***

There were a number of themes which highlighted how participants had personally experienced the individuals they had worked with, how this was influenced by the role they held, and with the inter-personal expectations and evaluations between SU and therapist.

*Personal Attributes*

Participants offered almost universal agreement on the traits they had observed in staff which encouraged their ongoing engagement. Therapists who were affable, personal, approachable, open, honest, used humour, listened, used eye contact, showed they cared, and showed a genuine interest were associated with positive engagement. Some participants were particularly affected by not being met with a direct approach from staff.

 *‘I’d rather be told straight, and given a straight answer than not…sometimes…they won’t tell you what’s going on, and you have to wait, and wait, and wait, and then it’s just losing your mind, it’s just like that’* (DEN).

*‘They are sort of sitting there going like this and it’s patronising, and you are like, come on, just tell me what you think, what you really want me to do and what you want, explain what you want out of me…let’s get down to the nitty-gritty and stop pulling punches on each other, that’s my perception of it anyway’* (HAL).

For some of the participants, engagement was enhanced when therapists related from their

own experiences, or the experiences of other SUs.

*‘They might have said “well this happened a couple of years ago, you are not the only person we done this with, and they got through that sticky patch”’* (JIM).

*‘And it’s like “we all know what it’s like to feel like that and for the feeling before we self-harmed”. So that’s good in a sense, because you have got people around you that have been in the same situation’* (OBE).

Participants favoured staff who gave the impression that they were doing the work specifically for their purpose.

*‘Making me feel like they are there for me, so that [makes] me feel better’* (FIN).

*Expectations and evaluations*

Staffs’ perceived positive evaluation of SUs was a motivating factor for a number of

participants.

*‘If there’s someone that’s doubting me or who I am or what I actually say then I will take it on board to…improve myself, it’s very important to me that people…perceive me as a good lad’* (ANT).

Many participants experienced anxiety as a result of feeling judged due to their offending,

despite their expectations of professional practice.

‘*I have been a bit, not paranoid, but a bit aware that what they think of me. I get that a lot with of the staff on the ward, like around my index offence. And it is embarrassing…I expect them not to judge me, as a professional. But then again, I sometimes get the feeling thinking “now what do they think of me?”’* (OBE).

Staff who did not outwardly judge participants were positively evaluated.

*‘Just good people…just the way they ask me questions and like don’t take anything, even if it’s offensive they don’t take it as a bad thing’* (BOB).

Participants were able to identify the motivations of therapeutic staff by consciously and subconsciously reading them. Some observed how staff would enter the participants’ worlds to carry out work on them, rather than connecting with them.

*‘I feel like they are not there to help me, they’re just coming in and doing the work and then they’re not bothered about you...you can tell by the body language, facial expressions...it felt bad you know’* (JIM).

*Staff Role*

Participants had differential engagement experiences with staff across defined professional roles. There was a consistently reported hierarchy of power headed by psychiatry.

*‘Whatever the doctor says goes, the doctor doesn’t have to listen to anybody’* (ANT).

Other staff roles discussed by participants included psychologists and nurses, as these were the predominant roles of ward staff. Although participants experienced individual differences within roles, they separated out the ‘professionals’ (psychologists and psychiatrists), from other ward staff, and the SU.

 *‘There is a them, them and an us’* (HAL).

*‘You got the doctors as in psychiatrist doctors, you got the doctors as in psychology, and you got the staff on the wards’* (ANT).

*‘I mean there’s like that professional boundary as well I suppose…it’s a little bit different from the [ward] staff…I wouldn’t fist pump my doctor’* (OBE).

However there was a distinction made in how their roles affected participants’ understanding of how the individual would engage.

*‘[Psychologists] get to the core of things, the [nursing] staff don’t want to do that. You can speak to them, but it’s not as deep as when you do psychology’* (BOB).

*‘The psychologist gives you tools to help…[ward] staff manage you, where psychologist give you like relaxation or write it down and stuff like that, staff will just talk to you’* (JIM).

Participants also spoke about psychologists having dual roles. As well as a formulatory and therapeutic role, psychologists also held a position of substantial power, particularly evidenced when producing reports, which affected participants’ progression through forensic care.

*‘[Staff number 13] is my psychology worker, I got my CPA [Care Programme Approach meeting] next month, and she says how well I am doing’* (TED).

*‘I know that a lot of things get wrote down and I know that it is mainly their job to do that…and sometimes you have to sort of hold back in conversation because you don’t want to say nothing that is going to get you, “oh why did you say this thing on this day”*’ (ANT).

***What the therapy entails***

How therapies had been established and conducted in the past were likely to affect participants’ future TE.

*Building a trusting relationship*

Building a trusting relationship was an integral theme for effective TE. Speaking to participants ‘with respect and dignity, as a person, not as a mental health patient (JIM)’, was considered an important first step for therapists. Participants did not trust in therapeutic staff by default.

*‘So it’s gotta be the right person you know. You might get a psychologist who you can’t talk to’* (JIM).

They required time to prove their trustworthiness, then they were able to disclose and speak about their ‘deep stuff’ (ANT).

*‘Unless I’ve got to know him over a period of time, I wouldn’t sort of open up to him much’* (HAL).

*‘I can trust them, I can speak with them, I don’t need to be caring if they know’* (FIN).

*‘It’s like a trust thing, I know he’s not going to say something that is going to make me upset’* (OBE).

An important prerequisite of trust was staff maintaining confidentiality. A break in confidentiality led to a break in trust and engagement.

*‘If I told them something in confidence they wouldn’t go telling everyone’* (OBE).

*‘If they did I’d feel let down by them, the trust would go, unless I gave my permission to do, obviously I’d feel a bit let down by them’* (DEN).

*Setting up and doing therapy*

TE was enhanced by staff being clear about the purpose and set up of therapy from the outset and then conducting it in a simple way without excessive burdens.

*‘Come and see me, explain about the course, explain if I have to do it or not, how long the course is going to be…shake my hand, introduce yourself, say where you are from…say look we’re going to be doing work with ya, it’s private and confidential…’* (JIM).

Many of the participants experienced burden as a result of doing work that was too complex, too long or involved home-work. There was a preference for doing things in simple, clear, repetitive ways, and within short regular sessions.

*‘It wasn’t head-burning, it wasn’t too overpowering, it wasn’t too much, it wasn’t easy, but it wasn’t too much’* (OBE).

*‘She explained everything in layman’s terms, like broke it all down and made it easier for me to understand what she was trying to do… a simple thing that she gave me was a set of traffic lights, and she was on about, “where am I in the traffic lights”…it was useful and I sort of dwelled on that, you know it was easy, easy to work out’* (HAL).

*‘I can take two or three things out of a group that I can do and that’s all good’* (ANT).

*Outcomes*

Desired outcomes to therapeutic work for participants were experienced in with the personal

gain of new skills, and losses of burdens.

 *‘I felt like a big load of weight had just been lifted from my shoulders’* (DEN).

*‘It sort of straightened my brain out if you like… it gave me some positive things and she was giving me positive things’ (HAL).*

*‘I feel it in myself…less voices, less feeling bad’* (FIN).

Staff were, however, experienced as being more interested in practical outcomes.

*‘That’s what they want anyway, for me to attend more’* (KEN).

***Control***

Participants reported a range of experiences that related to having or not having control. These included how having a choice about participation in therapy and staffs’ use of punishment and feedback regulated their TE.

*Having a choice*

Participants reported mandatory participation in therapies:

*‘It’s not a choice; I have to do it if I want to help* (FIN)’.

*‘There are some things like my anger management, that’s compulsory, like even if I don’t want to, I’ve got to do it* (DEN)’.

Having a choice about participation in therapeutic work was universally experienced as a motivating factor. Interestingly, Jim related his experience of being involved in the research interview itself:

*‘You’ve come up to me, you’ve asked me if I want to do this, and you’ve asked me nicely, and you told me “you don’t have to do it”’*.

For some, despite preferring to be involved in decisions about participation, there was a resignation about the clinical team having control over their treatment.

*‘I can take it either way, I can be fully involved and lead it, or I can just do what the team ask me, and there’s nothing more really you can do*’ (ANT).

Involvement in decisions relating to therapeutic care was considered a prerequisite for effective therapy. If participants were not involved in decisions, they might attend but were unlikely to be meaningfully engaged:

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

*‘Sometimes you haven’t got a choice who you gotta do it with, I’m not as open as I am with others, so I kind of hide myself away from them. Whereas if I was with somebody else then I’d be more open’* (DEN).

A majority of participants positively reported being given opportunities to take at least some responsibility for their treatment planning.

*‘There are times for me when I can make a decision on a proposal or what to do, and how to move forward, and what I want, and what the doctors want, so we do jointly make decisions and stuff like that’* (ROD).

*Responding to punishment and feedback*

Many participants spoke about their experiences of receiving feedback in the form of actual and perceived punishments which led to disengagement, and compared this with experiences of receiving tailored, personal constructive feedback which encouraged greater engagement. ‘If [the therapist] told someone about their progress or something like that then, you know then that’s good but if they come along with negatives it’ll kind of like bog you down and stuff like that, so no it’s not a good idea to put someone down, because you know, you want positive things’ (ROD).

**Discussion**

The aim of this study was to explore the TE experiences of SUs detained in secure care, to illuminate factors that might be considered when planning for, assessing, and being engaged in therapeutic work. The findings show a number of themes which were relevant to, and furthermore actively involved staff who are engaged in clinical work and research in forensic settings. Interpretation of the experiences described by participants produced themes which demonstrated how TE was influenced by the different worlds in which SUs and staffs occupy; what the individual brings to therapy; what the therapy entails; and SUs’ perceived control over their therapeutic care. Whilst the research was designed to concentrate on participants’ experiences of working with clinical psychologists, SUs’ responses included TE experiences with therapists from a range of professions.

 One unique finding suggests that SUs’ engagement was affected by an understanding of their positions in relation to therapeutic staff. For example, participants experienced coming from, and occupying different worlds and levels to therapists. Without conscious effort from the staff to scale different positions, the SUs were less inclined to engage. While other explanations could be considered, one psychological interpretation of the movement towards observing the world from the position of the SU fits with the humanistic therapeutic principle of ‘empathy’ (Rogers, 1961). This principle maintains that without viewing the world from the SUs’ point of view, therapists are only able to understand SUs from external frames of reference; and are therefore crucially unable to understand actions and behaviours as if they were the SU (Rogers, 1961). The findings of the current study suggested that as well as entering and observing the world from an SU position, the men also benefitted from the therapist making such movements known.

 A further foundation of the humanistic psychological approach is the proposal that therapists should provide unconditional positive regard (UPR) to SUs regardless of what they have done or where they have come from (Rogers, 1961; Standal, 1954). Therapists’ traits found to be predictors of effective TE in the current study including showing that they cared, and demonstrating a genuine interest, are commensurate with this notion of UPR. However, the study’s findings also showed that for some SUs, the differences in the worlds they occupied due to gender or culture were always likely to affect any meaningful engagement in interpersonal work, regardless of the UPR or other actions demonstrated by therapists.

 Such preferences are not unique to the current study’s findings. For example, ethnicity was one of a number of factors which comprised the culture ‘world’ described by some participants. A meta-analysis of ethnic therapy matching found moderately strong effect sizes for SU preference for (and positive perceptions of) therapists of their own ethnicity; however almost no therapeutic benefit effect according to shared ethnicity was found (Cabral & Smith, 2011). Whilst pairing SUs with therapists of the same background may be neither ethical nor possible in practice, awareness of such potential barriers or opportunities might be important factors to consider as part of establishing suggested pre-treatment preparation procedures (McMurran & Ward, 2010).

 Staff who were static, and did not make the necessary movement towards the level of the SU, were perceived as uncertain and untrustworthy. Trust was similarly reduced for any staff that were perceived to have breached confidentiality without just cause; or for those who were not direct and open about their motivations (for example discussing the men’s care as a team behind closed doors without the SUs’ involvement). In common with other recent SU perspective studies, being part of a trusting relationship was found to be required for ongoing TE (Mason & Adler, 2012; Willmot & McMurran, 2013). Promisingly, the current study’s findings suggested that staff were able to build the SUs’ trust by listening, and by giving the impression that they genuinely care about the individual they are working with.

 Regardless of staffs’ movements and efforts, it was apparent that SUs did not perceive that they had a choice to participate in many therapeutic activities; they had to do them. Due to the nature of the environment, whereby staff held hierarchical levels of power, the men were more likely to be involved in therapies without being meaningfully engaged, than risk any punishment or disruption to their path out of forensic care by not attending. Mason and Adler (2012) suggested that a sample of forensic SUs engaged in group work had a developed a sense of ‘learned helplessness’ (Seligman, 1975). Learned helplessness may be explained in the context of the current study. For example, the participants reported being forced to attend (potentially non-effective or counterproductive) therapies; however due to not having control over their involvement, they continued to attend even if they were not meaningfully engaged. Similarly, Mason and Adler (2012) also highlighted that being clear about proposed work from the outset was likely to aid in the choice making process and therefore TE.

 Schafer and Peternelj-Taylor (2003) found that SUs enrolled in a treatment programme for violent offending evaluated therapists’ genuineness and identified inconsistencies between therapists’ verbal and non-verbal presentations. Additionally, the current study found that SUs reported being skilled in consciously and intuitively ‘reading’ the motivations of staff. This skill was in part developed due to a unique necessity to be on guard to survive in forensic settings. The men accepted that staff had their ‘own lives’ when away from the wards, but also had an expectation that whilst at work their focus should be on helping SUs to get better. The SUs were confident that they could accurately predict how motivated staff were to meet this brief based on their observations, interactions and subconscious understandings (‘you just know’). Participants were also aware of the power that staff held over them, and how the therapists’ role affected how and to what degree they were likely to be engaged in therapeutic work. SUs were understandably motivated to ensure they received favourable feedback to aid with progression and eventual discharge.

 Finally, despite the reality for SUs that they were engaged in therapies in their own (scary, abnormal) home, experiences suggested that therapists did not regularly offer the choices or everyday comforts that participants expected, such as negotiating a time and duration of session. Although not recorded, another example was from Hal who explained that he had been in a weekly meeting for a number of years with his care team, and was never offered a drink despite there being a coffee jug in the room for staff to share each week; this added to a sense of ‘us and them’. Other normalising behaviours such as using humour as part of an overall affable personal presentation were also recognised as contributing to SUs’ positive evaluation of staff attributes. Humour as a fundamental aspect of treatment has shown promising effects within forensic settings (Minden, 2002); however considering the nature of some therapeutic work in a forensic ward it is understandable that this may not always be applicable to therapeutic sessions.

**Strengths and limitations**

In addition to offering some novel findings, a particular strength of this study was the engagement of appropriately experienced SUs as consultants from the outset in the study design, and in particular, the interview schedule. This ensured that interviews remained as close to participants’ experiences and worlds as possible, and therefore allows confidence to be placed on the findings.

While it was not possible to allow the participants to contribute to theme validation (due to the potential for anonymity and legal issues associated with forensic services, which could be considered a limitation), three participants who subsequently observed the finalised themes offered verbal validation and confirmation that the themes made sense to them individually, adding further rigour to the analysis and enhancing confidence in the findings.

Nonetheless, there are a number of limitations to the existing study. Firstly, there could be a positive bias on how participants reported experiencing engagement due, to being purposely selected by their responsible clinicians for inclusion. Also, although the study sought to investigate the lived experiences of SUs in TE, it was not possible (nor ethical) to restrict participants from speaking about other forms of engagement, for example social engagement within a ward setting. This was however considered during analysis and selection of extracts to highlight themes.

Seven potential participants did not wish their interviews to be audio recorded, and for consistency and to avoid missing important data through recording interviews by hand, were not included in the study It is acknowledged, however, that in excluding them, an opportunity to strengthen or contradict the findings of those who consented to audio recording has been lost.

 One participant did not use English as a first language; however he was able to understand the consent process. In common with other participants whereby difficulties with comprehension were observed, the participants’ responses must be considered in the context of the findings. These included a preference for presenting things in a simple way, and having to take time to build trust in staff before disclosing ‘deep stuff’. Despite three participants stating during the interviews that they trusted the interviewer, it is unlikely that sufficient interactions had occurred prior to interviews for all to trust the PI.

 Conducting interviews in rooms where the participants usually participated in therapies may also have been experienced in a way that was analogous to doing therapies themselves. Furthermore, a number of participants explicitly referenced feeling tired and/or being affected by psychotropic medication at the time of the interviews. Whilst every effort was taken to present the questions in a way that would be inclusive of a range of comprehension levels and presentations in a non-judgemental and confidential manner, it cannot be assumed that given these considerations, all participants gave a full reflection of their experiences.

**Clinical Implications**

The findings of this study are reflective of experiences in one NHS medium-secure forensic service; however it is expected that due to similarities in the environment and nature of treatments that the observed themes may be transferable to other forensic settings where men are detained and receive therapies aimed at offence recidivism and/or mental health improvement. They may also be transferrable to settings where women are detained, and would support findings on engagement and the therapeutic milieu in women’s secure environments (Long, Banyard et al., 2012; Long, Knight, et al., 2012).

 It is suggested that staff working therapeutically in forensic settings may be advantaged by considering how to use the themes reported in the current study. The findings suggest that meeting men ‘on their level’ by using preferred social greetings, by using humour, and being clear from the outset about the purpose of engagement, is likely to enhance TE. Also, whilst men are often detained against their personal wishes in secure hospitals, there is a potential for clinicians to offer choices to SUs regarding the set up and delivery of therapies; including a consideration of the SU’s preference to keep work simple. Furthermore, the findings suggest that being direct and open can prevent SUs from feeling excluded and more likely to enter into the trusting relationships required for effective TE. Staff may also benefit from remembering that their place of work is the SUs’ home. SUs are likely to already feel punished for being in secure care, therefore offering specific feedback is suggested to be a more advantageous strategy than punishment for SU errors.

**Conclusions**

A number of themes were found by conducting an interpretative phenomenological analysis of TE experiences reported by a sample of participants detained in a medium secure hospital. Unique findings included the conceptualisation of the different worlds occupied by staff and therapists, and the learned ability of SUs to evaluate the attributes and motivations of the staff they are working with. Other themes were congruent with existing qualitative research exploring engagement in forensic settings, including the importance of the social climate in the environment, building a trusting relationship, and offering SUs a choice in their care (Frost & Connolly, 2004; Howells et al., 2009; Mason & Adler, 2012; Sainsbury, Krishnan, & Evans, 2004; Milsom et al., 2014; Schafer & Peternelj-Taylor, 2003; Willmot & McMurran, 2013). The findings may be of utility to other clinicians and researchers seeking to understand how to improve TE in secure care.

**Future research**

The current study sought to investigate the lived experiences of a homogenous group of men in a medium secure setting. It is suggested that in line with the recommendations for engagement models to be produced (McMurran & Ward, 2010), that the experiences of a range of men and women in other forensic locations be investigated. By compiling the findings, it is expected this will contribute to the development of psychologically-robust quantitative measures to further investigate how variable approaches from staff affect TE in secure settings. This research also highlights the considerations and limitations for the active involvement of SUs in research design in secure settings. It is hoped that the observed potential for SU informed research will be realised in future studies.

**Disclaimer**

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**Table 1: Super-ordinate themes and sub-themes.**

|  |  |  |
| --- | --- | --- |
| Super-ordinate theme  | Sub-theme | Theme present in cases  |
| Different worlds | 1) Coming from different worlds  2) Meeting at the same level  3) Abnormal home environment  | Ant, Bob, Den, Hal, Ken, Obe, Rod. Ant, Den, Hal, Rod, Jim. Ant, Bob, Den, Fin, Hal, Jim, Ken, Obe, Ted. |
| What the individual brings  | 1) Personal attributes 2) Expectations and evaluations 3) Staff Role  | All cases. Ant, Den, Fin, Jim, Rod, Obe, Ted. All cases. |
| What the therapy entails  | 1) Building a trusting relationship  2) Setting up and doing therapy  3) Outcomes  | Bob, Den, Fin, Hal, Jim, Ken, Obe, Rod, Ted Ant, Den, Jim, Ken, Obe, Rod, Ted. Bob, Den, Hal, Ken, Obe, Ted. |
| Control | 1) Having a choice 2) Responding to punishment and feedback  | Ant, Bob, Den, Fin, Jim, Ken, Obe, Rod, Ted. Ant, Bob, Jim, Obe, Rod, Ted.  |