RECOVERY AFTER PSYCHOSIS: PATIENTS' PERSPECTIVES OF A COMPASSION FOCUSSED GROUP INTERVENTION

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"Recovery is being able to live a meaningful and satisfying life, as defined by each person, in the presence or absence of symptoms. It is about having control over and input into your own life. Each individual's recovery, like his or her experience of the mental health problems or illness, is a unique and deeply personal process." (Scottish Recovery Network, 2009).

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1 DECLARATION

I declare that I am the sole author of this thesis and that the work contained herein is my own. This thesis or any part of it, has not been submitted for any other degree or professional qualifications.

Lucy Abraham

February 2010

2   ACKNOWLEDGEMENTS

3   ABSTRACT

Background: Recovery in psychosis is increasingly recognised as more than merely symptom reduction, rather it is about rebuilding meaningful lives. Compassionate Mind Training (CMT) was trialled within community samples and found to reduce feelings of shame and self criticism that can act as barriers to recovery (Gilbert and Irons, 2004; Mayhew & Gilbert, 2008; Gilbert & Proctor, 2006). Forensic patients often suffer high levels of shame and stigma in relation to their illness, their crime and their detention (Laithwaite & Gumley, 2007). Laithwaite (2007) therefore developed and trialled a 'Recovery After Psychosis' (RAP) programme for forensic patients, based upon the principles of CMT. The programme has been found to have positive outcomes in terms of improving self esteem, and reducing both depression and general psychopathology (Laithwaite *et al.*, 2009). Due to the constraints of quantitative methodologies this study was however, unable to explore the process of change that occurred from a patients' perspective.

Aims: The current qualitative study aims to gain a better understanding of the process of change for participants of the RAP programme in order to inform both content and delivery methods of future programmes.

Method: Semi structured interviews were conducted with eight participants, following their participation in RAP. All interviews were transcribed and analysed using Interpretative Phenomenological Analysis (Smith *et al*, 2009).

Results: Six super-ordinate themes emerged in the patients responses: 'limited resources as consequences of upbringing'; 'mistrust'; 'the fragility of the mind'; 'institutional barriers to recovery'; 'self reflection and understanding' and 'personal development'.

Discussion: The participants told of a journey of personal development. They discussed their upbringing and how this limited their academic abilities. They described feelings of mistrust and anxiety surrounding the 'power of their mind' during psychosis, and their fears of discussing any of these issues with others. The group setting appears to have been a unique environment that acted as a vehicle to facilitate change, overcome fears and normalise their experiences. The themes raised recommendations for improving the RAP programme and provided more general recommendations to improve the experience of hospitalisation of forensic mental health patients.

4   INTRODUCTION

This study investigates patients' experiences of a 'Recovery After Psychosis' (RAP) programme run in a secure forensic environment. The literature review that follows will outline relevant information on psychotic disorders and the nature of recovery. This analysis will incorporate information regarding evidence based interventions and conclude with the rationale and content of the RAP programme currently under evaluation.

4.1   Psychosis

4.1.1   Psychosis: Clinician's perspective

In 2009 the 'National Institute of Clinical Excellence' (NICE) estimated that the lifetime prevalence of schizophrenia was between 0.4% and 1.4%. Schizophrenia was originally identified by Kraepelin (1887) who classified it as a progressive degenerative disorder. Bleuer (1911) was the first to attempt to widen this definition, coining the phrase 'group of schizophrenias'. When the twelve different psychotic disorders as defined by ICD-10 were included in the estimates of prevalence rates for psychotic disorders, the figures were found to be as high as 3.5% (Kingdon *et al*, 2008).

Schizophrenia is a term used to classify a cluster of symptoms, described as both positive and negative. These 'positive symptoms' include hallucinations, delusional beliefs, changes in behaviour and paranoia and are the definitive aspects of the disorder for both ICD-10 and DSM-IV (APA, 1994) diagnoses (Figure 1). A major weakness of the DSM- IV (APA, 1994) classification is that each patient presents with unique combinations of these symptoms and these impact to differing degrees upon their ability to function. 'Negative symptoms' include; cognitive problems such as memory and concentration difficulties, relationship difficulties, mood disorders, withdrawal from vocational and social interaction and a lack of self care (NICE, 2009). These are defined by the absence of a particular type of functioning, rather than the presence of behavioural problems, which means that they are sometimes missed or deemed less important in clinical settings.

In addition to 'schizophrenia' defined in DSM-IV (APA, 1994) (Figure 1) there are also other terms that refer to disorders with psychotic symptoms. This has arguably confused the diagnostic process further still, and hampered both clinical effectiveness and scientific

progress. Read *et al.* (2004) highlighted that according to the DSM-IV (APA, 1994) definition (Figure 1) individuals can meet the diagnostic criteria for schizophrenia in fifteen different ways without having any common symptoms.

Figure 1 DSM IV Diagnosis of schizophrenia (APA, 1994)

A. <u>**Characteristic symptoms**</u>: Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated):

    1. delusions
    2. hallucinations
    3. disorganized speech (e.g., frequent derailment or incoherence)
    4. grossly disorganized or catatonic behaviour
    5. negative symptoms, i.e., affective flattening, alogia, or avolition

    Note: Only one Criterion A symptom is required if delusions are bizarre or hallucinations consist of a voice keeping up a running commentary on the person's behaviour or thoughts, or two or more voices conversing with each other.

B. <u>**Social/occupational dysfunction**</u>: For a significant portion of the time since the onset of the disturbance, one or more major areas of functioning such as work, interpersonal relations, or self-care are markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, failure to achieve expected level of interpersonal, academic, or occupational achievement).

C. <u>**Duration**</u>: Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms (or less if successfully treated) that meet Criterion A (i.e., active-phase symptoms) and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or two or more symptoms listed in Criterion A present in an attenuated form (e.g., odd beliefs, unusual perceptual experiences).

D. <u>**Schizoaffective and mood disorder exclusion**</u>: Schizoaffective disorder and mood disorder with psychotic features have been ruled out because either (1) no major depressive, manic, or mixed episodes have occurred concurrently with the active-phase symptoms; or (2) if mood episodes have occurred during active-phase symptoms, their total duration has been brief relative to the duration of the active and residual periods.

E. <u>**Substance misuse/general medical condition exclusion**</u>: The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

F. <u>**Relationship to a pervasive developmental disorder**</u>: If there is a history of autistic disorder or another pervasive developmental disorder, the additional diagnosis of schizophrenia is made only if prominent delusions or hallucinations are also present for at least a month (or less if successfully treated).

DSM-IV (APA, 1994) definitions (Figure 1) also state that if "delusions are bizarre" then only one Criterion A factor is necessary for diagnosis. Mojtabi and Nicolson (1995), however, found that inter-rater reliability for the term "bizarre delusions" was only 0.38 - 0.43. Thus, if this crucial item in the DSM-IV (APA, 1994) diagnosis has poor reliability it follows that the term 'schizophrenia' may be an unreliable diagnostic label.

It is evident that schizophrenia can have multiple presentations and that the current diagnostic tools to define the disorder use a categorical system with poor reliability and overlapping concepts. The Mental Health Organisation (MHO) provide a highly contradictory explanation for the continued use of the term, suggesting that despite these concerns professionals should continue to use the term, due to its wide spread use in society as a whole (WHO, 1973). The term is currently used widely in forensic settings, due to its role in determining risk. This association between schizophrenia and forensic settings serves to perpetuate the stigmatising effect of the label.

Several attempts have been made to redefine the disorder and reduce the stigma associated with the label. Recognising the overlaps between Post Traumatic Stress Disorder (PTSD), bipolar disorder and schizophrenia, Kingdon *et al.* (2008) proposed that psychosis should be re-defined in categories of causal factors such as traumatic experiences. This would however, make diagnosis of patients more difficult since 'cause' is rarely one clear or isolated factor. A diagnostic disorder based on 'cause' may also make some patients feel that the distressing symptoms of their condition were not being adequately acknowledged during initial sessions. Alternatively, other patients may find this emphasis on cause, rather than medical symptoms easier to accept.

In the hope of creating a more clinically useful term for the disorder, Bentall (1990) argued that individual symptoms should be considered rather than diagnostic labels. Van Os (2009) also attempted to redefine schizophrenia as 'salience disregulation syndrome'. It involved six dimensions: positive symptoms-depressive symptoms; negative symptoms-developmental cognitive deficits and disorganisation-manic symptoms. Van Os (2009) believes it is more reliable to combine traditional categorical definitions with a dimensional component. This he suggests, aids clearer communication with the patient regarding causes of their disorder, treatment needs and chance of remission. Kingdon (2009) however, argues that this definition merely re-establishes the many short-falls of traditional terminology and ignores the subjective experiences of patients. This suggests that there is a need for more understanding of the

patients' experience of psychosis and a need for long term explorative research in this area (Davidson & Stayner, 1997; Drayton, Birchwood, & Trower, 1998; Estroff, 1989; Kingdon, 2009).

The term 'psychosis' arguably facilitates more openness and provides patients with the opportunity to explore not only the range of psychotic symptoms they have experienced, but also their personal, emotional and practical implications (Chadwick *et al*, 1996). Therefore the term 'psychosis' was used within the RAP programme and wherever possible in this thesis. Use of the term 'schizophrenia', will however, be necessary in relation to specific research studies that continue to use that criteria.

4.1.2 Psychosis: Patients' perspectives

Recently clinicians have developed increased awareness of the potential emotional impact of certain diagnostic terminology upon the patient. Davidson (1992) argued that when a patient receives a diagnosis of schizophrenia they become completely subsumed by it. There seems to be the implicit assumption that the person with schizophrenia is entirely, and only, a schizophrenic (Davidson, 1992; Estroff, 1989). Patients often chose to reject the label due to its perceived stigmatising association with violent and criminal behaviour. Kingdon (2008) presented patients with a variety of diagnoses on cards with brief definitions (schizophrenia, sensitivity psychosis, drug related psychosis, anxiety psychosis and traumatic psychosis). 63% of patients expressed negative attitudes to 'schizophrenia' compared to the alternatives. The 'schizophrenia' definition however, was a longer prose and it is unclear how this lengthier definition affected patient choices.

Boyd and Gumley (2007) conducted a targeted study of patients' experiences of 'persecutory paranoia' using a social construction version of grounded theory. This methodology allowed exploration of the individual meanings that patients associate with their condition. The authors emphasized that paranoia is defined by social interactions and expectations of others. When paranoia was most acute for participants, their lives were monopolised by defending themselves against threat and were preoccupied by possible outcomes and worry. They were hyper-vigilant and watchful of events and people in their environment. As a result of perceived threat they often became aggressive (fight) or isolated themselves (flight). Self isolation is believed to reduce help-seeking and maintain the symptoms of psychosis (Boyd & Gumley 2007).

Using grounded theory, Hirschfeld *et al.* (2005) conducted an evaluation of young men's wider experiences of psychosis, in a three to five year period, immediately following the first episode of their condition. Their analysis supported the therapeutic and academic move in recent years towards understanding patients' personal stories, rather than labelling. It highlighted the need to consider both their early development, and their relationships with others, because of the impact on these on their sense of self. The patients signalled the need for clinicians to acknowledge suicide and depression as an integral part of psychosis rather than a separate disorder. Indeed, major or minor depression is known to be a co-morbid condition in a 59% of patients with schizophrenia (Srivastava, 2008).

Hirschfeld *et al.* (2005) describe the 'ripples' that psychosis creates in the lives of young men. Psychosis does not simply produce positive symptoms, it 'ripples' outwards and eventually affects all areas of their lives; their relationships with others; their employment; their environment; their sense of self; their sense of the world; and their hopes for the future. Patients highlighted the fact that they often felt isolated from society due to the adversity and stigma they experienced in relation to their 'psychosis'. The clinical implications are that treatment approaches need to be based on the individual's personal experience and target all affected areas of their lives. This would allow them to rebuild a positive identity, develop confidence, understanding, and a more coherent sense of self.

4.1.3 Summary of 'psychosis'

Despite a century of research into the nature of schizophrenia there remains no agreement between clinicians on what defines the disorder, what to name this disorder or how the disorder presents in patients (Kelly & Gamble, 2005). Clinicians have continued to perpetuate the myth of schizophrenic disorders for political and legal requirements which has enhanced the stigma associated with the condition. Society continues to view this as an unpredictable and dangerous condition (e.g. Read *et al*, 2004; Kingdon *et al*, 2008; Davidson, 1992; Estroff, 1989). Service users highlight the need to look at the person behind the disorder and understand how their distress affects them personally (Hirschfeld *et al*, 2005).

4.2 Recovery

Recent government policy and discussion papers have ensured that the concept of 'recovery' has taken a centre stage (Department of Health, 1998, 2001a, 2001b, 2009). Progress is being made to recognise the cause of mental illness and develop an understanding of the routes to recovery. The white paper 'Modernising Mental Health Services' (Department of Health, 1998) planned to work towards fostering a social environment which addressed the root cause of mental health problems and enhanced physical and mental wellbeing in Scotland. It aimed to promote services that were safe and supportive. Key strategies included promoting greater access to employment and establishing social inclusion working parties. In the following year 'The National Services Framework (NSF) for Mental Health' (Department of Health, 1999) began to recognise the effects of societal stigma directed towards patients with mental health problems. NSF has now reached its ten year lifespan. The framework has increased investment to mental health services and with it an improved quality of care (Department of Health, 2009).

The recent publication of 'New Horizons' (Department of Health, 2009) aims to build upon the achievements of legislation such as the NSF and 'The Journey to Recovery: The Government's vision for mental health care' (Department of Health, 2001a). It plans to improve cross-government and cross-agency collaboration. This would enable the provision of more personalised services based on patient-identified needs for treatment and a reduction in the root causes of mental ill health.

Despite this increased political attention it remains unclear how recovery is measured or defined. In a review of literature, Davidson et al. (2005) found that few journals on recovery actually defined the concept. This means that calculation of accurate rates of 'recovery' is impossible to ascertain. In recent years attempts have been made to clarify this concept. This will be explored in the following chapters.

4.2.1 Recovery: A clinical concept

Schizophrenia was traditionally classified as a 'severe and enduring mental illness'. This medical approach to the disorder regards mental illness as a physical disease (Whitwell, 1999). Like most physical diseases the aim is to alleviate symptoms and return the patient to their former selves. (Jenkins & Carpenter-Song, 2009).

Recent clinical developments such as psychosis early intervention services, relapse prevention programmes and user led organisations such as the 'Hearing Voices Network' illustrate gradual progress from the traditional views of treatment and outcomes in schizophrenia. Kelly and Gamble (2005), however, emphasise that this progress is slow and most psychiatrists still have a traditional perspective on outcomes.

Gureje *et al.* (2004) investigated cases of symptomatic remission and found even after this was achieved there continued to be ongoing mood disorders that impacted upon the patients' quality of life. It appears that symptom reduction does not necessarily equate to improvement in executive functioning, emotional well being or family relationships (Davidson *et al.*, 2005). Any definition of 'remission' that is related only to the presence or absence of symptoms defined within the diagnostic criteria of schizophrenia leads to secondary consequences of the disorder being ignored, which may impact on long-term mental health problems. Thornton (2000) emphasises the range of factors that influence recovery. These include: the conditions' impact upon social support networks; the treatment received; personality; and individual goals and aspirations.

A lack of consensus regarding how to define 'recovery' has implications for both research and clinical work. 'The Remission in Schizophrenia Working Group' (Andreason *et al.*, 2005) was formed in order to clarify this important issue. The group formed in 2003 and reviewed available definitions, research in the field and techniques for measuring remission in schizophrenia. In 2005, the group published a consensus statement in which they defined 'remission' as 'a reduction of core psychotic symptoms to a maximum of mild intensity for a period of at least six months'. In contrast 'recovery' was regarded as the capability to live in the community, sustain employment and function socially for a minimum period of two years. Lambert (2008) questions the lack of reference made in this definition to the patients' perception of quality of life and he appeals for a broader definition of recovery to be established.

4.2.2 Recovery: A concept of rehabilitation

Anthony (1993) describes a 'recovery' movement that re-defined the concept of recovery from traditional 'clinical recovery' to 'social recovery'. Social recovery can occur without a reduction in symptomatology and without a defined time frame. It is aimed at developing self

awareness, an understanding of past difficulties and incorporating these into a positive sense of self which allows patients to foster hope for the future (Anthony, 1993). Patients should be viewed as experts in their experiences and this definition is therefore based upon their views (Brown & Kandirikirira, 2007). Professionals should work to support the patients' recovery by bringing in their own knowledge to the process only when necessary (Department of Health, 2005). The ultimate goal is to help patients build a meaningful life for themselves, with or without the continuing presence of mental health symptoms.

Increasingly, qualitative research has sought to explore patients' perspectives on recovery from psychosis (Davidson & Strauss 1992; Brown & Kandirikirira, 2007). Patients in these research studies rarely mentioned the reduction of symptoms as vital for recovery. Davidson and Strauss (1992) conducted qualitative interviews over a two to three year period with sixty-six patients' with serious mental health problems. The participants highlighted four different themes in the recovery process. These included 'discovering the possibility of a more agentic sense of self, developing self awareness of personal strengths and limitations, enhancing the positive aspects of oneself and enhancing the sense of self in the recovery process' (Laithwaite & Gumley, 2007).

A subsequent study by Andresen *et al.,* (2003) reviewed the published qualitative literature and concluded that there are four stages commonly described in the recovery process. These include: 'finding and maintaining hope; re-establishment of a positive identity; building a meaningful life and taking responsibility and control'. The authors proposed a five stage pathway to recovery. The initial stage is called 'moratorium' and is a period of denial, loss or confusion surrounding personal identity, hopelessness and withdrawal for self preservation. The second stage is 'awareness' where the person begins to hope for a better life and can see that recovery may be possible for them. The third stage is 'preparation' which involves developing self awareness, learning about their illness, the support available to them and developing recovery skills. The fourth stage is 'rebuilding'. This stage involves the patient taking responsibility for their condition and their life. The final stage is 'growth'. During this final stage the patient may not be symptom free but knows how to manage the illness and stay well. These phases, whilst aiming to foster hope and empowerment, are extremely prescriptive suggesting only one path to recovery.

The 'Scottish Recovery Network' (Brown & Kandirikirira, 2007) conducted a narrative analysis of patients' paths to recovery and identified a number of internal and external

elements that were important. In contrast to Andresen *et al.*, (2003) these authors emphasise that the phases do not necessarily need to occur in a predefined order, nor do all of the elements necessarily need to occur for recovery to take place. The internal factors include; belief in one's self and developing a positive self concept; recognising that recovery is possible; having enjoyable and fulfilling activities in life; developing positive relationships with others; understanding one's illness; one's mental and physical wellbeing and; actively engaging in techniques to stay well and manage emotional and psychological stress. The authors also identified six external factors; having supportive relationships with those whom do not undermine patient's self-determination; being regularly told that recovery is attainable; having achievements recognised and valued; having formal support that is reactive, containing and reflective of developing needs; living and working in a community where other people could see beyond one's diagnostic label; and having life choices accepted and validated. This study is particularly important to the current thesis as it is specifically carried out in a Scottish sample and therefore is unbiased by geographical differences in the formulation of recovery (Warner, 2009).

Whilst the definitions discussed in this section more accurately reflect patients' views, they are difficult concepts to measure and as a result some researchers continue to use symptom reduction measures as indicators of outcome. Other researchers have managed to provide encouraging statistical evidence that 'recovery' from psychosis is possible under these broader definitions and illustrates that these concepts can be measured. In a three year follow up study, Lambert (2008) found in a sample of 400 never treated patients with schizophrenia, remission rates for symptoms were 60%; for functioning were 45% and for subjective wellbeing were 57%. Recovery rates were 52%, 35% and 44% respectively. Complete recovery across all domains was found in 17% of case and this was maintained at three years follow up. This indicates that patients can make a meaningful recovery from psychosis despite the traditional beliefs regarding it as a condition of enduring nature. It further suggests that service users should be empowered through involvement in goal planning and provision of opportunities to adopt meaningful social roles.

4.2.3   Recovery: Integrating perspectives

Fitzpatrick (2002) suggests that recovery is a process involving three concepts on continuum: the medical (clinical) stage; the rehabilitative stage; and the final empowerment stage. The 'medical stage' refers to the removal of symptoms so that the individual can function at a pre-

morbid level. The 'rehabilitative' stage claims that the illness itself is incurable, but through rehabilitation the patient may still be able to return to a normal level of functioning. The final stage is 'empowerment' which regards psychosis as a sign of severe emotional distress as a result of environmental and interpersonal factors. This model suggests that the final stage of recovery can only be achieved through addressing relationships, social interactions and accepting the label of mental illness; viewing it as an illness rather than a defining characteristic of themselves.

De Hert *et al., (2007)* also suggest that models of recovery should include both rehabilitative and illness models. They conducted a large scale prospective study involving 1215 patients with DSM-IV (APA, 1993) diagnosis of Schizophrenia. All had a minimum of three evaluations over the course of a year to assess the presence of eight remission criteria involved in 'The Remission in Schizophrenia Working Groups' definition (Andreasen *et al.,* 2005). These include; delusions, unusual thought content, hallucinatory behaviour, conceptual disorganisation, mannerisms or posturing, blunted affect, social withdrawal and a lack of spontaneity. The authors concluded that symptom reduction may be a meaningful goal in the early stages of treatment, but that remission involved additional factors including; insight into illness; a higher level of functioning and better 'Activities of Daily Living' scores. Therefore the authors suggest that 'recovery' and 'remission' are different concepts that have relevance to different stages of treatment.

4.2.4   Recovery: Secure forensic patients' experiences

Despite political and academic attention now devoted to 'recovery' there has been very little published research into the role of recovery in forensic populations. The admission criteria of forensic mental health services enhance the medicalisation of the patients' condition. Patients are deemed to have distinct needs as a result of the severe and enduring nature of their illness and the compulsory nature of their treatment. Most have a background of abuse, disruptive family histories, poverty and traumatic life events (Laithwaite & Gumley 2007; Laithwaite *et al.,* 2009). These patients have highly complex needs and it is important to explore the ways in which their experiences of recovery differ from those of other patients with psychosis in community samples. As identified in previous sections hope and self efficacy are central to recovery from psychosis (Brown & Kandirikirira, 2007, Andresen *et al*, 2003). It can therefore be hypothesised that the process of recovery will differ within situations, such as secure hospital environment where self efficacy and freedom of choice is restricted.

It is a common misconception that patients within high security settings, such as The State Hospital will remain indefinitely within that environment. There are currently one hundred and sixty seven beds available at The State Hospital. Between January and December 2008 fifty one of these patients were transferred to other services: Thirty seven were transferred to NHS hospitals; five were transferred to prison; eight to court; and one back to community living. It is therefore important to consider how patients' hopes and expectations compare to these figures (The State Hospital, 2009a).

Laithwaite and Gumley (2007) completed a grounded theory evaluation into patient concepts of recovery from psychosis within The State Hospital. The authors found that the thirteen patients involved, provided differing levels of detail in their narratives. Some patients were only able to provide information about their current experience in the hospital whereas others could reflect and plan ahead. These patients described the hospital setting as both a frightening and safe environment, depending on the lives they were living in the community. Other patients were able to speak about early abuse and neglect in their relationships and how this led to difficulties in forming relationships with hospital staff. In relation to their recovery, the patients highlighted the importance of reconciling past relationships and forming new attachments. Patients emphasised the need to start to make sense of the past in order to recover. The authors hypothesise that forming relationships improves reflective functioning (awareness of others' mental states) and mentalising abilities (ability to make a narrative of one's own thoughts and feelings). This allows patients to consider the past and develop more coherent narratives of their experiences. Greater mentalising ability is believed not only to reduce psychotic symptomology, but also to create a barrier to future violent behaviour (Fonagy *et al,* 1998; Bateman & Fonagy, 2006). Laithwaite and colleagues appear to have conducted the only investigations to date into patients' experience of recovery from psychosis in a forensic setting. Her research provides a signpost for the development of future interventions.

In a later paper, Laithwaite *et al.,* (2009) suggested that a further barrier to recovery in a secure forensic mental health setting is self–critical thinking. Self criticism has been found to be significant in forensic populations, due to the shame and stigma felt in relation to their index offence, their hospitalisation and their mental illness (Scott, 2007). The broad range of potential triggers for self critical thinking increases the risk of this population internalising a sense of shame. This is believed to affect recovery as it reduces empowerment and devalues

their ability to function independently. The stigma felt may also result in them withdrawing from society and thus reducing the likelihood of help-seeking during lapses or relapses (Warner, 2009 & Lysaker, 2008). Surprisingly, despite the relevancy of this topic, it is under researched in forensic patient groups.

Jenkins and Carpenter-Song (2009) examined ninety interviews of community out-patients in the United States and found that 96% experienced stigma that impacted on their daily lives. The range of factors associated with stigma covered five domains and eleven categories. There was little correlation between perceived stigma and level of symptomatology. Regularly taking medication for mental health difficulties was, however, highly associated with awareness of stigma. Stigma is reframed as an interpersonal process, rather than a derogatory belief that is imposed on others. These patients were living independently in the community and therefore potentially had lower levels of symptomatology compared to many patients residing in The State Hospital. In forensic samples the level of shame experienced is arguably more severe and it raises questions as to the effect this has on forensic samples.

As described above, contrary to common belief, stigma is a relational process, and it is perceived more readily in strangers (Jenkins and Carpenter-Song, 2009). Stigmatisation attacks the patients' self-identity and results in a form 'self stigma' (Corrigan & Watson, 2002) that is commonly referred to as 'shame'. 'Attachment Theory' literature (Bowlby, 1969) explains that the likelihood of an individual recognising societal stigma and experiencing shame is dependent upon their early experiences. Individuals who develop insecure attachment styles are more likely to be threat focussed and perceive others as having the power to hurt and control them (Fonagy, 2001; Laithwaite & Gumley, 2007). Early experiences may result in individuals becoming hyper-vigilant to evidence of stigma in society and this may affect their self concept. During times of emotional distress, these individuals do not have the skills or abilities to self soothe as they lacked, as children, an appropriate role model to demonstrate this. (Gilbert & Irons, 2004; Laithwaite & Gumley, 2007). It is argued that for these individuals this feeling of inferiority is self perpetuating. Gilbert (2001) argued that patients often internalise a sense of self, which is characterised by the shame and lower social rank they experienced as children.

The impact of shame is further explained by 'Social Rank Theory' (Gilbert, 2001). The theory suggests that those with higher social rank, due to superior skills were able to threaten and intimidate less able or subordinate peers. Those in subordinate positions would defend

themselves by fleeing the situation or submitting to the super-ordinate other. This has negative consequences for those in subordinate roles, including lower self esteem, mood disorders, shame and humiliation. Those within a forensic setting often have been forced into subordinate roles throughout their lives (Gilbert, 2001; Laithwaite et al., 2009). In psychosis this has been found to result in command hallucinations that perpetuate the patients' role as the subordinate to their super-ordinate auditory hallucinations (Birchwood *et al.*, 2003).

Birchwood *et al.*, (2006) suggest that performance in socially competitive situations such as increasing resources, meeting a partner or gaining acceptance in social groups is dependent upon a person's social rank. Those who are socially anxious believe that they need to compete for acceptance, due to their socially unattractive traits. Social anxiety (measured by the Social Interaction Anxiety Scale) is higher in people that experienced schizophrenia, (measured by Positive and Negative Symptom Scale) due to the problems of shame (measured by Others as Shamer Scale). Patients with schizophrenia begin to view themselves as a lower social rank in comparison to others (measured by Social Comparison scale). They cope with this anxiety by either; avoidance; denial of their illness; or acceptance. During recovery their insight increases and they gain greater awareness of their perceived rank in relation to others, which further consolidates their beliefs. Social anxiety may develop post-illness due to a fear they will be rejected. Social anxiety has secondary consequences in reducing the patients' quality of life.

In addition to social anxiety, individuals experiencing high levels of shame are believed to be more susceptible to a range of psychopathologies: mood disorders (Blatt & Zuroff 1992); anger (Tangney & Dearing 2002); violence (Fonagy 2001); suicide (Blatt 1995); alcoholism (Potter-Efron, 2002); PTSD (Brewin, 2003); psychotic voice hearing (Gilbert *et al.*2003); affect dysregulation and personality disorders (Linehan 1993) and interpersonal difficulties (Zuroff *et al*, 1999). Shame appears to be closely associated with a perception of sub-ordinate social rank, which is linked to a range of mental health problems. For forensic mental health patients, being admitted to hospital can be a stigmatising experience. The role of patient results in a lower social rank compared with staff. In this sense, hospital environments aimed at providing care for these patients, may simultaneously create barriers to recovery, due to the social roles inherent to that setting.

4.2.5   Summary of recovery

'Recovery' after psychosis is a concept that has many different levels and stages. For many years clinicians have regarded the measurement of positive symptoms as a clear and easily defined way to monitor a patient's recovery. From the patient's perspective the positive symptoms they experience are not necessarily directly related to their perception of recovery. The vital aspect of recovery for patients is rebuilding a meaningful life that accepts their past behaviour without guilt or shame, and looks forward with hope to a future that involves positive and supportive relationships with others (Brown & Kandirikirira, 2007; Andresen *et al*, 2003). Therefore, as clinicians, there is a need to work more holistically with patients to repair their quality of life. This is arguably more difficult to achieve in forensic settings due to the restricted environment reducing self efficacy and hope. Forensic patients also have more sources of shame and stigma to overcome as a result of their illness, their index offence and their hospitalisation (Gilbert, 2009a; Scott, 2007).

4.3   Interventions

4.3.1   Cognitive-behavioural models of Psychosis

CBT was originally developed as an intervention for use with mood disorders (Beck, 1976). The treatment of psychosis is one of the most recent applications of this school of therapy. Since that time the models of CBT had adapted and changed in light of emerging data, but the traditional theoretical underpinning remain central.

Many cognitive behavioural interventions and models of psychosis are aimed at the reduction the positive symptoms of psychosis. Garety (2001) proposed arguably the most well known and influential theory of psychosis from a CBT perspective, which covers both hallucinations and delusions. His 'bio-psychosocial model' proposed that some individuals have a biological predisposition to developing psychosis. Those at risk individuals encounter emotional disturbances in relation to specific life events. These emotional changes cause cognitive disruption making it difficult for them to attend to what is going on around them, perceive the situation and make appropriate judgements. As a consequence of these cognitive disturbances further difficulties such as thought disorder, paranoia and hyper-vigilance may occur. This emphasis on the role of emotion in the development of psychosis was in light of findings that psychosis (residual symptoms of delusions and hallucinations) were more common in those

suffering from clinical depression. They went on to hypothesise that the feeling of hopelessness uncontrollability experienced by those with clinical depression contributes further to the maintenance of psychosis and further elevate the patients' distress (Birchwood & Iqbal, 1998).

Birchwood, *et al.* (2000) shared the view of a predisposing vulnerability to psychosis outlined by Garety (2001). Birchwood *et al.* (2000) however also incorporated the role of social cognition in their formulation in order to explain the relationship between the patient and their auditory hallucinations. The level of distress caused by the voice is dependent upon the patients' relationship with the voice, rather than the content of the voice. The typical nature of this relationship is subordination to the omnipotent voice. When this relationship occurs it is usually mirroring a previous abusive relationship with a significant other. These early experiences and relationships have consequences for not only the maintenance of psychosis but also self esteem and mood. Therefore consideration of attachment histories, early trauma and abuse are now also being more clearly incorporated into cognitive behavioural models (Read & Gumley, 2008) and addressed in CBT interventions (Gumley & Schwannaeur, 2006).

4.3.2 CBT for Psychosis

Early forms of CBT for psychosis was concerned with the alleviation of symptoms and in this sense therapy tended to be the alternative treatment choice for those that were treatment resistant to pharmacological interventions. Interventions were largely behavioural programmes to increase independent living skills. Auditory hallucinations were deemed to be out-with normal thought processes. Therefore cognitions were not explored in therapy until much later. In 1996, however, Chadwick and colleagues reformulated the psychological understanding of hallucinations as another form of intrusive thought. This enabled the CBT therapists to utilise many of the established CBT strategies used with other disorders with psychosis too (Kingdon & Turkington, 1994). Today in addition to standard trans-diagnostic approaches, CBT for Psychosis addresses issues such as stigma surrounding the patients' diagnosis. This is achieved through normalising, challenging thinking styles and offering explanations for the development of their condition. Sessions are also shorter in duration, homework is simplified and the approach for these patients is much more flexible (Tai &Turkington, 2009).

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4.3.3 Evidence base for Traditional CBT for psychosis interventions

De Hert *et al.*, (2007) found that one in three patients diagnosed with schizophrenia will meet the Remission Working Group's (Andreason *et al.*, 2005) criteria for 'remission' over a one year period. Thus the outlook for these patients appears to be better than previously thought. It follows that appropriate interventions need to be easily accessible to patients.

NICE (2009) recommends family therapy or CBT as the treatments of choice for patients suffering from schizophrenia. CBT is recommended for a minimum of sixteen weeks and therapists are advised to follow treatment manuals for which effectiveness has been proven in clinical trials. This approach allows less experienced staff the opportunity to work with this challenging patient group. The limited time frame for CBT intervention makes it cost effective and thus an obvious treatment choice of mental health services.

There is a large range of evidence for the application of CBT in the treatment of psychosis. Therefore to narrow this review the following sections will concentrate on those most relevant to the 'Recovery After Psychosis' programme. It will therefore consider, CBT for psychosis with treatment resistant clients, CBT for psychosis aimed at relapse prevention and CBT interventions in group settings. It will then consider patients perspectives on these interventions in studies using qualitative methodology. A review was also conducted into CBT in forensic settings, but only two studies have been conducted in this area and both were specific to anger rather than primarily psychosis (Haddock *et al.*, 2004; Haddock *et al.*, 2009).

Kuipers *et al.*, (1997) carried out a trial on sixty-six psychosis patients that had at least one positive and distressing symptom that was deemed treatment resistant. The patients were randomly assigned to either nine months of individual therapy or standard care. Participants in the CBT group had a 25% reduction in symptoms as measured by the brief psychiatric rating scale (BPRS) but showed no other signs of improvement. In a recent study by Turkington *et al.*, (2008) it was found that these benefits of CBT for treatment resistant psychosis are maintained at five years follow up. This study however again found that the benefits were in terms of symptom severity, but the authors make no indication of other more emotional and functional gains in relation to the goals of the recovery movement (Laithwaite *et al.*, 2009).

The application of CBT for psychosis in relapse prevention cases provides data on a broader range of outcome measures. A randomised control trial by Gumley *et al.*, (2003) compared treatment as usual to CBT in a group of one hundred and forty four individuals deemed 'relapse prone' (history of relapse in the last two years). The CBT group reported less hospital

readmissions, greater reductions in positive and negative symptoms, greater reduction in global psychopathology, greater improvement in pro-social activity and general functioning. In contrast Garety et al. (2008) found in a comparison of CBT for psychosis, family therapy and treatment as usual that CBT for psychosis did not reduce relapse rates at 12, or 24 months. The authors believed this was a consequence of therapists finding it difficult to focus therapy when there were no active psychotic symptoms. It may also be in part due to sampling occurring exclusively in hospitals following acute relapse.

Findings of Wykes et al. (2008) suggest group interventions of CBT have been found to have similar rates to individual CBT. Lawrence (2006) reviewed group behavioural interventions for psychosis and concluded that group CBT was more effective than treatment as usual in the reduction of social anxiety and more so in the reduction of depression. The studies involved in this review and those detailed earlier in this section, are however, extremely limited by methodological weaknesses such as; high drop-out rates, assessors being informed of treatment allocation and poor statistical power (Laithwaite et al. 2009). It is therefore interesting to consider research into patients' accounts of the CBT process.

McGowan et al., (2005) analysed patients' perspectives on CBT for psychosis. They interviewed eight patients about their experiences of therapy and found that the benefits of treatment are often not related specifically to the CBT approach. The mechanisms of change appear to be a sound therapeutic alliance facilitating the creation of shared goals developed in a truly collaborative manner. Patients who progressed better in treatment were able to remember the content of sessions and to think more clearly and more logically about the topics that were raised. The strongest predictor of positive outcomes was the ability of patients to let go of more distressing understandings of psychosis and begin to be open to alternative explanations. Therefore, therapists need to fully understand the attributions patients make about their illness and their personal goals (McGowan et al, 2005). Within in-patient settings, the therapeutic relationship is also identified as central to change. In this setting however, both therapists and patients recognised more coercion by the therapist, towards goals that increased chance of discharge, rather than patient identified targets (Messari & Hallam, 2003).

Qualitative evaluations suggest that benefits of CBT interventions are largely related to the quality of the therapeutic relationship. It has been found that patients with high levels of shame are able to understand the rationale of cognitive behavioural therapy, and could generate alternative thoughts to negative self appraisals. However, this process seems to have little emotional impact (Lee, 2005). The problems of guilt and shame remained, and their

understanding of psychosis was often enmeshed in the idea that they deserved to be punished. This need for self punishment meant that they continued to be distressed by symptoms of psychosis (Gilbert 2009a; Mayhew & Gilbert, 2008).

4.3.4 Advances in CBT interventions

Recent research has highlighted that in addition to thinking styles, emotion, attachment and interpersonal issues, loss and trauma, self-esteem and self to self relating (Tai & Turkington, 2009) all have a role in the development of psychoses. To address these issues CBT has moved away from addressing maladaptive thinking patterns towards instead identifying personal schema, self concepts and ways of relating to the self and others.

As described in previous sections a common problem in CBT appeared to be that patients could accept logical reasoning, but still had strong emotions to the contrary. As a result there is now a shift in CBT from primarily challenging the content of maladaptive thoughts to instead changing the persons' relationship to these thoughts. Increasingly the emphasis is upon acceptance and soothing of emotional responses, rather than suppression. This change in emphasis has led to the development of 'third wave' therapies which incorporate eclectic theories and philosophical approaches into the traditional CBT framework. Therapies include acceptance and commitment therapy, meta-cognitive therapy, mindfulness based interventions and Compassionate Mind Training (CMT). It is beyond the scope of this thesis to discuss all 'third wave' approaches, but the following section will provide further detail on CMT (Tai & Turkington, 2009).

4.3.5 CMT and Adult Mental Health

CMT was developed by Gilbert and colleagues to address some of the apparent limitations of using a purely CBT approach detailed in previous sections (Gilbert, 1992, 2001, 2004, 2006, 2009a, 2009b; Gilbert & Irons, 2005):

> "Compassion-focused therapy is an integrated and multimodal approach that draws from evolutionary, social, developmental and Buddhist psychology, and neuroscience. One of its key concerns is to use compassionate mind training to help people develop

and work with experiences of inner warmth, safeness and soothing, via compassion and self-compassion" (Gilbert 2009b, p.199)

Gilbert (2009a) developed CMT based on the observation that patients presenting to mental health services often experienced high levels of abuse and ill treatment during their childhood, resulting in shame and poor self worth. Throughout early development these patients continued to expect this pattern of negative interaction where they experienced others as harsh and critical towards them. As a consequence of the overwhelming sense of shame experienced by some patients, they find it very difficult to be kind and nurturing to themselves and consequently experience high levels of emotional distress.

Early life events influence the range of coping strategies used to regulate their emotions. Gilbert (2009b) describes three emotional regulation systems. These include "threat and protection systems; drive, resource-seeking and excitement systems; and contentment, soothing and safeness systems." (Gilbert, 2009b, p.200) Difficult early life events, such as abuse or neglect, may make people susceptible to over-development of the threat and protection system. This may cause them to feel inferior to others and avoid social interaction. These behaviours can increase the risk of developing mood disorders. CMT therapists aim to help the patient to recognise that these symptoms were previously used for safety, but are now causing them difficulties and they should not feel blame for behaving in the manner they did. Once the patient realises they are not to blame for their symptoms, they can start to develop new skills. This threat and protection system has a complex association with the 'drive, resource seeking and excitement system'. People consistently strive to prove themselves and to achieve in order to avoid rejection. The therapist must be aware of this system, aware of patients' goals and be vigilant to their reaction to setbacks. It is natural for people to be disappointed, but many with a history of abuse will also be self-attacking. Consistent achievement and euphoria is impossible to maintain. Therefore the goal of CMT and Buddhist disciplines is to activate the 'contentment and self soothing and safeness system' rather than the achievement system.

Links have also been made between CMT and attachment theory (Bowlby, 1969) as the parent-child relationship is vital for modelling the qualities of this system and developing safeness. If people received a high level of negative interactions from their caregiver they tend to develop an anxious-avoidant attachment style and find it hard to activate the containment system in order to soothe themselves at times of distress (Gilbert, 2009a). CMT is a recent

theoretical development from social mentality theory and social rank theory. Social mentality theory provided insights into the relationship between early attachment and the development of compassion. If an individual suffers a punitive or abusive attachment to a caregiver they will be more prone to feelings of shame which maintains psychotic symptoms on later life (Tai & Turkington, 2009). CMT aims to target these feelings of shame and develop compassion both to the self and others.

In CMT, the therapist aims to model the qualities of compassion for their patients and create an environment that is safe and accepting. The patients learn the skills of compassion in a similar way that a child learns from a positive relationship with their caregiver. This helps patients to be more compassionate to others and themselves, by internalising compassionate thinking and reducing self critical thought (Gilbert & Proctor, 2006). Specific techniques to aid the patients' ability to self soothe include the development of a 'compassionate other' or 'ideal friend'. This is an imaginary image of a compassionate person that can be brought to mind at times of distress. Mindfulness meditative techniques are also frequently employed (Gilbert, 2009a). Further details of these strategies are detailed in the programme content.

4.3.6   Evidence base for CMT

Gilbert and Irons (2004) taught CMT techniques to a sample of nine patients with depression in a group setting. They found that all patients reported improvements in their ability to self soothe. However, three patients reported difficulty developing a compassionate image and those who did manage initially found it difficult to maintain a positive image without it altering into something derogatory. This study had a small sample size with little scope for exploring the types of compassionate images that were easiest for patients to develop. The authors could provide little advice on how best to use these techniques to help support a patient in an inpatient facility. It is questionable whether people, who have no memories of a significant other caring for them, will ever be able to develop a compassionate image in therapy. Whilst some of the results of this study are encouraging, patients' experiences of these techniques needs further exploration.

Mayhew and Gilbert (2008) present a case series of three patients living in the community who suffered auditory hallucinations. The patients received twelve individual sessions of compassionate mind training and were asked to complete a diary that was analysed at the

completion of treatment. Six questionnaires were administered pre, post and at six months follow up. The questionnaires included 'The Beliefs about Voice Questionnaire'; a shortened version of 'Forms of Self-criticism or Self attacking and Reassuring scale'; a shortened version of the 'Functions of Self criticism or Attacking and Self Reassuring Scale'; a 'Symptom Inventory' (SCL-90) the 'Choice Rank Scale and the Self Compassion Scale'. Results should be accepted cautiously as the sample only involved three participants and many of the measures were in shortened formats. However, the authors concluded the intervention led to a reduction in anxiety, depression, paranoia, psychosis, interpersonal sensitivity and obsessive compulsive disorder. Their auditory hallucinations also became more reassuring and less malevolent or persecutory. These findings make theoretical sense if considered in relation to social rank theory (Gilbert, 2001). Through modelling compassion and developing skills in this area, the patients' auditory hallucinations begin to mirror their more positive real life interactions. Whilst the techniques were initially frightening and difficult to master, the longer term positive implications have been evidenced. As Mayhew and Gilbert (2008) conclude, there needs to be more exploration of the processes involved in the CMT intervention. There needs to be an understanding of how patients regard this approach, the role of the therapeutic relationship and how CMT could work in conjunction with other therapy styles.

Gilbert and Proctor (2006) trialled CMT in a group of six people with chronic mental health difficulties. Patients appeared to develop skills in emotion regulation and results indicated a reduction in anxiety, depression, self-criticism, shame, inferiority and submissive behaviour. Given the small sample size and the lack of a control group, it is again impossible to generalise from these results. The authors do, however, provide useful insights to inform the future development of CMT. Individuals with chronic conditions require additional help in grounding the mindfulness meditative exercises. This can be achieved through scene setting for their compassionate image to aid their imaginations and memory. They also suggest that pictures or letters to or from their 'compassionate other' may also aid the process. Overall they found that the most useful element of their programme was the group setting as it provided a forum to share experiences. This study is both informative and encouraging for the use of CMT in clinical practice. As a quantitative evaluation conducted on only two groups of six participants it lacks statistical power and the results should therefore be accepted with caution.

4.3.7 Theoretical rationale for a group intervention based on CMT

As detailed in the earlier recovery chapter the current mental health system has recognised that positive outcome for patients with psychosis is not merely about the reduction of positive symptoms. The Good lives model (Ward, 2002) proposes a recovery focussed approach when working with offenders. The model emphasises that treatment of offenders is not merely about risk management, but also about recovery and improving their quality of life.

Recovery incorporates fostering a more coherent and positive sense of self, developing meaningful relationships, being valued and respected. For forensic mental health patients these goals are difficult due to their previous experiences, their chronic conditions, the sense of shame and also the clinical hierarchical system in which they live. Compassionate mind training is based on social mentality theory and aims to develop compassion towards both the self and others. The hope is that the application of compassionate mind training in the treatment of patients in forensic environments will target the threat focussed social mentality and create a positive view of oneself, that includes and accepts their past and ongoing difficulties. The 'Recovery After Psychosis' programme will use CMT principles with the aim of promoting a sense of safety and developing participants' ability to self-soothe (Laithwaite *et al.*, 2009). A group forum was chosen as it aims to enable patients to normalise their experiences, develop relationships with others and hopefully learn from one another's experiences. Full details of the programme development are provided in section 4.4.

4.3.8 Summary of interventions

It appears from these research studies that the main success of CBT in this client group is due to factors that are present in any form of psychological intervention, such as therapeutic alliance and a safe place to share experiences (McGowan *et al.*, 2005; Messari & Hallam, 2003). The patient described an understanding of the clinician's viewpoint on a cognitive and logical level, but did not feel any emotional change in their level of self worth (Lee, 2005). It appears that whilst CBT may offer some success for patients with mild or recent onset psychosis, it lacks the ability to address emotional issues of shame that are experienced by long term psychiatric patients and those who have committed serious offences (Laithwaite *et al.*, 2007; Dickerson & Lehman, 2006). CMT however purports to target the emotional effects of psychosis (e.g. shame) and there are encouraging results of trials within community samples (Gilbert, 2009a; Gilbert & Proctor, 2006; Mayhew & Gilbert, 2008; Gilbert & Irons, 2004)

4.4   Development of the 'Recovery After Psychosis' programme

As discussed, there is a lack of research carried out into the recovery process for patients with psychosis in forensic settings. This population has complex and chronic needs as a result of early traumatic experiences and poor relationships with family and peers. Scott (2007) found that 20% of patients within this environment met the diagnostic criteria for PTSD (Post Traumatic Stress Disorder) as a result of experiences related to their early childhood, their index offence, their detention and their mental illness. Whilst all patients within this setting have a severe mental health condition, they often present with co-morbid conditions such as depression, anxiety, personality disorder, psychopathology, obsessive compulsive disorder and PTSD.

'Recovery' is a dual concept for patients in The State Hospital. It relates to recovery from mental illness whilst also seeking to manage criminal and violent behaviour. It is therefore important that the hospital can provide effective evidence based therapies that have been researched not only in community samples, but also trialled for use in forensic settings.

The RAP programme was developed by Laithwaite (2007) and is based on the principles of CMT discussed previously. The focus is on the effect that early developmental experiences have on attachment style and current functioning, and aims to develop the patients' ability to cope with criticism, tolerate high emotions, and modify distress. These goals were addressed by specific quantitative measures that will be discussed later in the chapter (Laithwaite *et al*, 2009).

4.4.1   Structure of the programme

The RAP Programme is a structured twenty session programme run over ten weeks, each one lasting one and a half hours with a break for coffee which allows more informal interaction. This aims to help improve rapport and openness within the group setting. The programme was organised by a team of four facilitators: two Specialist Mental Health Nurses, a Clinical Psychologist and a Trainee Clinical Psychologist. Due to security policy within the hospital a minimum of three facilitators were required, that included at least one male member of staff. There were between four and six patients in each group.

4.4.2 Content of the programme

The core concepts of this programme were based on CMT (Gilbert, 2001) but were developed with an understanding of the complex needs of a forensic population. The following information outlines the content of the RAP programme developed by Laithwaite (2007):

The programme is divided into three sections:-

4.4.2.1 Section One: 'Understanding psychosis and recovery'

As discussed previously psychosis and recovery are neither static nor definitive terms. McGowan, *et al*. (2005) highlighted the need for therapists to develop an understanding of the patients' views on their condition. The understanding a patient has of 'psychosis' and 'recovery' are unique to their experiences and the stage of their illness, but also hold many similarities. With the focus of clinical recovery on a reduction of symptoms, the patients often neglect the other areas of their lives that are also affected by illness. This part of the programme therefore concentrated on discussing as a group the different experiences that people had whilst unwell and also whilst recovering. This discussion aimed to explore the 'ripple' effect of psychosis described by Hirschfeld, *et al*., (2005). To focus the discussion patients were shown an image of a pebble dropping into a pool of water. The group then discussed what this metaphor may denote and how it made them feel. Patients were encouraged to consider all aspects of their lives, including relationships, environment, vocation and training, thoughts and feelings.

The same image was then used to understand the process of 'recovery'. In line with the government's current advice on 'recovery', group members were encouraged to think beyond recovery as exclusively symptom reduction, to also consider the impact upon their emotions, relationships with others and their environment (Department of Health, 2003). The patients' explored how progress in one area of their life may impact on another area.

Another group exercise involved using the metaphor of 'recovery as a journey'. This helped patients create a visual image of the many difficulties that they have overcome in the past and potential pitfalls they may face in the future. This image helped facilitate discussions about plans to cope with adversity or difficulties in the future. Patients often concentrated on a hill walking metaphor with the summit being the point at which they were discharged from The State Hospital. The descent represented the ongoing struggles they had to face after being

discharged. The image usually included undulations that allowed the patient to recognise that even at their worst moments there were some days that were better than others.

4.4.2.2 Section Two: 'Understanding compassion and developing the ideal friends'

It was highlighted in section 4.3.2 that patients within forensic settings often have not had experiences of compassionate role models in their lives. With this in mind the second section devoted time to exploring the concept of compassion, forgiveness, understanding, acceptance and trust. The strengths and weaknesses of these characteristics were discussed in depth. People were encouraged to reflect on any people in their lives who had shown them compassion and how the aspects of their body language, speech (tone and content) and actions displayed compassion. Role plays were introduced in later groups to provide group members with a visual representation of compassionate responding. These discussions were largely group based to allow the normalisation of experiences within the group setting.

These exercises then progressed to the creation of the 'ideal friend' or 'compassionate image'. Guided discovery techniques helped patients develop an image of a person they found helpful, warm and soothing. As an additional aid in this process group members were given a worksheet (Appendix 1) to help them to consider the details in the image such as smell, tone, touch and any other important characteristics of their personality and appearance. The intention of creating this 'ideal friend' was for patients to be able to refer to 'someone' who is compassionate and over time, it was anticipated that they would begin to internalise the characteristics of this ideal friend and develop self compassion. Once group members developed an image, they were encouraged to bring it to mind throughout the remainder of the group programme. Participants were asked to keep a diary of any negative emotions and self-critical thoughts they experienced during the week and how they responded to this using their 'ideal friend' (Appendix 2). Participants were also asked if they were willing to share their diary entries each week and, if appropriate, there was time for the group to discuss and reflect on shared experiences and common concerns. At the end of every session the group participated in a mindfulness exercise in which they were asked to focus upon the qualities of their 'ideal friend'. Mindfulness is a meditative technique that attempts to focus one's mind on what is happening in the moment in a non-judgemental way (Baer, 2006). Meditative techniques such as this have been shown to decrease symptoms of anxiety by controlling respiration, reducing heart rate, blood pressure and muscular tension (Gilbert, 2005).

4.4.2.3 Section Three: Developing plans for recovery after psychosis

The final module was aimed at reviewing the programme and using previous session material to help plan for the future. Group members developed a 'Recovery After Psychosis plan'. The plan was written individually by each group member with the use of a worksheet to help structure their response (Appendix 3). They specified triggers to their psychosis, early warning signs, use of safety behaviours, and an action plan and with agreed coping strategies.

The information in their RAP plan was then used to prompt and guide them in producing a more detailed and personally written 'compassionate letter' to themselves from the perspective of their ideal friend. The letter aimed to encapsulate all their 'ideal friend's' qualities discussed in the group. Participants' were encouraged to make the letter warm, compassionate and understanding of their past difficulties. It also aimed to provide advice on how to deal with future difficulties and suggest channels for them to seek appropriate help.

Due to the intellectual level of many group members it was felt that writing a long prose of this nature may initially appear quite daunting. Therefore, to help the process the group developed a generic letter together before embarking on their own, more personalised version. This helped them to think about the things they wanted to include.

4.4.3 Quantitative outcomes

Compassion focussed interventions have been recommended to reduce feelings of shame and improve self concept (Gilbert, 2001). Improvements in these areas have been linked to recovery in a range of psychopathologies. Therefore Laithwaite *et al.,* (2009) were interested in the symptomatic outcomes of CMT in forensic populations. The first RAP programme was run in The State Hospital in October 2007 and there have been four groups run to date, involving nineteen patients. Laithwaite *et al.,* (2009) assessed the clinical outcome of these groups of patients using a range of ten different psychometric questionnaires administered pre-group, mid-group, post-group and at six months follow up to assess change in both positive and negative symptoms of psychosis.

Laithwaite *et al.,* (2009) reported a highly significant reduction in levels of depression (BDI-II) and an increase in self-esteem (Rosenberg Self Esteem measure), moderate improvement in patients' views of themselves in comparison to peers (Social Comparison Scale) and an improvement in general psychopathology (PANNS). There were also small reductions

reported in levels of shame (Other as Shamer Scale). These results were maintained at six months follow up.

This study illustrated the statistical success of RAP in forensic settings. CMT based techniques are arguably successful in terms of helping patients to develop a compassionate self concept, that allows them to view themselves more favourably in relation to others. The study unfortunately could not include a non treatment control group, due to the nature of the setting, therefore outcomes may have been in part be influenced by other factors such as involvement in other psychotherapies and changes in medication during the programme. In light of these limitations a randomised control trial is being planned in Ayrshire and Arran by Christine Braehler.

In quantitative methodology, however, the researcher is constrained in the extent to which they can explore these findings. In contrast, a qualitative evaluation would allow analysis of the patients' experience of the programme and help identify the process of change that occurred.

4.5   Summary of theoretical background and methodological rationale

As described earlier, the last decade has witnessed a shift away from merely managing symptoms of psychosis, towards instead facilitating meaningful recovery and rebuilding lives. NICE (2009) recommends CBT treatments for patients with schizophrenia. Patients' perspectives however, highlight that CBT fails to facilitate change on an emotional level and does not address feelings of shame in relation to past experiences (Lee, 2005). CMT has been trialled within community samples and found to have encouraging results in terms of addressing shame (Gilbert, 2009). Forensic patients potentially suffer high levels of shame and stigma in relation to their illness, their crime and their detention but no studies to date have trialled CMT techniques on this population (Scott *et al*, 2007; Laithwaite *et al.*, 2009). Laithwaite and Gumley (2007) therefore developed the RAP programme for forensic patients and evidenced improvement in patients' self esteem, reduced symptoms of depression and reduction in general psychopathology (Laithwaite *et al*, 2009). Information on patients' experience of participating in the RAP programme and the process of change may influence both the debate about recovery in psychosis and inform future therapeutic interventions.

4.6 Research question

What are the patients' experiences of a 'Recovery After Psychosis' (RAP) intervention within a forensic environment?

4.6.1 Subsidiary research objectives

a. What was the patients' experience of the RAP programme?

b. What is the patients' current understanding of the following core programme modules?
    i.   Psychosis
    ii.   Recovery
    iii. Compassion

c. Do patients perceive CMT to be a successful intervention within forensic settings?

d. What improvements can be made to the RAP programme from the patients' perspective?

5   METHODS

5.1   Design

This is a qualitative evaluation employing Interpretive Phenomenological Analysis (IPA) (Smith, 1996) to analyse data from semi-structured interviews conducted with eight participants. The rationale and procedure for this analysis are discussed in subsequent sections.

5.2   Justification of qualitative research in this area

Quantitative evaluation of the RAP programme found positive clinical outcomes (Laithwaite *et al.,* 2009). This is important in assessing the applicability of the treatment to forensic settings. Quantitative assessments however, fail to explore which elements of the programme facilitated change. While quantitative methods can assess for specific associations between factors, they do not allow for the complexity of human behaviour or allow revelations that are not necessarily expected or hypothesised (Landridge, 2007). Qualitative methods of inquiry are arguably best suited to novel and unique areas of research such as this, in which researchers seek to understand the processes that lead to change and the meanings that people attach to these experiences (Smith *et al.,* 1999).

5.3   Reflective preface

5.3.1   Research context

Reid *et al.,* (2005) highlighted the importance of providing contextual and cultural background to research to allow researchers and their readers a better understanding of the meanings which participants attach to their experiences. The State Hospital is the high security hospital that cares for patients whom due to criminal, violent or dangerous behaviour cannot be cared for elsewhere. Most patients enter the hospital system directly from trial having been deemed mentally unwell. Others are referred from prison due to deterioration in their mental health during detention (The State Hospital, 2009a). There are currently three categories of ward; admissions, rehabilitation and continuing care. The majority of patients report difficult upbringings which include a variety of traumatic experiences; poverty; abuse; and neglect. 68% of patients have a primary diagnosis of schizophrenia and 16% have a multiple diagnosis (The State Hospital, 2009b). Co-morbid disorders include depression, anxiety, post-traumatic

stress disorder, substance abuse and obsessive compulsive disorder. The Psychology Department within The State Hospital offers a range of both group and individual psychological services.

The forensic network is currently undergoing substantial re-organisation. New medium secure facilities have been established in recent years, resulting in a plan to reduce patient numbers in the hospital from 167 to 140 by 2012 (The State Hospital, 2009a). This has implications for staffing and for the types of services that are offered.

A 'Full Business Case' (FBC) for redevelopment of the hospital has been approved by 'Scottish Government Health Directorates' (SGHD). It aims to develop an environment that recognises patient needs and facilitates rehabilitation. Building work commenced in March 2008 and patients should be housed in new 12 bedded ward areas by spring 2011. New ward areas aim to offer patients greater continuity of care, with more treatment services and therapeutic interventions based on the ward. It is intended that patients will remain with the same multi-disciplinary team throughout their stay. Pooled staffing resources also aim to increase the staff to patient ratio (The State Hospital, 2009b). This redevelopment aims to maximise the hospital's rehabilitative potential. The hospital management team has therefore requested more information on patients' views (The State Hospital, 2009a) and the current document provides an insight into the patients' perspective.

5.3.2 Researcher's background

Transparency is necessary in IPA research in order to ensure quality (Smith *et al.,* 1999). The approach acknowledges the influence of the researcher's background, experience and role upon analysis within IPA research (Brocki & Wearden, 2006). The following information details relevant background information.

At the time of writing, the researcher was a Specialist Psychological Practitioner on community placement two days per week and working within The State Hospital two days per week. The researcher was a facilitator of the RAP programme which is where her interest in this evaluation first began. The dual role of facilitator and researcher maximises the time spent with each patient. This, in turn provides an opportunity to establish a better rapport with respondents. This may reduce their anxiety during the interview and allows richer data to emerge. A disadvantage of this dual role is that hospital patients tend to regard clinicians as the

gatekeepers between themselves and future discharge. This could potentially create an imbalance of power within the interview. Introductory sections have introduced attachment theory (Bowlby, 1969) and social rank theory (Gilbert, 2001). In line with these theories the researchers relationship wither the subject could mirror the subordinate role they had with their super-ordinate punitive caregivers during childhood. This would not only be a negative situation for the patient to be placed in, but it would also make them view their input as unimportant. This would have a substantial impact on the content and depth of data acquired. The researcher aimed to be aware of this during interview and took a Columbo style approach to questioning that placed the patient as the expert in this field.

An additional difficulty was that the researcher had knowledge of the patients from her clinical work that may influence the interpretation of interviews. To allow transparency, a reflective log was made following interviews and anonymous case study information is provided (Appendix 10). In addition the researcher met regularly to discuss emerging themes with other clinicians and qualitative researchers. Participants were also consulted to ensure that themes were an accurate representation of what was said in interview.

The researcher also acknowledges potential effects of gender differences. All of the participants involved in this study are male. Patients within forensic settings often have some evidence of negative attitudes towards females (Webster *et al.*, 1997) which may affect the relationship during interview. The young age of the researcher in relation to some of the respondents and her socio-economic background may have a similar impact upon analysis and the participants' interactions during interview.

5.3.3 Brief description of IPA methodology

IPA is underpinned by theories of both phenomenology and symbolic interactionism and its phenomenological origins are based on Husserl's philosophy (Smith *et al.*, 2009) The central aim of this approach is to understand the meaning that "particular experiences, events, states, hold for participants" (Smith & Osborn, 2008, p.53).

IPA accepts that individuals give a subjective account of their experiences that is based on their interpretation of events rather than an unbiased factual account. During the interview the participant attempts to make sense of their experiences and the researcher attempts to make sense of the participants' understanding. The researcher therefore attempts to balance an

empathic hermeneutic to aid the participants' understanding, whilst also developing an inquiring hermeneutic to develop their own understanding. Symbolic interaction and hermeneutic traditions accept that the meanings which individuals hold are a result of their interpretations of interactions with others, and so transparency regarding the interests of both researchers and participants is necessary (Brocki & Wearden, 2006).

IPA analysis involves the building of a logical understanding through systematic interrogation of the data. The aim is for the researcher to work reflectively to identify patterns and themes both across, and within, the narratives of each participant (Landridge, 2008). High quality analysis will incorporate both these broader themes and specific details, such as metaphor and language, in order to aid a complete understanding.

Davidson (1992) outlines three basic assumptions important for working from an interpretative phenomenological perspective: intentionality, temporality and meaning. Intentionality is the idea that a person is the agent in pursuit of a particular goal. Issues regarding 'intentionality' in schizophrenia may be considered similar to imprisonment, war or natural disaster in that it temporarily affects the person's ability to pursue their goals due to illness and hospitalisation (Davidson, 1992). 'Temporality' refers to the long term nature of activity. In IPA research schizophrenia should be considered as impacting across lifespan. The final assumption is 'meaning'. IPA suggests that actions are not isolated events, rather they are related in meaningful ways. Therefore, psychotic episodes may affect the patients' interpretation of the world and themselves as dangerous or unpredictable (Davidson, 1992).

Brocki and Wearden (2006) suggest that many researchers employing IPA methodology believe it to be a useful supplement to quantitative methodology. It enables an in-depth exploration of the complex meaning which people attribute to events, rather than simply providing the statistical outcomes provided by quantitative data. Smith and Osborne (2008) specify that IPA is particularly useful when the research matter is "concerned with complexity, process or novelty."

A range of qualitative approaches were identified and explored for this analysis, but full explanation of the decisions taken is beyond the scope of this discussion. In brief, IPA was selected for the following reasons; firstly, it allows exploration of the experience of patients attending a treatment programme that is novel to both patients and staff; Secondly, the inductive nature of IPA allows for and acknowledges the effect that the researcher's

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experience and theoretical knowledge may have upon the process (section 5.3.2) (Brocki & Wearden, 2006); thirdly, it is a simpler approach for inexperienced researchers (Dallos & Vetere, 2005); finally, it allows an exploration of the processes that facilitated the positive clinical outcomes outlined by Laithwaite *et al.*, (2009) in their quantitative evaluation of the RAP programme.

5.4 Procedure

5.4.1 Ethical considerations

Lothian Ethics board had previously approved the quantitative evaluation of the RAP programme (Laithwaite *et al.*, 2009). A substantial amendment was then submitted to add a qualitative element to the evaluation. As part of the amendment the current author's name was added as a researcher of the qualitative component. Ethical approval was granted by Lothian Ethics board, The State Hospital Research and Development Committee and the Ethics Panel for the University of Edinburgh Doctorate in Clinical Psychology (Appendix 4). The key ethical issues were addressed at this stage and are as follows.

5.4.2 Informed consent

Carpenter and Conley (1999) describe ethical issues specifically in relation to research with patients in a secure environment. The authors highlight the possibility that symptomatolgy and cognitive deficits may impair a patient's capacity to give informed consent. To safeguard against this, only patients identified by their Responsible Medical Officer as being able to give informed consent were approached (Appendix 5). The researcher approached patients and provided details of the study and an information leaflet (Appendix 6). They were given a minimum of one week to read this and decide whether to participate. If patients were still willing to participate they signed the consent form (Appendix 7). Some critics argue that the researcher should not be involved with seeking consent, while Carpenter and Conley (1999) disagree with that rationale. Firstly, the researcher should never be removed from the personal responsibility for the integrity of their research. Secondly, the researcher can monitor the ongoing consent process rather than a one off meeting. Thirdly, if another clinician directly involved in their care approaches the patient then this arguably adds to the sense of coercion.

5.4.3 Confidentiality

Issues regarding confidentiality were explained to participants when first approached for consent and prior to interview. Participants were informed that the information provided during interview would not affect their main care and treatment and that interview transcripts were not stored with their main medical files. No information about their interview would be supplied to the clinical team unless there was reason for concern about their safety or the safety of others. This information was provided to participants in both verbal and written form.

5.4.4 Data storage

Tape recordings were stored digitally in a password protected computer, housed in the hospital Psychology Department. Entry to the Psychology building is through three computerised entry gates that require the presentation of both a staff identification card and corresponding pincode.

All identifying information was removed from the transcripts that were held electronically on the computer described above and a secure laptop.

5.4.5 Participants

Many qualitative methodologies aim to develop themes and theories of the broader population, but IPA studies tend to study divergence and convergence in small sample sizes (Brocki & Wearden, 2006) The sampling in IPA methodology tends to more purposive and homogenous as it aims for depth of analysis rather than representative samples (Touroni & Coyle, 2002).

Eleven participants were approached to take part in the study. Two declined at first approach and one changed his mind on the day of the scheduled interview. They explained that they were reluctant to take part as they were nearing discharge from the hospital and did not want anything to interfere with future plans.

In accordance with the guidance above, a total of eight patients were ultimately interviewed as part of the current study. This surpasses the figure of five (plus or minus two) which is recommended for time-limited doctoral IPA studies (Dallos & Vetere, 2005). As this psychological intervention is intended as a pre-discharge group there were a finite number of

patients remaining within the hospital at the time of data collection. It was therefore felt that gaining a complete representation of the views of all patients remaining would be beneficial. The patient details and relevant information for analysis are contained in Table 1 and case studies (Appendix 10). Patients provided consent for the researcher to review their files to obtain up-to-date information. All names and identifying information has been changed in the interest of confidentiality.

5.4.6 Development of interview schedule

Semi structured interviews were employed in the current study. This is a preferred form of data collection within IPA research as it provides participants with some guidance regarding the nature of the interview, whilst still allowing the participant to provide a greater depth of information (Willig, 2001). The researcher attended a one day workshop on IPA run by Paul Flowers, University of Glasgow. Based on information and advice provided within the workshop and additional reading, a semi-structured interview schedule was developed (Appendix 8). This was then reviewed by two supervisors and modified based on their comments.

5.4.7 Pilot interviews

A pilot interview was conducted with a facilitator of the RAP programme. This was to allow the researcher the opportunity to improve interview skills and also led to modification of the semi-structured interview schedule. For example despite RAP being founded on CMT there was, surprisingly, no discussion of compassion. It was unclear whether that was a result of the subtle processes involved or due to an absence of compassion in the group. Therefore specific questions were incorporated that enquired into the experience of compassion in the group (Appendix 8). Whilst the research focus was different in the pilot interviews due to the facilitator's role, the research focus and exact research questions, it still provided specific queries that were incorporated into the final interview schedule (Appendix 8). The pilot interview also provided an indication as to the duration of the interviews. Length of interviews ranged from thirty minutes to one hour and twenty minutes.

5.4.8 Transcription

All interviews were initially transcribed verbatim and were sensitive to the individual's accent, pauses in narrative and background interruptions. This was useful for the researcher to immerse herself in the data. However, this level of detail can make the 'Theme identification and analysis' section of the document more difficult to read. IPA does not require a highly detailed transcription as it aims to interpret meaning and the transcription in itself is an interpretive activity (Smith *et al.*, 2009). Therefore, there have been some minor changes made to the extracts since transcription. These include the removal of minor interruptions, spelling has been corrected to more conventional formats and the phrase "you know" has been removed, as has repetition of words (unless considered important to the meaning of the text). All removed parts of transcript have been symbolised in the extracts by an ellipsis. Information removed for confidentiality is stated in parenthesis. An example of a transcript is provided in (Appendix 9).

5.4.9 Analytical strategy

Interviews were analysed in accordance with procedures recommended by Smith *et al.* (2009) and Landridge (2007). These procedures were intended to act as a guide, but were adapted based on the specific needs and preferences of the researcher. Key principles of IPA methodology include development of themes in relation to specific individuals prior to developing shared group level themes. The types of themes identified should also be initially descriptive in nature prior to deeper interpretive analysis. These are the only prescribed requirements of IPA as the method does not aim to achieve objectivity through standardised procedures (Brocki & Wearden, 2006). Therefore, as an inexperienced researcher in IPA methodology, there were some adaptations to the strategy to assist the process, which will be discussed.

Transcripts were initially entered into NVivo 7 for analysis. This is a computer package that helps to organise qualitative data. The researcher found the software restrictive in terms of the depth of the analysis and resulted in an ordering of the themes that were felt to be more akin to content analysis. Barbour (2008) has argued that this use of Computer Assisted Qualitative Data Analysis is problematic for some researchers, and that it should not automatically replace other forms of analysis. A more traditional form of analysis was therefore used instead:

The interviews were transcribed and the audio was listened to repeatedly in order to become immersed in the data and to gain a sense of tone of speech, humour and subtlety that is not clear from merely reviewing the interview transcripts.

The transcripts were also read and re-read in order for the researcher to ensure that the interpretation accurately reflected the interview. Three types of annotations were made in the right hand margin: descriptive comments to summarise the data; linguistic comments exploring specific use of language; and conceptual comments that began to analyse and question the content of the material (Smith *et al.*, 2009). The interview was later re-read noting broader themes in the left hand margin. The themes were not static at this stage. Analysis in IPA is iterative and should be revisited later in light of new material and knowledge from relevant literature (Landridge, 2007).

The themes were first listed in chronological order and then re-ordered into a more theoretically relevant way that was based on common themes and relationships (Landridge, 2007). Based on this list, a table of themes was produced that detailed the presence of themes for each participant. This visual representation allowed larger themes across participants (super-ordinate) to be easily recognised. Super-ordinate themes indicate discussions of a similar topic between participants. However, there may still remain variation between participants' narratives, due to presence or absence of different subthemes at an individual level. A summary table of super-ordinate themes is provided (Table 2).

Once Table 1 had been completed for a participant, the process recommenced with the next transcript (Landridge, 2007). The researcher had an awareness of the themes that had emerged from the previous respondent, but in order to sustain an idiographic approach, notes were made of the novel themes and of any convergences with and divergences from previous transcripts. As new themes emerged, the researcher returned to previous transcripts to ensure that data had not been missed.

Once all eight transcripts had been analysed, a master summary table of themes was produced (Table 2). This detailed the themes that were present for each individual and whether the participants' narrative converged or diverged from the group theme. This allowed the researcher to gain an immediate sense of patterning of themes that could be explored further during the final analysis (Smith *et al*, 2009).

The transcript and interpretation at each stage of analysis was discussed with professionals and academics with knowledge of the field. Emphasis was placed on further interpretation and analysis of recurrent shared themes (Landridge, 2007). A subset of participants was also asked whether themes accurately reflected the content of their interview. This ensured quality and made participants involvement in the research process inclusive in line with the user-movement (Wallcroft & Bryant, 2003).

5.4.10 The researcher's reflective diary

Smith *et al.* (2009) recommend the use of a reflective diary during the researcher's investigation. Smith (2004) argues that the quality of the final analysis is dependent upon "The personal analytic work done at each stage of the procedure," (p.223) A diary note was made following each interview and at significant points in analysis. These notes will be detailed in the participant case studies (Appendix 10) and reflected upon more generally throughout the analysis.

5.5 Ensuring quality in IPA methodology

Debates are ongoing regarding methods to ensure quality in qualitative research. This issue is complex due to the large variety of approaches. Diversity of methodologies is a strength of qualitative research, as it allows the flexibility to explore unique topic areas in the most appropriate manner. Unfortunately, this diversity of methods also makes it difficult to apply clear criteria for assessing validity of projects (Yardley, 2000). Yardley (2000) however, outlined four criteria to assess quality in qualitative research; 'sensitivity to context; commitment and rigour; transparency and coherence; impact and importance'. These four areas will be discussed in turn, allowing reflection about the relationship between the criteria and the current study:

5.5.1 Sensitivity to context

It is important to be sensitive to the theoretical context of the research. The Introduction to this study provides a broad outline of relevant topic areas; concepts of psychosis; concepts of recovery; and other treatment approaches within the field. This review of the literature allows the researcher to be aware of the knowledge that may be affecting the research process.

It is also important to be aware of the socio-economic and cultural backgrounds of both the researcher and the participants, who are the focus of the study. Therefore, section 5.3 and Appendix 10 are devoted to exploring both participant and researcher characteristics to make these issues transparent (Yardley, 2000).

As mentioned earlier, it is important to be aware of the potential power imbalance between the researcher and the participant. Some researchers have attempted to address this by meeting with patients in more relaxed environments and wearing non work attire. This was not possible in this research setting. The researcher did, however, emphasise that the study was for fulfilment of an academic qualification and did not affect care and treatment.

5.5.2   Commitment and rigour

'Commitment' refers largely to the skill of the researcher. As a Specialist Psychological Practitioner, the researcher is a novice in this form of research. The researcher was, however, aware of this potential weakness and therefore did considerable background reading and attended a workshop on IPA methodology. She also ensured that the supervisors involved in this project already had substantial experience in conducting qualitative research. Commitment was also a consideration in the selection of research methodology (Yardley, 2000). IPA is arguably more suitable for a novice researcher, working within a restricted time-frame, than grounded theory which has substantially more variants within the theory making it harder to learn.

'Rigour' refers to the completeness of the data set and whether it allows enough depth and breadth of information for the task. Dallos and Vetere (2005) advise that smaller samples are recommended in time-limited projects such as theses for Clinical Psychology doctorates. In order to retain an idiographic focus they recommend a sample size of five (plus or minus two). The current study interviewed eight participants in total. It involved a cohort of one group that attended at the same time, plus participants from other groups as a comparison. The current study therefore has both breadth and depth of information. The analysis was similarly thorough (see analysis procedure).

5.5.3 Transparency and coherence

Transparency relates to the clear presentation of findings. A detailed description of the research included both contextual factors and interview schedule. The results section also includes verbatim quotations to allow clarity and transparency. The extensive use of quotation allows the reader to also judge for themselves the validity of the researcher's interpretation.

As a means of triangulation, themes were discussed with both participants and researchers during the analysis process. This aimed to ensure that identified themes were persuasive and clear. The themes must be "not only a probable interpretation, but also the most probable," (Landridge, 2007, pp.157).

5.5.4 Impact and importance

Yardley (2000) argues that it is important that the research has an impact on wider society. This is undoubtedly the case in the current study which may lead to re-evaluation of patient concepts of psychosis, and their views on the recovery process. It may also have implications on the treat of patients within high secure forensic settings.

6   CASE STUDIES

Maintaining an idiographic approach is more complex in large sample IPA studies. Therefore, it is recommended that analysis commences at an individual level prior to searching for themes across participants (Smith *et al.*, 2009). Based on these recommendations, and in the interests of transparency, case studies have been prepared and included in Appendix 10. The case study includes background file information for all participants and a brief summary of the main themes emerging from each transcript. Themes are cross referenced with the numbered extracts in section 7. In order to enhance the readability, full analysis of extracts will occur only within the 'Theme Analysis and Identification' (section 7). All names and identifiable material have been removed or modified for the purposes of confidentiality. A visual representation of the themes for each participant is provided in Table 1 and follows for quick reference:

6.1 Summary of participant characteristics

	Dom	Danny	Paul	Roger	Tom	Robert	Stevie	Sam
Age	48	35	45	26	34	46	47	39
TSH date of admission	2006	2006	2001	2005	2008	1997	2007	2006
First contact with psychiatric services	1996	1996	1987	2004	2001	1992	1997	1994
Diagnoses	Paranoid psychosis	Functional illness such as paranoid schizophrenia or schizo-affective disorder or drug induced psychosis.	Paranoid psychosis	Paranoid schizophrenia. Drug induced psychosis	Paranoid schizophrenia	Paranoid schizophrenia. Schizo-affective disorder	Paranoid schizophrenia Mental behavioural disorder due to multiple drug use	Paranoid schizophrenia
Index offence	Murder	Murder	Murder	Culpable homicide	Attempted murder	Murder	Explosive substances	Murder
Ward type	Continuing care	Continuing care	Rehabilitation	Rehabilitation	Rehabilitation	Continuing care	Continuing care	Continuing care
Previous input from researcher?*	Yes	Yes	NO	No	No	Yes	Yes	No
RAP start date	22.10.08	22.10.08	22.10.08	7.3.07	7.3.07	13.2.08	22.10.08	22.10.08

Table 1: A summary of participants' characteristics.

*RAP referral criteria includes previous therapeutic intervention. This information is merely to enable transparency for potential bias in results.

7   THEME IDENTIFICATION AND ANALYSIS

As outlined in the description of IPA methodology, this form of analysis often incorporates the identification of themes with reflection on the current literature (Landridge, 2007). In a sense the sections referred to as 'results' and 'discussion' in quantitative studies are combined into one narrative entitled 'Theme Identification and Analysis'. This allows transparency in that the reader can follow the development of the researchers' understanding and is able to easily refer to the extracts that support their interpretation of the data.

7.1   Themes overview

Six super-ordinate themes emerged in the patients' responses: 'limited resources as consequences of upbringing'; 'mistrust'; 'fragility of the mind'; 'institutional barriers to recovery'; 'self reflection and understanding'; and 'personal development.' These super-ordinate themes were comprised of a further twenty sub-themes across all participants. The super-ordinate themes are represented in a summary table of themes (Table 2). Smith *et al.*, (2009) suggest the use of summary tables in larger samples. There is currently no agreement between IPA researchers regarding the adequate level of recurrence to signify the presence of group themes. In the current study a group level theme is defined by recurrence rates of over 50% based on recommendations of Smith *et al.*, (2009).

Super-ordinate themes	Dom	Danny	Paul	Roger	Tom	Robert	Stevie	Sam	Group level?
Limited skills as a consequence of upbringing	Yes	Yes	Yes	Yes	Yes	No	No	No	Yes
Fragility of the mind	Yes	Yes	Yes*	Yes	Yes	Yes	Yes	Yes*	Yes
Mistrust	Yes	Yes	No	Yes	Yes	Yes	No	Yes	Yes
Institutional barriers to recovery	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Self refection and understanding	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Personal development	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Table 2: The recurrence of themes across participants
*=The participant's perspective differs significantly from the group theme.

Differences emerged between participants in terms of the stage of recovery they felt they had achieved by the time of interview. This had implications for the themes they discussed and their ability to articulate their responses. Case studies (Appendix 10) and Table 1 provide information regarding the patients' backgrounds and current situation. Patients residing in rehabilitation wards tend to be closer to discharge from the hospital and seemed to speak more about their experiences. Their ward provides some indication of their stage of recovery from a staff perspective. In order to maintain an idiographic approach, themes will be discussed with relevance to the individuals' situation. Connections between these themes and current literature will be provided throughout the analysis and summarised at the end of the chapter.

Each super-ordinate theme will be introduced in turn with the relevant sub-themes. The interconnections between themes will be discussed in the prose and displayed diagrammatically in Figure 2. As can be seen in the diagram, the 'zone of isolation and the removal of self efficacy' includes three interconnecting themes that enhance isolation and destroy faith in the ability to both make decisions and know whom to trust. These themes include; 'fragility of the mind'; 'mistrust'; and 'institutional barriers to recovery'. The central themes on the diagram identify aspects of both their illness and their environment that lead to isolation and restriction of thought.

Predisposing characteristics identified in 'limited resources as a consequence of upbringing' enter the 'zone of isolation and removal of self-efficacy' from the base of the diagram. This is to illustrate factors that increase the person's vulnerability to becoming trapped and isolated.

Recovery is possible through the opportunity for self reflection and understanding within the safe environment of the RAP group. This developed the patients' confidence to try and develop new skills to recover in 'personal development'. The participants' narratives appear to present a journey of personal development from their early upbringing through their illness, and hospitalisation and towards hopes of recovery. The themes will be discussed in a sequence from the base of the diagram in order to mirror this journey of personal development and recovery.

During the discussion references are provided that relate to relevant interview extracts within this document. For participant' quotations where a full extract is not included in the document, line numbers are provided that refer to the relevant sections of transcript.
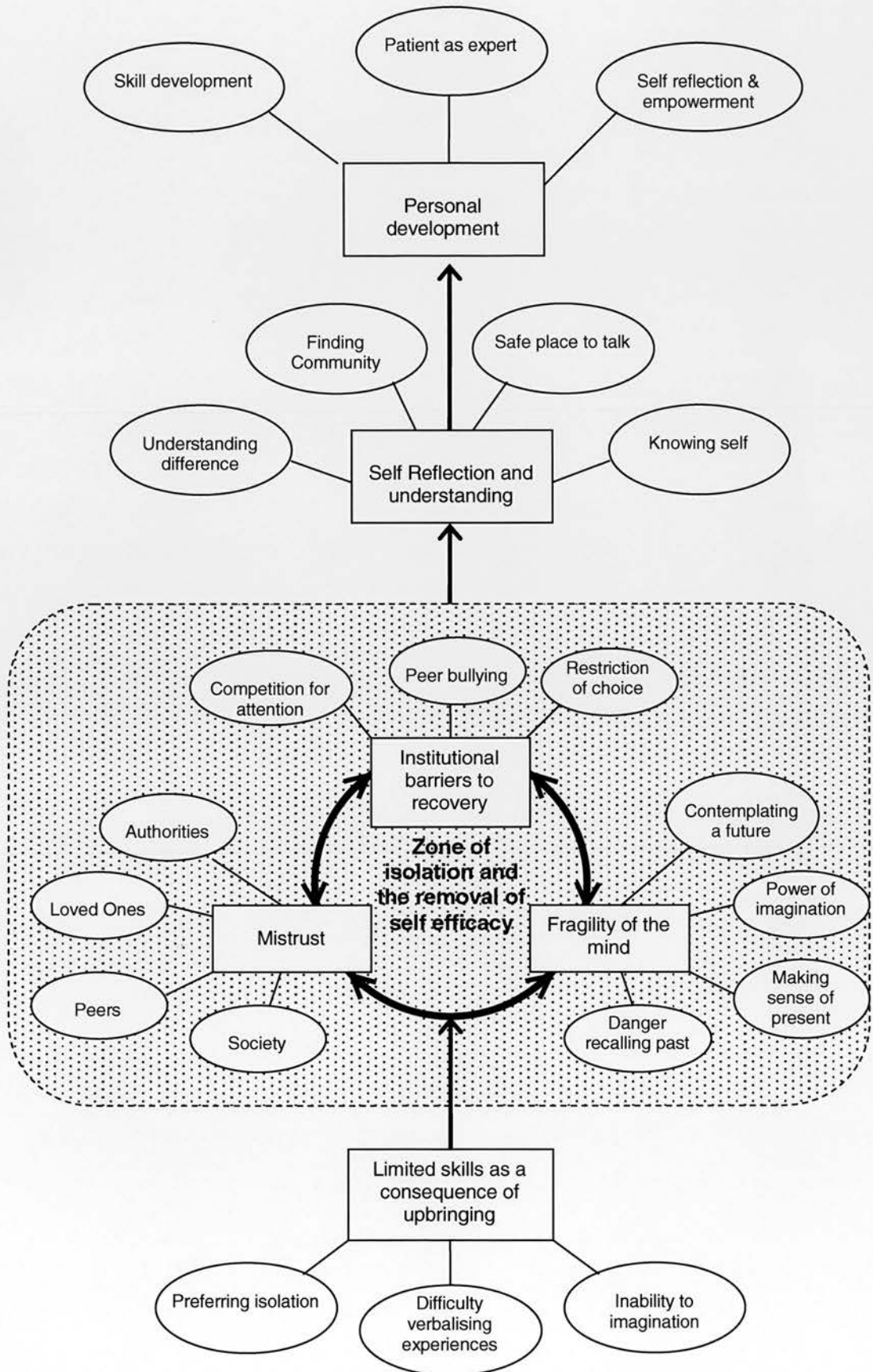
Figure 2. A diagrammatic illustration of themes

7.2   Super-ordinate theme: Limited skills as a consequence of upbringing

The theme of 'limited skills as a consequence of upbringing' was seen in the interviews of Dom, Danny, Paul, Roger and Tom and refers to participants' descriptions of struggling to meet the expectations of the clinical staff, due to their early life experiences and specific personality traits. In contrast Robert, Stevie and Sam felt that they had more positive upbringings.

> Extract 1: Paul; 508-513
> Just worried... that it would be beyond me and I couldn't cope with it...   I wouldn't know what to do...   But I don't think that anything happened in the group that was beyond me and that I couldn't cope with, with a bit o' help of course.   I mean there was always people there to ask.

Paul describes worries in relation to the perceived limits to his capabilities (Extract 1). The repetition of the word "beyond me" signifies the belief that some skills are unreachable and beyond his capabilities. Paul acknowledged he had poorer expectations regarding his abilities than he demonstrated in reality. The 'safe place to talk' (section 7.6.1) experienced in the RAP group, provided the necessary reassurance and support for him to overcome feelings of self doubt. Later, in 'personal development', (section 7.7.2) Paul highlights that by the end of the programme he has adopted a role of expert patient helping his peers (Extract 91; Extract 92).

Roger also describes in Extract 2 struggling with group tasks. He regarded himself as having poor memory for session material. Unlike Paul (Extract 1) this belief appears more pervasive:

> Extract 2: Roger; 290-291
> I think the groups alright, it's just the memory part. Keeping them in your heid.

Despite his negative appraisal of his memory abilities, Roger is still able to recall programme content two years after the group. This surpasses expectations based on research into the ability of non-clinical samples to retain learnt material (Williams, 2010). This suggests that while ability to remember information has been found to have an important impact on outcome (McGowan *et al.*, 2005), mild learning disabilities and lack of confidence in intellectual strengths may be overcome through the use of metaphor, the salience of the topic and high levels of patient participation.

Later in the interview Roger explained that the clinical team wished him to repeat psychological therapies due to a limited recall of the programme (Extract 49). The consistent

message from staff that Roger's memory is poor may consolidate his potentially inaccurate belief that he has attained limited benefit from participation in the programme.

7.2.1 Limited skills as a consequence of upbringing: Preferring isolation

Danny, Paul, and Tom described a wish to live and fulfil their goals independently:

> Extract 3: Roger; 169-172
> I: What makes you like to keep things to yourself?
> P: It's just the way I've always been. I've always wanted ta be myself. Like when I was young I didn't want ma mum or ma dad around with ma mum. A just wanted ta look after myself but ma dad was always there and I just always liked to take care of ma things for myself. A just wanted to be number 1. Just by looking out for myself and taking care of myself.

Roger has high expectations for himself, but it is important that he can achieve these without assistance (Extract 3). He explains that his father was around during his upbringing, but he would have preferred him not to have been. It is unclear whether wanting to be 'number 1' reflects difficulties in relating to others and accepting that people have reciprocal needs or whether it is a lack of appropriate care giving by his parents. Despite his preference for seclusion and independence, he acknowledges the benefits of sharing information as a group. The reasons he was able to achieve this are explored in the subordinate theme 'self-reflection and understanding' (section 7.6).

Danny also had difficulties initially with the group environment due to social anxiety. Social anxiety has been shown to be higher in patients with psychosis (Malberg *et al.*, 1998). Danny describes in Extract 4 avoiding large social groupings and preferring to talk with people on an individual basis. He believes that his main achievement in the group was overcoming these anxieties. The potential reasons for this progress will be discussed further in section 7.6.1.

> Extract 4: Danny; 70-84
> P: At first it was a bit nerve wracking. I wasn't too comfortable 'cause the the a was actually in a group and couldn't avoid. When a go to the gym a go with a lot of people but see sitting in a group, a kin avoid it in the hall in the ward sometimes... I just avoid a big group of people. When I talk I prefer a one to one or a couple of people to one. So I prefer that kinda thing. Eh but as the group went on it got easier and easier. Like you's told me about anxiety goes up so much that it needs to come back down so eh, that did help you's saying that 'cause a was really anxious. Ocht a knew it was self... it could only go so, could only, you could only be so much anxious before it kinda settles you know so em it did help hearing that,

Danny describes the group as being a place he can "no longer avoid" people (Extract 4). The repetition of the word 'avoid' throughout Extract 4 emphasises the desire to flee from group situations when anxious. Towards the end of the extract he begins to refer to strategies he has been taught to help him interpret past anxiety provoking situations and link this knowledge to experience.

Paul describes in Extract 5 that he can also be quite a quiet person. He believes that the clinical team tend to interpret his more solitary behaviour as an indication that that he is not motivated to participate and lacks emotional expression. Extract 5 led the researcher to question the degree to which institutions allow for individual personality differences, rather than favouring a pre-defined notion of what constitutes mental wellbeing. Future research may wish to explore staff perceptions of recovery in The State Hospital.

> Extract 5: Paul; 410-423
> I've always been quite a quiet person really an' eh so a think it's hard sometimes for, people to understand how [Paul] is because ... some of the time I just didn't speak. That's why a felt that it was important to try and participate as much as a could in the group so as the staff could see that.. I do have feeling's and I care and I want to participate. It's just that I like going to my room at night and just watching Coronation Street and all that kind of thing and I am quite quiet but, a don't like to be alone all the time.... sometimes a can be in a group but I'm still quite quiet in it but I'm glad to be part of it ...and be able to ... participate in it if I need to.

Tom describes in Extract 6 finding initial groups difficult because he was more "withdrawn" than his peers. He explains that he is more isolative as a result of both personality and psychotic symptomatology. "Psychotic feelings" and anxieties impacted upon his ability to encode information presented in the group. The use of metaphor "the temperature is on" illustrates the pressure felt by Tom in initial group sessions. This pressure subsides after the first couple of sessions with a reduction in psychotic symptoms. He appears to closely connect his anxiety to his psychosis:

> Extract 6: Tom; 165-175
> P: It is pretty nerve wracking together. Once I got on I got it was alright. The temperature's on for the first 2 weeks, it was harder but after that there was nae big problem.[raises and lowers hand]
> I: Mmh. Up and down in terms of ...[raises and lowers hand]
> P: Other people, see I'm no a great one for sitting with people. I've always been that way. But. Ocht. I'm quite happy with this. But I'm better withdrawn from people. Ah. Once I was in there for two or three weeks, a started, listening to what was said. Started getting' over the psychotic feelings.

As described in Figure 1. Social isolation in schizophrenia is also a defining characteristic of the disorder (APA, 1994). Social withdrawal is regarded as a common reaction for patients suffering from psychotic disorders (Boyd & Gumley, 2007). The extracts above however, suggest that for some patients with psychosis, isolation is a pre-disposing factor in mental illness rather than solely part of the behavioural presentation of the condition. The period in which the person first became socially withdrawn is difficult to determine retrospectively and therefore it is important that clinicians seek to understand the person behind the illness. This may enhance both accuracy of diagnosis and suitability of treatment.

7.2.2 Limited skills as a consequence of upbringing: Difficulty verbalising experience

Dom, Paul and Tom described a difficulty verbalising their experiences. This appears to be due to two factors; firstly, the enormity of the participants' experiences are difficult to articulate and "It cannae be put in tae words" (Tom: 198). Secondly, the participant's limited education, results in a poorer range of vocabulary for self expression. During the programme all participants were asked to write a compassionate letter to themselves about their experiences. Extract 7 describes how Dom found it difficult to summarise in a letter the 'wild' experiences of his past:

> Extract 7: Dom; 74-80
> The problem was actually putting it into words...'cause these experiences that you have are pretty wild... you have, gone by the boundaries of ...what is normal and it was hard to express ... these experiences that I've actually been through. It's hard to write down on paper eh, hard to talk about let alone write down on paper..

Later in his narrative Dom elaborated by explaining that the most difficult element was attempting to write with self compassion. In Extract 8 he explains that he always had difficulties with self appraisal, particularly giving himself praise. This may be related to Dom's experiences of childhood sexual abuse, the incidence of which are higher in the sufferers of psychotic disorders (Morrison *et al*, 2003). Extract 8 has resonances with the work of Gilbert (2005) suggesting individuals with a history of childhood abuse are likely to internalise blame and find it difficult to be compassionate to oneself. McGowan *et al*., (2005) highlighted the tendency for some participants with traumatic histories to hold onto feelings of shame. This appears to be the case for Dom who described finding it hard to be self soothing. More preparatory work would have been useful so that this patient could understand the function that shame has in his self concept.

Whilst Dom describes self appraisal as a long established difficulty, he did recognise he had "softened down" in recent years, suggesting that Dom perceives praise and self-appraisal to be "soft" qualities. Whilst he recognises the 'softening' of some traits, he regards the difficulty with self appraisal as an enduring and unchangeable aspect of himself that may not be amenable to change through psychological interventions:

> Extract 8: Dom; 46-68
> P: Sometimes I find it hard to express myself. I don't go for praise very much and I don't like praise, self appraisal and this was what the letter was really. It was telling you that you're alright and been through hard times, things will be getting better, you're doing well. Em it's all kinda self appraisal and I find it very hard to do that. I always have I think I have more softened down ever such a great deal....
> I: You said that that's something you find difficult to do, to appraise yourself. {{yeh. A always have}} What was difficult about that for you?
> P: Self appraise? Eh it's just something I've been born into really. It's part of ma make up...the way I've been brought up. It's just me as an individual. ...I think the rest of the guys there caught on well with the letter and it was just me as an individual eh as a say I've been a bit hard with self appraise....

Paul also found the letter one of the most difficult aspects of the programme (Extract 9). McGowan *et al.*, (2005) found that logical thought was a skill that developed during therapy rather than a being a requirement prior to commencing therapeutic work. Paul displayed the ability to develop this skill through the course of the group, whereas Dom did not. Paul was initially concerned about his ability to write a letter due to a lack of practice writing, but with group support he was able to overcome concerns regarding his abilities and write a letter he was proud of:

> Extract 9: Paul; 142-179
> P: Well, I got a bit worried in the sessions...we had to write a kinda letter to ourselves and I got a bit worried about it because I thought that a couldn't I wouldn't be able to do it, but I think with the time that was spent going over it and what we needed to do and all that.., it became quite easy when a actually sat down and to do it... By sitting down in my room one night after one of the facilitators come to see me up here and I spoke to them about it. Then I managed I just went to ma room and sat and done it that night and it wasn't really a, terribly hard thing. ...
> I:... What was it about that that made you worry?
> P: Well, I think it's just that I'm not a great writer. I don't really write I used to write letters and things when a first came into the hospital but, it's been years that have gone by that a had a never really had to sit and think... So I think I just worried that I just thought negatively and thought I wouldn't be able to do this. But, I was perfectly able to do it.
> I: Mmh. And you said that you then were able to do it. How did you find that doing it in the end?
> P: Eh, a quite enjoyed doing it.

Paul has not experienced the same traumatic early life events as Dom. Paul's upbringing was loving, but lacked consistent parental guidance. Extract 10 explains that Paul's upbringing made it difficult for him to write about his experiences.

> Extract 10: Paul; 317-334
> I wasn't very, a wasn't very, a was never confident at school… nobody really challenged me about it so a got away with it whereas if I'd had a normal life… living with a family, I would've had a mum and a dad saying 'get to school' and all that kind of thing, but I didn't have that so I didn't go because…I felt, em shy in the class. I found it hard to put my hand up. I hated reading in the class. I just felt embarrassed. It was easier just to go to work. I worked in a dairy and like I never really spent any time at school in the secondary school. So I suppose its about what you learn at school as to know to interact with all these people in the classroom which I think I have kinda learnt to do in TSH because I've been on so many groups…had no choice.

Extract 10 commences with stammering and is symbolic of the difficulties with language which he is describing. There were no appropriate role models during his childhood to act as sources of motivation and encouragement. He regularly truanted as he had no parental figure to raise concerns about his academic progress. He recognises both the academic and social consequences of this upon his development. He describes an uncertainty in relation appropriate interaction in group and social situations. Since his admission The State Hospital team has fulfilled this role of parental figure, encouraging his participation in group work. The clinical team has successfully provided a secure base (Goodwin *et al.*, 2003). Extract 10 contrasts sharply with the theme 'institutional barriers to recovery'. He is confident that he has now developed the social and academic skills which he was previously lacking.

7.2.3   Limited skills as a consequence of upbringing: Inability to imagine

It is discussed in 'fragility of the mind' (section 7.3) that Dom found imaginative techniques such as the 'ideal friend' "extremely dangerous" (Dom: 449). He believed that to open the mind to other possibilities could increase the risk of relapse. Extract 11 demonstrates that, for Danny, the ability to imagine an 'ideal friend' was not something to be feared, rather it was something completely inaccessible to him.

Extract 11: Danny; 126-159

P: I thought if I could get it to work it would be pretty good you know. But a found it really hard doing it…but a think that can be helpful sometimes. You're strugglin' or something'… on a bad day, you can imagine new friends givin' you compliments…Saying, you've had bad days before it can only get better. That would be helpful if I could do it but it's a wee bit tricky that one.

I: You found it a bit tricky. What was tricky about it?

P: I can imagine ma daughters and that and ma sons. I think of my ex's and that…but thinking of something I don't know. Imagine imaginary. That's what I found hard.

I: Okay. You found the imagery quite difficult? the imagination? What is it about that?

P: I just can't do it. I just think of a person there giving you good advice. You don't get that much in the hospital...

I: You don't tend to get that in the hospital?

P: No. I've obviously have got questions for staff or something. What about me? or who've a got comin' ta visit? What was I trying to say here? aye eh most of the things that you do it yourself. It's you cope yourself, you struggle yourself or you're happy yourself you know. Does that make sense? you've got to do it yourself in here you know. Eh, through experience with living well with doctors and nurses it can be pretty dodgy. I'd ask them questions and he wouldnae know things he should know a thought at the time 'so that didn't help'.

Danny explains in Extract 11 that he is able to recall concrete examples of people that have been involved in his life in the past, but is unable to imagine or create a more abstract image. He explains that this is because he has very few examples of people giving him good advice within the hospital. He suggests that he has limited memories to refer to because he has always had to try to cope on his own. Within the hospital this feeling of receiving insufficient information, advice and support continues. He feels unsupported by medical staff and cannot use them as examples of compassionate responding. Being unsupported in the hospital is explained further in the super-ordinate theme 'institutional barriers to recovery' (section 7.5). In some ways Extract 11 reflects Bowlby's (1969) idea of the "stronger wiser other." This idea refers to the manner in which patients enter therapeutic settings feeling anxious and vulnerable to ill treatment and seek a 'stronger wiser other' for support. The staff role in this situation is very demanding. If services do not have time or facilities to allow this, staff can suffer what Gilbert (2005) referred to as 'compassion fatigue'. In these settings staff can often ignore their own needs whilst concentrating on the high demands of patients. Compassionate fatigue can manifest as withdrawal, isolation, loss of professional boundaries and loss of pleasure in work. Gilbert (2005) suggests that the risk of compassion fatigue is associated with lack of social support. Social support from supervisors to allow reassurance and time for reflection, is an important element in ensuring against this condition, maintaining the health of staff and quality of care for patients.

Dom found the use of abstract techniques, such as the use of metaphor, concerning as they were "too far out there" (Extract 12).

> Extract 12: Dom; 428-429
> When we were going on a journey it was just too much out there. It go to the silly stages like... packing a pair of socks for the journey...

Throughout the current super-ordinate theme, there is a sense that Dom finds it difficult to talk about more abstract concepts including; self appraisal; writing a compassionate letter; metaphor; and the use of the 'ideal friend'. This has been found to be a common difficulty for patients suffering from psychotic disorders (Gilbert & Proctor, 2006).

7.3   Super-ordinate theme: Fragility of the mind.

The interviews referred to the super-ordinate theme 'fragility of the mind'. Their minds were regarded as weak for becoming unwell, rather than strong for coping with adversity. The mind was believed to be susceptible to relapse, if it was exposed to thoughts of a damaging or distressing nature. For some patients, thoughts that were believed to be most damaging were memories of the past, for others, the danger was in imagining a future that may not happen. For many, imagination was either something that they could not utilise, or that they viewed as dangerous to use, due to the potential consequences. The interviews described a narrow range of thoughts that were restricted to the present and the observable.

7.3.1   Fragility of the mind: Danger of recalling the past

Danny, Paul, Tom, Stevie and Sam describe a reluctance to discuss past experiences. Extract 13 describes Danny's belief that memories of the past are difficult to cope with during psychosis. Some participants regarded time as a healer and the further away their experiences were the more they could recover. There is a sense that if they "dwell" (Danny: Extract 13) on memories of the past they risk destroying any progress they have achieved:

> Extract 13: Danny: 585-595
> ...in your psycho psychotic episode you can't really deal with it you know just, in this different world, everything's totally different. Some of it's no nice and some of it's alright... and when it's when it's scary when it's horrib when it's scary it's scary... But I got to the hospital and got treated and back home on with life again, so I don't really dwell on psychosis, I moved all ma life to get a life, ta get a job an a partner. I'd hope to move on from it you know and try and forget it.

Avoidance of the thoughts of the past are arguably a consequence of the distressing nature of thought. Danny's experience of psychosis is described in Extract 13 using extremely emotive language. His repetition of the word "scary" to describe his experiences explains his current fear of bringing memories of that period back into consciousness. The metaphor a "different world" highlights the way in which Danny distinguishes between what he perceives to be two separate worlds; psychosis verses normality. This may be related to feelings of isolation and stigmatisation experienced when unwell. Later in the interview he emphasised how this preference for thoughts grounded in the here and now affects his choice of treatment (Extract 14):

>Extract 14: Danny: 333-337
>We do the DBT group here the now, its good coz they look at the now instead of back or forward you know.

Extract 15 displays particular fears of recalling memories of his childhood. Tom has never spoken in detail about his childhood and avoids discussions on the topic, because he becomes emotional when he recalls the child abuse he suffered.

>Extract 15: Tom; 267-272
>You've got to try an bring back. See, I haven't spoken about ma childhood. [you haven't spoken about it] No, no in any detail. This I find difficult. It upsets me a bit minding what happened. The abuse I took. It can sometimes come back to me in the flashbacks on them.

Whilst Tom recognises a need to address the issues in his past, he finds it very difficult. The flashbacks and intrusions that Tom experiences are likely to enhance his belief that thoughts have the power to control the mind and behaviour, rather than the reverse. Briere (2002) suggests that thought suppression excludes these traumatic memories from conscious awareness, because of a fear that they will trigger an extreme emotional reaction that the patient does not have adequate skills to cope with. Unfortunately suppression requires a considerable level of cognitive resources and when this cannot be maintained, the flashbacks described by Tom can occur (Briere, 2002).

Stevie described his auditory hallucinations making reference to aspects of his past that he wanted to forget (Extract 16). These thoughts were then very difficult to stop reoccurring. The repetition of the word "over" emphasises the "ground hog day" (Robert: 84) experience in which patients feel that their symptoms and situation are repetitive and inescapable.

Extract 16: Stevie; 112-115
I: What made you not want to talk mentally to them?
P: Coz it brings out everything in the past, it brings it all forward. You just keep going over and over it and over it.

Extract 17 explains the upsetting nature of thoughts of the past. Sam feels as if he is "slipping" back into negative times. The use of the word "slipping" may be significant in terms of the uncontrollable, scary aspect of these thoughts:

Extract 17: Sam; 507-509
I have on occasions when thinking about that time in my life, I get a big sinking feeling in my chest and I get scared and I feel slip that I'm slipping to a bad place in my mind where I'm very upset about things.

Techniques used in the RAP group allowed Sam to consider his past as an undulating curve fluctuating between highs and lows, rather than an entirely negative experience (Extract 18). He felt this strategy allowed him to view his past more clearly than before:

Extract 18: Sam; 189-193
The variant inclines and declines in the graph represented, good, neutral or bad life and different periods of my life. This is bad life, this is better life, this is much better life and whatever, and I could see, I could look back and see my life clearer than now I'd ever seen before.

Similarly, Paul was positive about group discussions of the past (Extract 19). Paul explained that it has been six years since he last felt unwell. In the past he tended to push the memories of the past out of his mind and had not thought about his illness for a long time. During the group he found it useful to remind himself of what it feels like to have been unwell. It may be significant that Paul is the only respondent that has moved onto a less secure setting since the time of interview. This suggests that the ability to be comfortable with thoughts of the past may only be possible once the patient perceives themselves as recovered, and a safe distance away from their illness. This theme supports the findings of Laithwaite and Gumley (2007) who found that the detail of patients' narratives varied with their ability to contemplate the past, mentalise (Fonagy *et al*, 1998) and use reflective functioning (Bateman & Fonagy, 2006). It is suggested that there is a relationship between depth and detail of patients' narratives and the severity of their mental illness.

Extract 19: Paul; 203-218

..it's good to be reminded of the illness. A haven't been ill now for over 6 years. You can kind of put it to the back of your mind and not think about it and just hope that it never happens again, but I think it was useful when we had the discussions round the room with other patients ... saying things that happened to them and I got lots of identification with how they were feeling and things that they thought while they were unwell, and things like that, so it was really good and useful. I'd like to do that group again one day. If I'm still in hospital just to remind me of ma illness....

7.3.2   Fragility of the mind: Making sense of the present

'Making sense of the present' was a theme in the narratives of Dom, Paul, Stevie and Sam. Extract 20 illustrates the difficulty Dom has in making sense of philosophical, religious and other abstract concepts.   He finds the knowledge that certain ideas may be true has the potential to "blow your mind". These more abstract concepts seem to further blur his ability to distinguish between what is real and unreal:

Extract 20: Dom; 305-319

There is dimensions, scientists know there are dimensions and ... knowledge like that can blow your mind to a certain degree ... you can step over the line of. I'm trying to find the word for it... of reality basically and become involved in unreal things. I know certain things, I know that there's a God, God exists, that's enough to blow your mind. There is dimensions. There's Hell. Hell exists. That blows your mind as well. Eh hegar pergatory that exists as well. I don't know if Heaven does, but I take it for granted that it does. To know all of these things or learn all of these things can be mind blowing experiences and then what happens is it just comes to a great crescendo and because that is possible and this is possible and learning new things can blow your mind.

The language used in Extract 20 highlights the strength and power that thoughts and beliefs can have on a person's sense of being able to cope.   There is a clear fear that consideration of more abstract theories can "blow the mind" (Dom: Extract 20) and lead to the "great crescendo" (Dom: Extract 20) of psychosis. He describes "stepping over the line" (Dom: Extract 20) of reality into more delusional beliefs. It is interesting that places with negative connotations such as Hell and Purgatory are very real to him, whereas the existence of Heaven is less clear.

Extract 21 further describes past difficulties in distinguishing between internal thoughts and auditory hallucinations. Stevie believes that recovery commenced when he could start to objectively appraise situations once more and began to distinguish between his voices and his own thoughts. He currently believes himself to be still in the process of recovery, because at

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times he continues to struggle to distinguish between his thoughts and his auditory hallucinations. He developed techniques during the programme to address this difficulty. These will be discussed further in the theme 'personal development', (section 7.7)

> Extract 21: Stevie; 502-522
> P: Its just like putting things into perspective. Whereas before I would think, voices, aliens now I think me, my illness and I think about that. There was a lot of getting used to the fact that I wasn't hearing any voices, nothing strange was happening and my recovery started from there. It started from then even up to this day. I still think I am recovering. But I have recovered an awful, awful lot than what I was when I first came in here.
> I... what is continuing about your recovery?
> P: Well I can watch the TV now with no problem what so ever. Sometimes... I think about something and something similar is on the TV. Now I say to myself 'I would of actually believed that that was referring to me a few months ago, but now its no, I know it no.'....

Extract 22 describes the mental effort required for Danny to control these thoughts and "tricks" (Danny: 528) of the mind, whilst still managing to listen to the programme material. The use of the word "tricks" (Danny: 528) suggests that the mind is distinguished from the person and purposely antagonises the individual:

> Extract 22: Danny; 175-177
> kinda struggled through it. Ma head was done in so a tried to listen and control ma thoughts at the same time

Similarly Sam recognises ongoing symptoms of mental illness (Extract 23). Unlike other participants he is comfortable thinking about this due to a confidence that these problems will subside with time:

> Extract 23: Sam; 266-267
> last vestiges of being unwell that still exist in the healthy mind that
> will go away in time. The last the remnants of mental illness is still there which will go away in time...

7.3.3 Fragility of the mind: Contemplating a future

Dom, Danny, Paul, Tom, Stevie and Sam discussed their thoughts about the future, while Danny and Stevie tended to avoid thoughts of the future. Danny felt that making future plans would merely "tease" (Danny: Extract 24) him and result in disappointment and potentially depression or relapse.

> Extract 24: Danny; 316-337
> P: I can't look forward a can't see anythin' in front of me I can't see a future, a just see this place and that's it …I just kinda live here and that's it at the moment.
> I: can you tell me a bit more about …
> P: Just some people are here, and two or three are getting left whatever they do. [they plan to get] girlfriends when they go out with a nice house and a pub, go to barbecues an all that stuff. A just try not to listen cause I don't even think of the future. It seems a long time and I just kinda blank what they are saying 'cause a don't really look at the future a don't want to tease myself with motors, and motorbikes and engines and things. There is no point in thinking like that if I am in here

Danny explains in Extract 24 a belief that some patients will remain in the hospital indefinitely. He appears to fear that this may happen to him. He does not want to think about the future, because the attainment of those goals is something that is a decision of the clinical team and therefore not something he can personally control or strive for. This theme is likely to be particularly salient for Danny as he has fourteen years remaining on his sentence.

Tom explains in Extract 25 this lack of control regarding future plans can not only be disempowering, but also foster fears and anxieties. Past experiences of being in prison with a mental health problem makes Tom fearful of returning to that situation. This theme links closely to the super-ordinate theme 'institutional barriers to recovery' (section 7.5). The patient believes that he has no direct control over his future, and regards it as the clinical teams' decision:

> Extract 25: Tom; 175-178
> Ma fear is prison. They say I'll no go there. I've been here six years an two months. An' still no too sure whether they're gonna take it back to court.

Stevie also experienced anxieties regarding thoughts about the future, and tried to avoid thoughts or discussions on the topic (Extract 26). When Stevie first spoke about the future during the group he had "never realised that there was something ahead." Future plans were avoided, but are also highly important to him. It appears that he avoided thoughts of the future

due to a fear that he would not succeed. The only thoughts he was comfortable thinking about was "being in here and being safe" (Stevie: 334):

> Extract 26: Stevie; 281-313
> P: They looked into the future whereas I wasn't looking into the future. I just stopped. I couldn't see myself in the future, being well and whatever. But it was good to talk about recovery itself cause... I never realised that there was something ahead of me and that I could plan for things in the future...
> I:... ..[when] thoughts of the future came into your mind. How did you feel?
> P: I would just put them out my mind. Aye put them right out. Then I would end up thinking about it all day and trying to argue with it all day.
> I: Trying to argue with it?
> P: Well I would be like, shut up I don't want to think about you or being outside, or getting a job, shut up, I don't want to talk about it.......

This section of the transcript was particularly moving for the researcher and raised a series of further questions that she details in her reflective diary:

> Reflective Log (11 February.2009):
> I was struck by the patient's statement that he did not previously perceive a future. Is this the result of psychotic symptoms monopolising the thoughts of these patient or is it a result of the societal perception of psychosis as a pervasive disease and the hospital being viewed as an institution for long term detention? How can hope, self efficacy and motivation to change be enhanced if patients cannot conceive of a future out-with the hospital? How can we as clinicians make the idea of a more positive future more tangible for patients?

In contrast, to other participants Dom and Paul spoke openly and confidently about their future plans. Paul believes that planning for the future is an important stage in recovery (Extract 27). Unlike the previous participants, Dom and Paul do not regard themselves as currently unwell. There may be some association between perceived mental illness and the inability or unwillingness to plan a future. Poor reflective functioning (Fonagy *et al*, 1998) and mentalising (Bateman & Fonagy, 2006) may make it difficult for participants to not only think about the past, but also to contemplate a future.

> Extract 27: Paul; 287-298
> there was different parts of recovery like getting' back to work. Having some, positive kinda goal for leaving the hospital … it might be when you go to a local hospital. I think it was two thirds of the way by the time I got to leaving The State Hospital then there would be time in a local hospital and then there would be maybe college or work experience of some kind and then, getting' your own home and having' employment which would be the goal to get there and stay well and just live a kinda normalish life in the future.

It is relevant that Paul is the only patient involved in this study that has been discharged from the hospital following the interview. He was the closest to discharge and therefore arguably the most recovered patient in the study. Perhaps he is most comfortable talking about the future because it was perceived to be a more immediate possibility for him.

Sam was the only person interviewed who described clear plans for the future that were unsupported by the clinical team. This disparity in the expectations of staff and the patient led to a breakdown in the therapeutic relationship. As described in Extract 28 the patient no longer discusses issues with less optimistic or less encouraging members of the team:

> Extract 28: Sam; 785-794
> Oh no no no [Sam], you can't do that in the future. Oh no no no [Sam] that's not realistic. No [Sam], you can't live your life with your family and friends and have all the stuff to cope with and everything, and I walked away from that and I got really concerned. But there's somebody else, who knows what I'm talking to my friends who contradicted that, and a Psychiatrist contradicted that as well. And a Psychologist really, so I don't eh, approach the same members of staff again about certain issues, I can't do it because I know that they're wrong.

Central to recovery and part of a clinicians' role is to instil hope (Andresen *et al.*, 2003). Staff in secure environments, need to find a balance between fostering hope and being realistic about future plans. As illustrated in Extract 28 if clinicians fail to achieve this balance it can have negative consequences on the therapeutic relationship.

7.3.4   Fragility of the mind: Power of imagination

As discussed in the introduction, the 'ideal friend' is an imaginative technique that aims to aid self-soothing through visualising a compassionate other. In relation to this technique Dom, Danny, Paul, Robert and Stevie discussed the power of the imagination. For Dom, Robert and Stevie there were differing degrees of concern about the close relationship between the imagination and psychotic experiences. However Danny, Paul, Robert and Stevie found the technique beneficial once they developed skills.

Dom was unique in his description of this technique; stating that it is "extremely dangerous" (Dom: 449) to ask mental health patients to use such a skill. In Extract 29 he describes the power of the mind to "take over". The choice of words 'open up' illustrates a feeling of vulnerability involved in using these imaginative techniques:

Extract 29: Dom; 470-480
"One of them said they couldn't get her to stop talking. Your imagination takes over you, … You're asking the mind to open up, a subconscious or whatever it is, and just taking over and this is the problem with lots of people in here because they hear voices talking to do certain things and then you're asking us again, we'll open up again to this possibility and you have an imaginary friend and then the next thing it starts telling you to do things and eh its an illness in itself."

Danny, Paul, Robert and Stevie were all members of the same RAP group as Dom. They all empathised with Dom and could relate to his concerns when the technique was first introduced. Since using the technique on a regular basis they have developed a more positive view of the technique. This is described in Extract 30 by Robert:

Extract 30: Robert; 131-149
P: It's a bit strange at first, you put that down as illness. (patient laughing) Your imaginary friend. But, it's not. I've used it a couple o' times myself.
I: Can you tell me a bit more about what you said there about putting it down as illness?
P: ….if you say somebody's got an ideal friend that talks to me and I talk to them and all that, they think you're a bit potty. You're like that oh aye, very good.
I: Is that a reaction you've experienced?
P: When you tell people about it they kinda look at you strange. The wards just say oh aye, you havin' a relapse (patient laughing).

Facilitators of RAP refer to this imagery technique as the 'ideal friend'. Across the narratives patients refer to the "imaginary friend." It is significant that patients have created their own terminology and it is important to reflect on the possible symbolic significance. "Imaginary friend" may be a simpler term for patients to relate to, as it is regularly used in wider society. The researcher however, also recognised the potentially negative connotations of the term. As "imaginary friends" are used during childhood, the term may be a reflection of their perception of the technique as immature, simplistic or patronising.

Stevie could also understand the concerns of Dom (Extract 31). As the group progressed however, he found the imagery technique very useful. Stevie interpreted the continued and fixed concerns voiced by Dom during the programme, as an indication he was still unwell. Stevie felt sympathy for Dom and wanted to help him to use the technique appropriately. Stevie found the 'ideal friend' acted as source of support during difficult decisions. He was keen for Dom to also experience this form of support and reassurance:

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Extract 31: Stevie; 60-110

I: So in what way did you use the ideal friend?

P: If I was thinking things maybe things about being outside. If I get into a situation where I would need advice I could go back to my friend and discuss it. To see what they come up with.

I: So when would you tend to use it?

P: When I find things difficult. Its just like another opinion. Of course if it was any worse then I would go to my CPN or go to my doctor and tell my doctor...but for small things.

I: So you said earlier that one person didn't agree with the ideal friend? How did that feel having that kind of disagreement in the group?

P: I could understand it, coz first of all I was like that "what they want me to talk to an imaginary friend!" Whereas with the voices and the aliens I was like "no way man" then you's kept on about it, just let it go, just see how it goes and it worked fine. But it worked just as well with the guy that dinnae want to do anything and I could understand him. I could empathise with him.

I: So when you say that you could empathise with him and you thought at the start "no way" What were your reasons for thinking that way?

P: Well I was hearing voices of the aliens and there was one alien that was always kind and she wasn't as bad as the other ones. And my voice had taught me and I can imagine them saying 'well they want me to talk to her'. Well I didn't want to talk to her, I didn't want to talk mentally to her, to anything.

Paul also commented on the strong opinions of Dom (Extract 32). Whilst Paul did not find the approach as useful as Stevie and Robert, he still experimented with the techniques.

Extract 32: Paul; 590-603

...some patients were saying that, they didn't see the point, it's a load of rubbish and all that kinda thing and that they're seeing a big fluffy white rabbit... I just thought they weren't trying really and they were being negative in the group ... I think at first I thought ah well, can I do this as well, I'm not gonna be able to do this...But, when we talked through everything... close your eyes and get on with it. I didn't have a problem havin' a kinda positive time of it .

As described in Extract 32, Dom told the group that his ideal friend was a "big fluffy white rabbit." Paul interpreted this as a negative statement that indicated Dom was not genuinely attempting to use the technique. As discussed earlier, Dom found this imaginative technique "dangerous" (Dom: 449) due a perceived risk of lapsing back into mental illness. This fantastical character for his ideal friend may be an attempt to utilise humour to cope with a task he found frightening. In the theme 'making sense of the present' (section 7.3.2.) he described a difficulty distinguishing between what is real and unreal. By making the ideal friend so fantastical he ensures that the division between reality and the unreal world is clearly distinguishable.

7.4   Super-ordinate theme: Mistrust

The theme of 'mistrust' was referred to in the interviews of Dom, Danny, Roger, Tom, Robert and Sam. This theme links closely to the super-ordinate theme a 'fragile mind'. These participants describe being unable to trust people they have contact with during their illness. As their health deteriorates they begin to mistrust not only the actions of others, but also their own ability to interpret information and make informed judgements. Dom describes the impact of mistrust on his relationships in Extract 33. He became so isolated, that life became a separate and unreal world.

Extract 33 has a strong emotional impact through the use of metaphor that describes mistrust running over him:

> Extract 33: Dom; 295-298
> Trying not to isolate yourself when you do become unwell, because it just sets in, just blows you over and you feel it running over the top of you in a very short space of time, and eh the world can be a very unreal place for you

Roger explains that this feeling of mistrust and fear is not simply a cognitive process, but becomes a bodily reaction (Enbxtract 34). It spreads from a thought about one person, to family and wider society. He recognises that sharing his feelings allows him to take the weight of these experiences "off ma chest".

> Enbxtract 34: Roger; 99-111
> P: Its best ta talk about it instead of cutting off all communication like what a done. Just isolate yourself an sit in a seat all day and just don't speak ta anyone. That's the way I done it, but the best way is to start talking about it.
> I: what does talking about it do?
> P: It helps you realise what, what wh. It releases the pressure a bit... When I went unwell like that I had to talk to the staff. A told ma mum ta no come ta see me anymare, an .... It's a feeling with ma body, felt all strange and a wanted ta be left alone.

Tom describes how this form of mistrust can eventually trigger mental health problems "Depression, anger, mistrust. These things are key triggers ta being no well." (Tom:231). This is supported by the findings of Boyd and Gumley (2007) who proposed that these types of triggers led to social isolation that that reduces help seeking and increases risk of psychosis.

7.4.1 Mistrust: Loved ones

Danny described an increasing 'mistrust' of loved ones (Extract 35). He explained that his parents were initially the first people he turned to for support. They contradicted his paranoid thoughts and attempted to reassure him that he was mistaken. This unfortunately led to his fears, anxieties and paranoid ideation escalating further. His parents' efforts to support him ultimately led to them also becoming suspected of trying to harm him:

> Extract 35: Danny; 529-538
> Delusional an just thinking people are gonna get you... A remember [patient mimics shouts] "mum, mum there's people coming to get me" and ma maws "no there's no." "there is you know" and one time it was afore my Dad came ta see me and I was like that. Two minutes later, he's coming to pick me up about two miles away. I ran away. A thought he was going to run me over and it goes on and on.

In Extract 35 he fears that his father will cause him physical harm by running him over whilst driving. Other respondents briefly described fears that their loved ones would collude with medics to admit them to hospital. The stigma associated with hospitals made this prospect extremely anxiety provoking for the respondents.

Discussion of family members' involvement when unwell was absent from most participants' narratives. Sam was unique in positively describing the ongoing support he receives from his parents in Extract 36:

> Extract 36: Sam; 355-360
> I get on with my mum and dad so well, like all the good things that would be there in a relationship were there. I never had any fear of them not being there for me or not having all these values for me.

7.4.2 Mistrust: Authorities

Dom, Danny and Sam described 'mistrust' of health care professionals. They explained that this fear reduced the likelihood of seeking help, and increased isolation. This theme links closely to 'mistrust: society' in which respondents highlighted the stigma experienced in relation to mental health problems, The State Hospital and their criminal behaviour. As described previously within the theme 'preferring isolation', Danny continues to believe as an inpatient that health professionals are at times unhelpful and regards his illness as an independent "struggle" (Danny:154).

Extract 37: Danny; 577-578
Its like 'don't phone the doctor!' 'cause I thought he was gonna get me too. So at first
it was hard getting help.

Dom is also unwilling to approach authorities as a result of negative past experiences with
psychiatric services. He explains in Extract 38 that he would prefer instead to ask his partner
for help:

Extract 38: Dom; 326-337
P: to be honest with you if a was outside and I was ill, the last place I'd come to is the
authorities. That's be the last place that I'd go.
I: The authorities would be the last place you'd go?
P: Yeh. Because…my experiences here.

During analysis the researcher entered the following extract into her reflective diary:

Reflective log (13 December 09):
Dom recognises that he had a psychotic episode in the distant past, but he does not
believe himself to be currently unwell. As a result his stay in the hospital may feel
more akin to wrongful imprisonment rather than treatment. I wonder how a belief such
as this may inform how we work with this patient? How does the belief itself impact
upon mood, interactions with others and his ability to trust professionals?

Sam also feels he was let down by authorities, but for different reasons. Sam continues to feel
anger that he was unwell for such a long time prior to authorities recognising his mental health
problems (Extract 39). Thus Dom's and Sam's experiences are in contrast because for one
patient intervention was too extreme and for the other it was absent for too long:

Extract 39: Sam; 487-492
I spent the next eleven years floating around the prison system with full blown
Schizophrenia and no help. And then I got to hospital about two and a half years ago,
so by, experience of mental illness, I get angry, because of what this person did to me
and how the system failed me.

7.4.3 Mistrust: Peers

The theme of 'mistrust: peers' links closely to the themes of 'peer bullying' and 'competition
for attention'. Unfortunately, participants' narratives suggest that the hospital environment
does not facilitate trust and support between peers. Danny describes in Extract 40 his need to
create boundaries and limits to what he will discuss with fellow patients. There is a fear that
things discussed with peers will be gossiped about throughout the ward. Danny participated in

RAP with another patient on his ward. Despite this dynamic he felt comfortable talking about things in the group, due to the boundaries, rules and general atmosphere (section 7.6.1).

> Extract 40: Danny; 646-684
> P: you don't want some'hin' like eh - - - (3 secs) or talk about me index offence or some'hin' like...and then half the half the hospital's talkin' about it you know. The trust 'hing is a good thing definitely aye 'cause, some people you cannae trust on the ward though it's awright in a group setting tae talk aboot 'hings wi' 10 other people'll… I'm quite wary what a say on them in the in the ward but the groups a kinda trust them. I still won't tell them ma intimate secrets but I trust them with certain things... In the group like it's all up for discussion. If I think it's interesting enough to bring up in the group.
> I: What sort of things might it be that you wouldn't discuss?
> P: Core index offence… Ma relationships nothin' to do with them is it?

Danny discusses in Extract 40, differing degrees of trust with peers. He has a limited degree of trust with them and will only talk to them about a limited range of topics. He believes this is due to past experiences. He provides a teenage example of mistrust prior to his illness:

> Extract 41: Danny; 678-684
> people'll get the wrong idea or 'hings or something... about ma crime or some'hin' talkin' about it off the group. It's hard trustin' some people, in the past you listen to people an' they let you down you know. You learn from your mistakes wi' people. Trusting people then they tell their secret like a kissed someone else then…some'hin' like that. I've learned in the past no to trust a lot of people.

In the RAP group Danny describes talking about most things but not "intimate secrets" which he describes as his index offence and relationships. It is interesting that his definition of "intimate secrets" includes his index offence, despite being currently detained on treatment orders in part due to these "violent pros entities" (State Hospital, 2009)

Sam also explains the development of mistrust as a result of past experiences. In Extract 42 he believes he was betrayed by a friend and that this led to him committing murder and being arrested:

> Extract 42: Sam; 483-486
> I had developed schizophrenia, and there was another boy in that college who had very bad intentions towards me, and he found out that I had schizophrenia, and somehow manipulated me into taking somebody's life, which I did do. I was arrested.

Sam now finds it difficult to form attachments with patients in the hospital (Extract 43). He does not believe them to be his equals or his peers. He uses emotive language to describe the negative impact that peers may have upon him. He states that they may "contaminate him:"

> Extract 43: Sam; 383-404
> P: If I'm honest with myself, the whole life experience of living in this hospital, I was getting really lonely and I was getting scared that I wasn't living my life. Those things like friendship and love and whatever are very, very important. I was trying to keep myself only to the type of people that I want to be with, but there are very few in here, but then I thought to myself well, there are other people who you could be in acquaintance with and chat away and say hello without anything happening too deeply. And there the acquaintance there possibly might turn into a friendship with a very few bunch of people.
> I: You said there about within the general hospital not feeling like you had things in common...
> P: I just didn't want to know because they were not the type of people that I would want to know and I felt a little bitty like I was being contaminated. If I let them in too close and my life would eh, I'd be getting myself into a situation that I didn't want to be in. But then I realised well why not get a bit closer to people generally.

7.4.4 Mistrust: Society

Dom, Danny, Robert and Sam described a strong belief that society would stigmatise them for their mental health problems. Sam described in Extract 44 being stigmatised by inmates in the prison population:

> Extract 44: Sam; 576-592
> I found, that the whole prison population shut me out and did not want to know, and in some instances I was treated exceptionally badly because they considered that I was one of those people that committed an exceptionally antisocial effects and there shunned by the rest so.... I relate it to this time in my life in the past, and I can see, ignorance, misunderstanding. Eh, just like mental and social stigma, and loads of different things that were there for all of those years

When patients hear past experiences such as these it potentially raises concerns and anxieties for them. Danny describes his belief that society lacks understanding of his condition and this may result in them unfairly laughing at his situation and his behaviour whilst unwell (Extract 45):

> Extract 45: Danny; 941-955
> P: Some people might laugh at some people. Same as the thought control people, go "ha, ha, ha.. its crazy, you're mad!" and that... But if they tried it themselves they wouldn't be so... quick to laugh at it..."

I: You said that some people might laugh at you? Who do you mean when you said some people?

P: Just all the people, outside people, just normal people. People without the illness. They might laugh at certain things that schizophrenia can cause to people... its an infliction, its not very nice thing to happen to people.... its just one of those things people don't understand.

Extract 45 describes fears in relation to societal reactions to illness. There appears to be some degree of projection of Danny's own beliefs onto those of society. It is interesting that he refers to society as "outside people, just normal people." Through the suggestion that others are "normal" it implies that he views himself as abnormal. Corrigan and Watson (2003) refer to this experience as 'self-stigma' in which the person turns societal stigma in on themselves. It is possible that he is objecting to the ridicule he expects to receive from society, because it is how he views himself. These concerns regarding the reactions of society appear to contribute to participants leading very isolated lives, which increases the chance of developing mental illness and reduces help-seeking (Davidson & Stayner, 1997, Lysaker 2008, Warner 2009 etc). This pattern is described further by Robert in Extract 46:

Extract 46: Robert; 452-460

P..someone says they cut theirselves up and shuts up in their flat or their house. Dinnae go out, dinnae communicate with people. Cut theirself off from the world. I done the same sorta thing.

7.5   Super-ordinate theme: Institutional barriers to recovery.

Goodwin *et al.* (2003) suggest that in inpatient facilities the main goal of the clinical team should be the creation of a secure base for the patient. Staff need to model emotional containment and provide a continuity and consistency of care. Similarly to a parent, the ward staff need a balance between providing a supportive environment and encouraging the patient to gain independence. Unfortunately, some patients did not believe that this level of care was consistently available. Every participant in the study alluded to the restrictive nature of the hospital environment. It will be explained in the relevant sub-sections that the experiences of many of the participants appear to be more associated with childhood than adulthood.

7.5.1 Institutional barriers to recovery: Restriction of choice and lack of control

Dom, Danny, Paul, Roger and Tom described feeling restricted in the hospital environment. A theme of restriction was also highlighted in a qualitative State Hospital study by Laithwaite and Gumley (2007). The authors emphasised a sense of restricted choice, due to the indefinite nature of the patients' detention. The current study found that this feeling of restriction includes and extends beyond that found in previous research to affect everyday functioning. The patients lack control over important decisions in their life such as their medication, their involvement in psychological therapies and their future plans. Extract 47 describes concerns that recovery is impossible in a restricted environment.

> Extract 47: Roger; 222-241
> ...You never are recovered in a place like this but. You might think....you're recovered, recovering 'cause you take medicine. But eh a way I put it. I think well I don't think. I'm taking medicine at the moment cause I think I'm recovered. But no ones really recovered.... sometimes it doesn't feel like am in the right place. Cause I'm like a prisoner...I've always had folk saying ta me that this is what's wrong, but I've never actually came out with it once and said what was wrong, but that was because my granddad died. I was suffering a hard time, but... I've had people saying to me this is you, this is what's wrong with you, this is a paranoid schizophrenia and that. I've just took it in. You know what I mean? I've thought... I've never really thought, I've never really asked for help. I was prepared to stay in the jail before I came here. So its just a way I've been shown.

Extract 47 highlights a sense of confusion. Roger appears to be currently in a state of unquestioning passive acceptance regarding his situation and diagnosis. The participant has a sense that "it doesn't feel like I'm in the right place" and yet he has never challenged the clinical team. He has never questioned the label of 'paranoid schizophrenia', rather he just "took it in." He states that he has never asked for help, rather he was told he was unwell. There is a sense similar to that of a child-parent relationship in which the parent, or in this case, the clinician is omnipotent and ultimately is perceived to know the best way forward.

The researcher reflected (Reflective log 14 December 2009) that the passive acceptance about his situation is in many ways self protective. It is the clinical team after all, whom makes decisions about the treatment he receives, the privileges they are given and the date or path of discharge. The patient can have input into decisions, they can make requests and can behave in a manner that is consistent with the teams' expectations. Clinical teams, however, control final decisions about issues that affect the patients' lives. Patients are very aware of this

situation and as a consequence try to behave in a way they believe will be perceived positively by clinicians:

> Extract 48: Paul; 440-463
> P: It helps the staff to see that I am engaged in something quite sincerely, want to be involved in it for my own benefit. For the clinical team to see that I want to make an impression in it so as they can see am not dead
> I: You're not dead?
> P: Yeah, you know in the brain. So's they know I am working ok.
> I: That your working ok? What do you mean by 'working ok'?
> P: So they know that you know ma mind's working ok an that I'm engaging and contributing to what's going on.
> I: So is that something that you felt that you need to prove?
> P: Yeah because of reports that I've had in the past that said I wasn't engaging.

Extract 48 explains the dual motivations that influence patients' engagement in therapies within this hospital. In the first sentence he declares that that he wants to attend placement "for my own benefit" and later states that it is in order "to make an impression so they [the clinical team] know I'm not dead." The use of the word "dead" in Extract 48 is particularly salient. There is a sense of a struggle to be noticed by the clinical team. The role of the clinical team and their expectations influence patients' choice. A similar theme was also identified by Messari and Hallam's (2006) grounded theory evaluation of CBT for psychosis in an inpatient setting. This suggests that this experience may not be unique to forensic settings.

Dom explained that his motivations to attend the group were due to fears of reprisal, rather than any expectation of clinical benefit. He states that "a still did ma course so there'd be no fall backs. I've done it, I've sat, I've listened." (Dom: 246) There is a sense of doing what he is told in order to avoid punishment. He attended the group and did what was required, but perhaps did not fully engage in the process. Similarly, Roger explained that he was directly warned of the potential consequences of not attending psychological therapies (Extract 49):

> Extract 49: Roger; 189-193
> Basically what I got told in ma Annual review... if a start putting ma feet up and lounging' about the place and no getting' up ta work I will be getting' sent back to jail and they'll have no use for me in the hospital, but if I benefit from the groups they might be able to help us in the future.

Robert was also encouraged to attend by the potential reward of moving to a lower security setting (Extract 50). This transfer has not yet occurred, and Robert continues to reside in The State Hospital:

Extract 50: Robert; 49-52
It's easy to go, good for me going to [medium security] if a, completed the group so a stuck in tae the group. But once I stuck at it a quite liked it.

It is sometimes necessary for the clinical team to remove grounds access, stop placements, cancel visits or postpone plans for transfer. Roger describes in Extract 51 the upset he felt as a result of these decisions. He felt the need to talk to staff about the situation, but unfortunately when he did talk with staff he received conflicting messages. This uncertainty caused additional stress:

Extract 51: Roger; 145-151
They said that a possibly be going back to prison after a served ma year in the Rehab and I was getting' ma days out cancelled for a year as well, I wasnae getting' nae days out for a year, so I felt for that for me tae get that off ma chest a had tae speak tae other people and speak tae different members of staff but I was getting' all these different ideas back an' a didnae know which one tae listen to....

Similarly Tom was afraid of returning to prison, but believes he has not been informed about whether or not this is likely to happen (Extract 25). These patients have little sense of what will happen in the future and their behaviour is controlled by the hope of rewards and the fear of punishment. Without self efficacy (Bandura, 1997) the patients lack meaning in their lives, it affects the goals they make and their perception of whether these are achievable. This naturally has implications in terms of recovery and relapse prevention, because it removes hope. Roger describes in Extract 52 the fading away of any purpose in his life during his stay in the hospital:

Extract 52: Roger; 301-303
You've got placements and different nights and different days and different weeks and different months and different years an' it aw just fades away

7.5.2   Institutional barriers to recovery: Peer bullying

Throughout the interviews there was a distinction made between the atmosphere within the group and the ward. The group appears to have developed a supportive and trusting atmosphere, which is not experienced elsewhere in the hospital. Danny and Tom describe examples of peer bullying. In Extract 53 Tom displayed particular sensitivity to the attitude of other patients towards him:

Extract 53: Tom; 318-334
P: On the ward you've got carry on. Right. Joke a joke oot it. Personally I don't like jokes. It minds me of when a was young. To take the mickey out eh me.
I: Did they take the mickey?
P: Ocht. A can can take so much then a walk away…. Its no good.
I: So how does it make you feel when people take the mickey?
P: Upsets us. It just very, it minds me, what a went through when I was young. And I um just a hate you's, a hate you, a hate you. A still mind all that. Said ta say it all the time. Very heavily. That's verbal abuse. It is another form of abuse. But all that's in ma past now. A try and keep that in ma past.

Tom is reflecting upon past experiences to make sense of his current treatment. There is a contradiction between the vocabulary he uses at the beginning of the abstract, that refers to "mickey taking" and that used in the later stages referring to "abuse." Tom reflects on how the abuse he experienced in early childhood has made him hyper-sensitive to the "jokes" that peers now make. Patients residing within the hospital include both perpetrators and victims of child abuse. Extract 53 highlights the need for staff to remain aware that comments by peers could have resonance for the patient, due to their association to their past experiences. In severe cases there is the risk of re-traumatisation. Re-traumatisation refers to a process in which actions in the present trigger memories of past traumatic events, causing the individual to feel as if they have returned to the original trauma situation (Rothbaum & Foa, 1993).

Later in the interview, Tom describes the level of bullying he received from one patient that has now left the hospital (Extract 54). He attempts to minimise the malicious intent in the actions of the other patient, but acknowledges the emotional impact it had for him:

Extract 54: Tom; 352-360
There was one particular boy who all through. A wouldnae say he was a bad boy, but he really got me upset kicking me and just saying gee's a wee kick. He pushed me about. Upset us. ... He's no really a bad lad. He's mare just trying tae have fun, making fun of me, but it gets very upsetting. Then a get flashbacks, about ma childhood.

Danny also expresses grievances against a particular individual. He describes in Extract 55 feeling annoyed that Dom told other patients about his 'ideal friend'. He explains that time spent in the hospital has made him emotionally numb to comments of others:

Extract 55: Danny; 1088-1101
P: He was tellin' everyone on the ward ... [Danny] I'm your imaginary friend and all
that so it kinda tellin' everyone ... I was quite annoyed ... annoyed him sayin' that.
I: How did that feel for you being on the ward with that happening?
P: It'd no bother me. A can sit and the guys would make fun of me now you know so
(patient laughing) I'm kinda used to them you know. 'Whatever' so I've been there
that long I've no much feeling. At first it's like that, then it's like that 'whatever' you
know.

7.5.3   Institutional barriers to recovery: Competition for attention

Life within the hospital's continuing care wards is described as busy and noisy by Dom,

Danny, Paul, and Stevie. The continuing care wards often house the highest volume and

complexity of patients. The patients are limited in that they cannot make drinks for themselves

etc. These demands reduce the amount of time and attention staff can dedicate to the patients.

Danny highlights in Extract 56 the competition for attention within the ward setting. There is a

sense that the behaviour of patients becomes more challenging in order to increase the chance

that staff respond to their needs:

Extract 56: Danny; 393-442
P.... when he's in the group... he speaks dead proper ....but on the ward he's total
manic yet the group's kinda ... more matured you know in the group. He's not silly.
... people do change for the groups ... I've noticed anyway big time....
I: So what do you think it is about the group that makes them behave differently?
P: I think cause there when you start talking, there's a lot of focus on you. A lot of
people looking at you at the same time and listening to what your points going to be,
maybe listening more than they would on the ward. When a was talking they would
listen more just 'cause the group may be a bit more interesting than the usual talking
on the ward you know about usually to your topics but a think in the group it's
different things so maybe, you know they're getting' listened to any way you know so
they don't need to be loud

This problem appears to be unique to continuing care wards. Paul and Stevie have recently

moved from the continuing care ward to a rehabilitation ward within the hospital. They both

regard their new ward as much better for them than their last wards.

Extract 57 explains the feeling of returning to a continuing care ward after the positive

atmosphere of the group. Stevie describes the high volume of patients on the ward which

creates a lot of noise. This means that he is unable to relax or listen to music without the use of

headphones. In this sense the commotion on the ward is making him retreat more and block

out noise through the use of headphones. Unfortunately the environment appears to be

encouraging isolative behaviour in a similar way to his illness in the past. He is again blocking out voices, but this time they are real rather than imagined.

Extract 57: Stevie; 427-456
P: you feel really good [following the group] and you go back into the [continuing care] ward and you're back to the same old routine. Its not so bad up here [rehabilitation ward] coz it's a lot different up here.
I: In what way is it different up here [rehabilitation ward]?
P: Oh erm, there's not as many people and there's not as many people with an illness, you know in the early stages of an illness. The men here are all sort of at the same level of their illness. Ah the quietness as well oh the quietness, and most of the staff just let you get on with it . You want to sit and read your book, then you read your book, if you want to sit and watch the TV then you watch the TV, its no problem.
I: Was doing things more of a problem [on your previous ward]
P: Yeah coz you couldn't really listen to the TV or read a book. There would always be someone talking or a lot people talking. I just used to put my headphones on and read my book, you know, but up here I don't need to use the headphones I can just read my book.
I: And how does it feel to be on [a continuing care ward]?
...I felt closed in coz there is that many people. I think there is about 25 or something down there and I think there was always somebody arguing or things like that

Extract 58 describes the negative affect the busy ward environment is perceived to have upon the patients' mental health. There is the suggestion that it is more difficult to 'recover' in the continuing care wards.

Extract 58: Paul; 270-276
I was depressed for a long time after a became well because, I was still on [a continuing care] ward and there was so many ill people round about me every day that a found it really stressful but, I think that a great part of ma recovery was to see myself in [a rehabilitation] ward because, all the guys were well an' it was a completely different atmosphere living here .

Sam also described how the busy ward environment limits the amount of time staff can devote to listening and responding to his needs. In Extract 59 he feels that he has requested psychological interventions, but is still waiting for additional help. The hospital requires greater flexibility in the referral paths for psychological interventions and could consider strategies for self referral to reduce this problem and enhance self efficacy:

Extract 59: Sam; 807-816
I'm very very keen, on sorting my head out, and sorting my life out, in The State Hospital before I move on, so I need, the ward staff, Psychologists, Social Workers, Psychiatrists, I need their help. I need psychotherapy. I need counselling. I need one to one work. I need to do group work. And I want to get to all that properly. I don't know how true this is, I know there are only limited resources in the hospital because the finite members of staff and loads of patients, but look at me, I need the help, em, I

won't waste your time 'cause I really need it and eh, I'd like to get it all done and sorted properly.

7.6   Super-ordinate theme: Self refection and understanding

Participants appreciated the opportunity to openly share experiences with peers. They recognised that they initially found this difficult, but through the support and encouragement of the group they developed confidence. The group increased not only their understanding of themselves, but also of their peers. The development of compassion and inner warmth was a key component of the RAP programme. Whilst it is never discussed explicitly by participants there is a sense throughout their narratives of increased empathy and understanding.

7.6.1   Self reflection and understanding: Safe place to talk

Dom, Danny, Paul, Roger, Robert, Stevie and Sam describe the group setting as a uniquely safe and trusting environment in which to share their experiences. This theme mirrors findings of Newton *et al*., (2006) for young men with early onset psychosis. Extract 60 and Extract 61 illustrate that a safe environment in which to share experiences is important regardless of age or duration of mental health problems:

> Extract 60: Sam; 301-307
> a safe environment that was watched over by the staff, patients had the choice if they want to risk some personal information or not with other people. Part of it it's in place to come together in safety to talk about relevant things

> Extract 61: Paul; 666-668
> A felt very comfortable in the group that a was in. A found the guys all quite friendly towards me and I think the staff were all great as well because they were all friendly too

The group members encouraged each other to contribute to the discussions and trusted each other to keep any disclosures private. Many of the qualities that are discussed in the content of the programme were recognised by patients as qualities witnessed in the group. In Extract 62 and Extract 63 participants recognise that trust within the group was a positive aspect:

> Extract 62: Roger; 58-60
> It was a confidential group. Everything was kept in the group. It wasnae exactly spread about the hospital. It was very private

Extract 63: Robert; 310-313
Mostly what was in the group stayed in the group. That's what helped as well. It's no
as if somebody's gonna run aboot an' say aye such an' such said this
an' that.

Danny and Robert felt the group allowed them to speak without the risk of "mickey" taking
(Danny: Extract 65) or fear people would "laugh at you" (Robert: Extract 64). The quotations
below have a strong relationship to earlier themes describing "peer bullying" (section 7.5.2).
By highlighting that nobody laughed in the group setting it may implicitly imply that it is quite
common for them to be laughed at elsewhere.

Extract 64: Robert; 595-599
Just it was good to share experiences in the group where you could speak openly,
where nobody would laugh tae whatever. Ah, it was pretty good in the group rather as
being a single individual person with ideas and your thoughts in the room. We shared
them.

Extract 65: Danny; 966-971
It wasn't there to take it wasn't there to laugh at you're it wasn't there to take the
mickey out you.

Danny suffered social anxiety and had not tolerated group settings previously. He describes
staff making small changes to improve the experience. Fellow group members also made him
feel safe and comfortable through providing support and encouragement. The discussions were
largely related to his personal experience of psychosis and therefore were not "too much brain
rocket science" (Danny: Extract 66). It was a topic which he felt an expert in:

Extract 66: Danny; 222-234
I felt better after speaking up and being part of the group as I wasnae hiding in the
background. Whenever I put something in the people would encourage it, kinda help
me along with it. ...Em, it's not too much brain rocket science you know it makes it
better. A wouldn't like it to get all complicated stuff I don't understand that'd
probably stress me even more but eh, most of the stuff it made sense, it was
understandable.....

Extract 67: Danny; 1143-1146
the group's not too big....If you to start off the staff eh, surprisingly make you feel
dead comfortable in the group. You're not peer pressured into doing stand up and
tellin' them aboot your life, you say what you want to

There is the sense in the narratives of Danny (Extract 66; Extract 67) and that of Stevie
(Extract 68) that group members felt comfortable and contributed much more to discussions,
because they were allowed the freedom to set their own boundaries, regarding the content and

amount of information they shared with the group. The questioning was open and explorative in nature and Stevie recognises that this made it easier for him to contribute. Ultimately this prevented them from feeling "peer pressured" (Danny: Extract 67),

Extract 68: Stevie; 236-255
I: What was it about the way it was asked?
P: Just the wordings of whatever it was you were talking about. I cant really think of a for instance, but we spoke about stuff and we could get it out you know? And after it you feel really, really good.
I: what do you mean when you say 'good'?
P: Just like a weight lifted.

7.6.2 Self reflection and understanding: Finding commonality

Dom, Danny, Paul, Roger, Tom, Robert, Stevie and Sam all described the benefits of hearing other group members describing similar experiences to their own. Danny described in Extract 69 that he was surprised to hear that other people felt similarly to the way he felt:

Extract 69: Danny; 270-279
I: What happened to make you feel comfortable?
P: Just the allocating the same patients, some of them come out with stuff like they were kinda worried about the group starting and some of the conversations just guys just like me. So I wasn't the only one, the only patient there actually worrying about it …. I was kinda quite surprised that other people were going through the same thing

Dom, Roger, Tom and Robert below explain that when they were ill they thought they were the only ones suffering from mental illness (Extract 70; Extract 71; Extract 72). Hearing the views of other group members helped instil hope and confidence through hearing the description of their peers' recovery.

Extract 70: Dom; 515-519
When you're ill you think its just you, you're against the wall. Em so since then I've heard peoples points of view, people who went through maybe similar things as myself and other people had, had it really hard and they're getting there....

Extract 71: Roger; 86-88
Just realised that I was not the only one who's gone unwell. There was other folk gone unwell as well and you think everything's alright ..

Extract 72: Robert; 282-293
It felt good tae know that other people in a strange way to know that other people go through the same thing like you weren't going through it alone, that there's other people suffering just as bad as you've suffered. Aha. And it it is treatable. You can become well again.

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Extract 72: Tom; 309-312
Your confidence grew very quickly. You're sharing similar similarities it helped. Not that they were any worse or any better than you. We were equal. That helped

Tom describes in Extract 72 being equal to others in terms of some of their experiences and their ability to contribute meaningfully to discussions. He believes this helped him to have the confidence to contribute.

Danny, Paul and Stevie realised through group discussions that even the most "crazy" (Paul: Extract 74) beliefs he experienced are similar to other group members. This helped them to realise that they are not "stupid" (Stevie: Extract 75) for thinking that way and it should not reflect badly on them as people. Participants realised that these beliefs were symptoms of schizophrenia and are experienced by many intelligent peers. This can be shown in Extract 73 and Extract 74 :

Extract 73: Danny; 878-885
I'm not the only one going through that, there's a lot of people in here that...think people read their thoughts so I wasn't the only one going through that. so other people on the wards were, were radios talking to them, TV's talking to them.

Extract 74: Paul; 203-249
One of the patients said that he had a listening dev he thought he had a listening device... in his car and I thought this as well, so I was driving around with the music full blast which I don't like but thinking that, and I wasn't talking to anyone in the car. I was just myself. Just I thought they were listening to ma thoughts and what I was saying and, all this kind of thing. So, that was, eh, probably quite a wee while before a became really, really, really unwell and committed ma offence and all that but, it's still one of the things, that, was there, leading up to, towards the, the coming in to The State Hospital... So, it's all these wee things that other people experience that that make you just think well, I'm not the only one that was thinking these really crazy things

Stevie explains in Extract 75 that hearing similar experiences from peers in the group helped him to realise that he was unwell. After he first realised, he experienced negative feelings of stupidity for not realising earlier, but the group provided some relief from these negative self-appraisals. Theories outlined by Gilbert (2005) would suggest that Stevie's internal working model lacks a compassionate template and instead is characterised by aggression. This is suggested in the reference to himself as "stupid" on the realisation of his mental illness. CMT can then be used to create an alternative compassionate inner role model (Gilbert & Irons, 2005). This was achieved by Stevie who credits the compassion of other group members and his ideal friend as being significant in helping him overcome this negative view of himself.

Group treatments generally have been shown to have a normalising and de-stigmatising affect for individuals through the realisation that they are not the only ones to have experienced difficulties with their mental health (Newton *et al*, 2006). For Stevie this normalising effect appears to have been as a result of simultaneously receiving both internal (Extract 99; Extract 100) and external sources of compassionate and normalising responses.

Extract 75: Stevie; 208-234
P: At first I didn't believe there was anything wrong with me. I thought that everything was ok. Until the TV and the radio and the papers. Everything seemed to point to me. And doing the group it was like that for other people as well. Then it began to sink in that it was my illness and I was ill....
I: How did that feel when you realised?
P: Well I felt quite stupid... that I listened to these voices and everything and I believed them. I felt quite silly that I did believe them. Coz the now I am like 'that was stupid!' But back then... aye I felt quite stupid.
I: so you said you felt quite stupid for the things you believed during your illness? So how did it feel talking about those things in the group?
P: It felt good to get it off, get it off my chest and talk to other people. To talk to other members of the group and be like aye, ae you had that as well, so did I, I thought that the TV could communicate with me as well and it does it takes quite a lot off you it was a big sigh of relief.

Similarly, Sam found it useful listening to the experiences of other group members, but he also found the situation difficult at times (Extract 76). This is because he does not regard the patients in the hospital to be his peers or equals. Contributing to the group discussions required him to recognise the common experiences he had with other patients and accept the impact that mental illness had upon his life:

Extract 76: Sam; 203-229
P: I didn't much like eh listening to other people talk about their lives. Did I? No, there's eh there's there's two points to this. I did and I didn't. Part of me was of my duty here with these people, I don't want to know. But part of it eh, it was interesting and inform informative, and specially for myself because of the way things have been for me since I got here, I actually and because I I I did one or two courses and at group before and that's all, it was interesting and novel and never really heard people speak like this before about their lives. It's very interesting. It's very informative, but on the other side of it, I was saying to myself you know em, I don't really want to know.
I: Em. What made you feel you didn't want to know?
P: My peers. The people I went to school with, eh I left in 1993. Eh. After the summer holidays I went to University, got a degree em and then started in the work place and have now been in the work place for ten, fifteen years, so the way I eh measure my life, is with measuring against their lives. So I was sitting there and I said I'm in a psychiatric hospital, I'm in a group full of psychiatric patients, talking about all this horrible stuff, that I wish wasn't relevant to me, and I should be, with my peers, eh freedom in the work place, so I didn't I really, parts of me really disliked it and parts of me thought it was great because it was relevant to me and it did help me with myself.

Overall, Danny acknowledged that there were some differences in the patients' experiences, but despite this everyone was understanding due to their shared diagnosis. Danny in Extract 77 viewed their experiences as having a common cause:

Extract 77: Danny; 912-914
it's like all to do with the same illness. It's all to do with the same Schizophrenia…. It was aw the same kinda connection with the balance in the brain the chemistry or something like it it's all related to the same thing even though we're talking about different things.

7.6.3 Self reflection and Understanding: Understanding difference.

Dom, Danny, Roger, Tom, Robert, Stevie and Sam discuss the differences in the contributions different group members made to the discussions:

Extract 78: Danny; 609-633
[other group members] talking about UFO's and things. I dinnae laugh or nothing, a found it funny but I never had anything like that, but I kin imagine probably what it would be like to be delusional actually... Need to avoid being enclosed and that you know so I believed in certain things that weren't true it was all just your mind playin' tricks on you. So their experience with psychosis was different to mine. You know totally different, like ye hear the police and other people what we're talking about….. different stories all together in the mind… .. Even though its different things its all to do with the same illness. You know its quite interesting and a felt a wee bit sorry for them what they went through the things I went through you know like an infliction. Mmmh I don't like to see people go through things like that. Eh mine was totally different than that. Eh, just thought control I think.

Participants recognise the differences in their experiences, but learn from these and are empathic and accepting of each other (Extract 78). A central theme particularly in Danny's account was the understanding that he gained of other peoples' experiences. He recognised some similarity in their beliefs and experiences, despite these at times appearing incongruent with his own. He emphasised the importance of working to understand and learn from others' experiences (Extract 79; Extract 80).

Extract 79: Roger; 73-77
In ma case it was when ma granddad died a took a relapse an' a didnae feel too well but in some other folks's just wake up one mornin' an' they're no feelin' well so it's different it's different situations for each individual

Extract 80: Tom; 73-95

Each person, had a different idea of the vicious circle. The, situations that led to them becoming no well, each bit of it. Aw different. Everybody had their own idea how tae work through it. Which is relevant tae everybody…..It's a bit strange but no everybody's going through the same situation. They have different method of recovery

Patients in the hospital are taught psycho-education on the nature of schizophrenia, causes of the disorder, routes to recovery and plans for staying well. Extract 81 and Extract 82 explain the additional insight that Dom and Robert gained from hearing others' experiences first hand. Hearing personal narratives may have more impact on patients than psycho-education provided by clinicians (Newton *et al.*, 2006).

Extract 81: Dom; 249-263

I: Do you feel your understanding of psychosis changed at all when doing the Recovery after Psychosis programme?

P: It changed. Eh, no doubt through today about whether it's eh built in me or whether it's society made. Listening to other people's experiences, it's a combination of things …. Whether it was caused by the way you're brought up, society itself, drug induced or just by the pressures of living and it gave ya kinda mixture eh of all the possibilities of all the ways you can get yourself in ta trouble with mental illness

I: We also talked in the group a lot about recovery. How did you find that as a concept to be discussing in a group?

P: Recovery? {{yeh}} Well, again it was quite a mixture of waves of recovery. Some people's eh may might recover a lot better. Eh, maybe certain things like the type of music, a certain type of music. Fine, that may work for one but what works for somebody else em, again, you know different variety of ways, of finding themselves recovered, talking to a relative and eh, it's just down to individuals. How the individuals we are coping with mental illness.

Extract 82: Robert; 226-241

I: Mmh. What is it that you, that you better understand?

P: Looking out for just signs of relapse starting as well… The way ta spot it, when ta act, when ta seek help. That's more switched on regardin' illness.

I: Right. Eh, more switched on? {{aye}} So what do you think it was about the group that brought about that change?

P: Just the information I was told and the information… gained from other patients stories.

Stevie is able to understand the views of others even when they differ to his own. As highlighted in Extract 31 and Extract 83 Stevie explains that he could understand Dom's rejection of the 'ideal friend' technique and interpreted this refusal to try the technique as an indication that he was still recovering from his illness. He felt empathy for Dom and wanted to help him learn the techniques:

Extract 83: Stevie: 355-371
I: Would you say other people in the group were at the same stage of recovery?
P: I wouldn't think so no… one guy he sticks out. I don't think he was quite ready for whatever it was in the group. … he just wasnae in agreement with it. Whereas I was. Most of the group were..... It makes me want to help him. I was going help him and talk through it with him, but he wasn't having any of that...

7.6.4   Self Reflection and Understanding: Knowing yourself

Dom, Paul, and Tom explained that the group allowed them to not simply learn from others, but also gain a sense of how they compared with others in terms of the severity of their mental illness. Within this theme all patients tended to minimise the severity of their own illness and gain some relief that they were not as "damaged" (Dom: 449) as others. This appears to be a genuine appraisal and not something communicated to promote their chance of discharge. Instead of pride in their recovery, they are remorseful for the reassurance they are gaining from the adversity of others "It's a selfish thing to do" (Dom: 543).

Extract 84: Dom; 219-228
...we all like to judge how unwell we are, or hear how we've been . Och well, you're in Carstairs, you must be unwell, but how unwell am I? and you kin only do that by weighing up each other people's individual experiences with that. Eh a faired quite well eh compared to some of the other guys. It gave me a scoring system for want of a better expression and a thought well, I've nothing to worry about...

Extract 85: Paul; 384-392
I have actually come through ma illness, kinda unscathed. Like …I can cook, and I've still got all ma functions and I can take care of myself really and that and get on ok. But some of the guys like I think still have kinda odd beliefs and things like that to do with their illness an' a a a could see how lucky I am really, with things that we were talking about in the group.

Extract 86: Tom; 285-287
…puttin' yourself, in their shoes, for the time being. Just shows you how lucky you are that you're no as heavy as some people. No as bad as others.

It is significant that all patients regarded their experiences as less severe in comparison to peers (Extract 84; Extract 85; Extract 86). This theme contrasts with the findings of Newton *et al.* (2006) that young men with auditory hallucinations benefited from being able to see people at different stages of recovery. Some people in their sample believed themselves to be more ill than others and gained hope from hearing the recovery narratives of others. In the current sample all patients viewed themselves as "lucky" in comparison to their peers, whom they perceived as more severely unwell. This difference in appraisal may be due to the fact that the

sample involved in the Newton *et al.* (2006) study was younger, and suffering from adolescent onset psychosis. Perhaps the long term nature of mental health problems in the current sample affects their ability to make comparative judgements. Unfortunately the reasons for this disparity currently remain unclear. This theme does however add support to Gilbert (1992) social rank theory (Gilbert, 2001) outlined in the introduction. Psychosis arguably produces feelings of loss and humiliation which impact upon patients' perception of social status. The RAP group appears to have facilitated a reappraisal of their social rank in comparison to their peers. RAP quantitative evaluations have revealed improvement in self esteem, reduction of depression and improvements in the patients' own perceptions of themselves in relation to others (Laithwaite *et al.*, 2009). The narratives of patients in the current thesis support these findings. This has the secondary benefits of increasing their hopes and aspirations for a future without psychosis.

7.7 Super-ordinate theme: Personal development

All participants described the beneficial impact of attending the RAP programme. Many of the positive outcomes for participants have emerged within other themes discussed. This final super-ordinate theme is an attempt to briefly summarise some areas of personal development and growth that are not detailed elsewhere in the document:

7.7.1 Personal development: Self reflection and empowerment

Dom, Danny and Stevie described aspects of the group that enabled them to explore their lives in greater detail and increase the hope that they could create a better future for themselves. Stevie explains in Extract 87 that he enjoyed the opportunity to discuss things in a novel and in depth way. He particularly liked the use of metaphor which challenged him to "think outside the box" (Stevie: Extract 87). This form of abstract thinking is not experienced elsewhere in the hospital and he enjoyed this intellectual challenge:

> Extract 87: Stevie; 139-154
> P: Well I like all the… is it acronyms you call them? {{metaphors?}} I like all them, I liked the pebble and in the water it caused an effect. I liked all them and thinking bout things outside the box. It made me think about other things. It was quite good.
> I: What was it you liked about thinking outside the box?
> It challenges you. I'd say it challenges you to stop and think. To really think about things that ' not just open your mouth and talk a lot of garbage.' It would be to stop and think and listen to the questions and think about them before answering them.

Dom explains in Extract 88 that the group made him more aware of the signs of relapse and this knowledge enabled him to be confident that he could take control and seek appropriate help in the future:

Extract 88: Dom; 96-106
I would say it was useful because it reminds you of the triggers, the little things that happen, that tell you you're becoming unwell, you're going off the track and the quicker you catch that the better it is for you ….Noticing whether you've lost your appetite, you're getting' a bit paranoid, grumpy, you're questioning things, you're just a bit upset and you notice these things and say well I kin see something's wrong here and take advice on it or act upon it and before it full blown.

As described in 'fragility of the mind' (section 7.3). Danny was reluctant to look back on the past due to a fear of recalling distressing memories. He evidences in Extract 89 his ability to now recall the past without distress and explains that his current goal is to tolerate his emotions. He is reflecting on progress made since his admission to indicate that he is recovering:

Extract 89: Danny; 778-831
P: Cause it's good to recover and get better 'cause it's a struggle. When you're better you feel better. You can try and get happiness and... a wee bit of sadness again if that happens but eh it's good to be normal again and not living in a delusional world …..
I'm no a lazy...I'm enjoying things again....' I'm quite athletic and that but eh when the psychosis was in it's worse form it was quite tricky doing anything getting' the motivation, the confidence back. … it's a lot better than what it was... from the psychosis sense and that but eh... when you're better you can appreciate rehab getting' a wee bit better 'cause you've been through all that….. The main things medication and eh probably keep yourself entertained instead of sitting on a ward all day.
I: So you said that there when you're better you're happier. {{aye, a wee bit}} Yeah?
P: Something I'm dealing with the 1:1 on a Friday sort of saying when we're talking away and eh talking about emotions 'cause sometimes we've got too happy sometimes we've got too sad and, just trying to work on my emotions see if a can get happier and see what emotions are again 'cause I don't really get much emotion. I don't think I do anyway even though I'm get slightly better or wee bit happier but, to be totally happy like some people like that but we're working on that the now anyway the 1:1, think that's important. Working on me feelings, what triggers them and how to control them and things like that. That's quite good I'm enjoying that.

In Extract 89 Danny describes his character with positive attributes such as "athletic" rather than being isolated to the here and now and defined by illness. Hirchfield *et al. (*2005) found that maintaining a positive sense of self is an important part of recovery from psychosis for

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young men such as Danny. It allows them to maintain a connection with the world when they feel isolated by their psychotic symptoms.

7.7.2 Personal development: Patient as expert

Danny, Paul and Stevie described the roles that patients had in helping each other with work and with sharing the skills and knowledge which they had acquired. This theme is relevant to recent government objectives (Department of Health, 2001a) and helps patients gain self esteem and rebuild a meaningful life for themselves. Danny describes with admiration the capabilities of other group members to contribute to 'intense' discussions (Extract 90):

> Extract 90: Danny; 1040-1045
> 'cause these guys are doing quite well with talking and speaking am telling discuss ma problems and discuss this an' that about their life and eh, they're actually pretty good at it you know for patients, so, it's quite intense a think sometime. Quite an intense… conversation in the group.

Paul discusses in Extract 91 and Extract 92 his role in the group. He felt that, due to his participation in previous groups he was closer to discharge, and therefore took more of a lead in the RAP group. He volunteered to write on the board and he assisted other group members in one-to-one tasks:

> Extract 91: Paul; 55-60
> ..some of the guys were a bit quieter than others. A felt that eh, I volunteered personally to kinda read things up the board an' all that kinda thing, because I think that other people weren't doing that and I felt a should because I had a bit of experience through other groups that I'd been on.

> Extract 92: Paul; 305-310
> somebody wasn't too sure on what to do, em, when we sat down at the Table to to write this wee thing… I was just happy to, I was quite happy to share what a thought it was 'cause a wasn't sure if I was right in what I was doing until one of the staff came along and said that's fine

Stevie believed that mindfulness techniques made a significant difference in terms of his ability to cope with everyday stressors (Extract 93). He was so pleased with the positive impact these skills had upon his life that he wanted to share this with fellow patients:

Extract 93: Stevie; 579-565
P: Were you the group that I used to come back and tell the other patients all about what we had done?.... Telling them about the mindfulness? I would come back and tell some of my mates. I'd tell them and they would be like "ah right!" {{patient laughs}}
I: And did they take it on board? {{yeah}} what made you want to tell everybody?
P: Coz I knew it made me feel good and it would make my friends feel good as well. The ones that I knew could understand what we were getting at. Some just rolled the eyes but some of them were like that "ah right what's this weeks' dilemma?"
I: So they were really keen to hear about it {{yeah}}

Stevie above is not only acting as a patient expert helping others, but is also displaying empathy and concern for his "mates" on the ward. Following the analysis of this section of transcript, the researcher entered in her reflective log:

Reflective log (21 December 2009)
It is encouraging to see a patient getting excited about the progress they have made and wanting to help others in a similar way. The patients have very few opportunities to help others in any formal way. The patients may benefit from peer mentors (but this has obvious risks in a setting such as this). Perhaps a more open group environment where patients can share new skills learnt and reflect on their days in the evening. This may facilitate more trust on the ward and enable some patients to take the lead in discussions using the empowering role as expert patient more often.

7.7.3   Personal development: Skill development

Dom, Danny, Roger, Robert and Stevie detailed benefits of group participation that are not explored elsewhere. The most significant benefit of the group for Danny was assisting him to overcome his anxieties about social situation:

Extract 94: Danny; 1155-1161
it helped with my anxiety a bit ....it helped with sitting in a group of people an' kinda, trying to fit in.

Dom and Roger describe in Extract 95 and Extract 96 finding group discussions useful as it provided insight into their illness and how to respond to signs of relapse

Extract 95: Roger; 123-126
Helped me to discuss my problems instead of bottling them up and keeping them all to myself. If I've got any problems if you share with others and speak to folk that are trained in these kinda problems without keeping it tae yirself.

Extract 96: Dom; 546-552
Find out what other people, what they thought, what was their illness for and how they came by, what actually happened to them. Eh it was the first step and the next step was

lapsing back into psychosis. Em I picked up points on that and then how to recover from it if I did ever did return again, how, how you would cope with it, the best ways to deal with that and eh. So it's, its all in different stages.

As discussed in earlier sections there were concerns expressed when the 'ideal friend' technique was first introduced. Despite these initial concerns Paul, Robert and Stevie believed it to be one of the most beneficial aspects of the programme (Extract 97; Extract 98; Extract 99; Extract 100).

Extract 97: Paul; 575-583
I found it quite useful. A thought it was quite a good idea. {{why}} Because I've got a good friend who always kinda, turns out his a very positive way of looking at everything towards me and I kinda think of them as well when I think of this compassionate friend and what they might say to me when I'm feeling low and things are a wee bit hard or if I need a bit of advice and a think that eh it's a good way to think. Positive. Positive friend.

Extract 98: Robert; 586-589
Just to like what I've learned from the group, if I need it I'll use it. {{aha}} Ma ideal friend sorta thing. If I've got a wee need it in future, it's there for me, a coping mechanism.

Extract 99: Stevie; 336-342
I: Has you idea of recovery changed through the group?
P: No, oh through doing the group? That sort of brought out the thoughts, and the thinking about the future. Through my mindfulness and my ideal friend I could control it and get to understand what it was I was scared to think about. It was good doing that……

Extract 100: Stevie; 126- 130
I would put that down to having an ideal friend. It just started getting better, and better, and better when I went in every week. I don't really need an ideal friend now, but I know its still there, I can still go to it at anytime in the future if anything happens.

7.8 Summary of theme analysis

The main research question posed in this study was to explore the patients' experiences of the RAP programme. Overall the participants described the experience as a positive one leading to personally significant change.

Participants were initially anxious about attending the group because of their perceived 'lack of ability as a consequence of their early upbringing' (section 7.2). Despite initial anxieties all participants felt they benefited from the programme. The perceived benefits from the patients' perspective appear to support the quantitative outcomes of the programme (Laithwaite *et al*, 2009). Patients felt that the positive atmosphere of the group was supportive and empathic. The group normalised their experiences of mental illness and made them feel more positively about themselves in relation to others.

Patients' ability to recall the RAP programme despite the significant time frame which had elapsed, illustrates strength in the design of the RAP protocol and also the skills of the facilitators. Prompts that stimulated recall were the metaphors from the programme. It is therefore hypothesised that the use of metaphor aided this retention of programme material.

Participants also retained a sense of the atmosphere within the group. They differentiated between the continuing care wards and the atmosphere of the group setting. The RAP group provided a safe and supportive environment in which they were encouraged to share experiences and think more analytically about the meaning of these. The super-ordinate theme 'self reflection and understanding' (section 7.6) provides full exploration of this theme. The safety of the environment appears to have been created via the awareness of boundaries, the structure of the session and the relationship and roles within the group (Gilbert, 2009b).

There was also a feeling of trust that developed early in the therapeutic process. The patients described a good relationship with both staff and peers. Generally this was not something that was felt in other areas of the hospital. Gilbert (2009b) argues that one of the central goals of CMT is to develop inner warmth and compassion through the modelling of these skills. This appears to have occurred within the current group.

Cooley (1902) developed the term 'Looking Glass Self' to highlight the importance of others opinions in developing a feeling of self worth. The safe group atmosphere is likely to be related to the ways in which participants imagined they were viewed in the minds of other

group members. Gilbert (2009) argues that all human beings strive to "belong" (p.320). This feeling of belonging appears to be provided by the group environment. Through sharing experiences participants gained insights into the mind of the other group members. This enables participants to form trusting supportive relationships. Whenever participants *"put something in the people would encourage it."* (Danny; Extract 66) This encouragement offered acceptance of each other's experiences that they had previously hidden away in shame.

Through the development of a safe environment patients felt able to discuss a range of topics that they previously felt unable to contemplate, either alone or in discussions with others. Sharing experiences made participants feel that they 'were not alone' and that they were not "stupid" (Stevie: Extract 75). Themes provide further support for 'social rank' theory (Birchwood *et al.*, 2006) in that the group provided reassurance of how ill patients were in comparison to others. As described by Dom *"you're in Carstairs, you must be unwell, but how unwell am I? and you kin only do that by weighing up each other people's individual experiences"* (Extract 84). The patients appear to experience a subordinate social rank within the ward environment due to the 'institutional barriers to recovery', whereas the group environment facilitated the development of super-ordinate social ranks (Gilbert, 2001). These narratives support the quantitative findings that patients had an improved sense of self in comparison to others (Laithwaite *et al.*, 2009). This improved sense of self fostered hope and as a consequence made thoughts of a future more accessible to them. As discussed in section 1.4.3, the development of hope is central to the empowerment model, and clinicians should be encouraging patients to have an optimistic and hopeful view of their future (Andreason *et al*, 2003).

As displayed diagrammatically in Figure 2, when patients develop psychosis and are admitted to the hospital there is a sense of isolation across three dimensions: relationships, range of thought and freedom of choice. The process of change in the RAP group appeared to involve the addressing of these three issues. Firstly, participants described being isolated in terms of their range of thought. This is discussed in full within the super-ordinate theme 'fragility of the mind' (section 7.3). Participants view their thoughts as potentially destructive in nature. As a result participants describe avoiding memories of the past, abstract or imaginative thinking and making any plans for the future. The group provided a supportive environment in which they began to expand their range of thought by beginning to make links between past experiences and their current situation. They also began to learn from the past and make plans for the future. Many participants, despite initial anxieties, utilised and benefited from imaginative

techniques. The participants appeared to gain a greater sense that they were in control of their thoughts rather than vice versa. Skills developed by participants are discussed fully in the theme 'personal development' (section 7.7).

Secondly, the participants are isolated in terms of their relationships. This is discussed in full in the theme 'mistrust' (section 7.4). They found it difficult to trust others as a result of early experiences and their mental illness. By the end of the group however, many participants described forming trusting relationships with other group members. This ability to form and maintain relationships is important in reducing the risk of both reoffending (Webster *et al*, 1997) and relapse in mental health (Bowlby, 1969, Pfäfflin & Adshead, 2004; Laithwaite *et al*, 2009)

Thirdly, participants feel isolated and restricted in their environment. This is discussed in full in the theme 'institutional barriers to recovery' (section 7.5). Participants have little control or information in relation to daily decisions or their future. They often feel unsupported by the clinical team due to the demands of busy ward settings. Goodwin *et al.*, (2003) highlighted the need for clinical teams to act as parental figures to patients offering a secure base and modelling appropriate behaviour and compassionate responding. Unfortunately when ward environments are busy this can be difficult to achieve. Gilbert (2005) has highlighted the risk of compassionate fatigue within clinical teams working with special populations such as high security hospitals. Gilbert (2005) suggests social support from supervisors, allows reassurance and time for reflection. This is important to ensure against this condition, maintain the health of staff, and improve the quality of care for patients.

Unfortunately it appears that the positive atmosphere within the group setting is not experienced elsewhere in the hospital. In relation to life within the hospital Roger stated that "*You never are recovered in a place like this*" (Extract 47). The accuracy of this statement is dependent on personal definitions of 'recovery'. What does remain apparent from the patients' narratives is that there are a number of factors within the hospital environment that participants believe may impede their progress. The current redevelopment of the Hospital is an opportunity to foster a therapeutic milieu that mirrors the positive aspects of the group environment. Future recommendations will be explored in the following sections.

7.9 Theoretical discussion of results

Patient narratives have highlighted themes of the recovery movement, social mentality theory (Gilbert, 2001; Laithwaite *et al.*, 2009) and attachment theory (Bowlby, 1969). These will be discussed in turn in relation to the findings of the current study.

In line with the ethos of the recovery movement (Anthony, 1993) and the recent developments in CBT (Tai & Turkington, 2009) patients appear to view their progress and form their goals around the formation of positive intrapersonal and interpersonal relationships. During psychotic periods they lacked trust in their own minds and in the intention of others. Through sharing of experiences in a group setting they have gained respect, developed better relationships and instilled hope. Andresen *et al.,* (2003) highlighted hope as integral to the process of recovery and the participants confirm this theory.

Group participants described finding it difficult to trust others, form relationships and develop compassionate images of the 'ideal friend.' All of these difficulties are explained by the absence of an internal model of compassion for these individuals. Social mentality theory (Gilbert, 2001; Laithwaite *et al.*, 2009) helps understand how difficult early attachment histories increase the risk of individuals becoming hyper-vigilant to the chance of further abuse and developing a 'threat focussed' mentality (interpersonal strategy) that does not trust those around them. During childhood forensic patients often lacked a caregiver that was reliably available. This resulted in these individuals lacking knowledge and skills in affect regulation. This in turn means that these individuals also have little sense of security or safeness. They cannot develop an internal working concept of compassion as they have had few compassionate relationships in their lives to model it upon (Read & Gumley, 2008; Laithwaite *et al.* 2009).

Shame and stigma associated with the experience of psychosis and hospitalisation may maintain the 'threat focussed' mentality for patients. Once hospitalised the role of a patient receiving treatment from professionals and having to abide by the rules and restrictions of the institution can reinforce the individuals' low social rank. Social Rank theory (Gilbert, 2001), described in previous sections, helps explain themes in the participants narrative describing the institutional barriers to recovery. Unavoidably a primary goal of a forensic mental health service is public safety and that means restrictions for patients. It is important to consider the system in which therapy is offered. The patients described a therapeutic environment that often lacked compassion. This is likely to have reduced the overall benefits of the programme.

Participants were leaving the group environment elevated and feeling respected, but were returning to a position of lower social rank within the ward environment for the majority of the week. Significant service changes need to occur. These are described in Section 8.

Compassion mind training underpins the content of the 'RAP' programme. Patients described improvements in their interpersonal relationships and by the end of the programme some described developing the ability to form a compassionate image and use this image to soothe their distress. Thus despite the limitations inherent in the institutional environment patients described being able to learn skills in compassionate responding. This suggests that their internal model of compassion has begun to be developed and may address some of the issues inherent in their difficult early attachments. Overall patient narratives appear to support the theoretical underpinnings of the RAP programme.

8   RECOMMENDATIONS

A subsidiary research objective was to gain suggestions for the improvement of the RAP programme. The following describes user-identified areas for the improvement to both the programme and the wider hospital:

8.1   Improvements to the RAP programme

Most recommendations to improve the programme are in relation to the issues prior to the group commencing. Some participants such as Dom, may have benefited from initial preparatory work to identify the causes of shame and the role that shame has in his life. He appeared to be in a stage of denial regarding his schizophrenia diagnosis and therefore rejected many of the therapeutic techniques (Birchwood *et al.*, 2006). Preparatory work may have increased the therapeutic benefits of him participating in the programme.

Improvements could also be made to the referral path. Participants such as Sam felt that they could not access appropriate psychological interventions in the hospital (Extract 59). An additional system for self referral which involved the patient filling in the referral form or phoning a designated line, would not only empower participants to take more control of their treatment, but also improve access to psychotherapies.

The participants all voiced initial concerns regarding the use of the 'ideal friend' technique with voice hearers. The technique appears to be successful at alleviating distress once patients have started to recover a sense of confidence in their minds ability to distinguish between reality and fantasy. Read *et al.*, (2004) highlights the necessity to work therapeutically with the needs of the patient on an individual rather than a diagnostic level. When suggesting this technique the clinician needs to be aware of the patients' current functioning and their stage of recovery. If used with patients at an appropriate stage of change, it can however have significant benefits.

In addition to the benefits of sharing experiences in a safe environment, patients also identified specific techniques within of the RAP programme that they felt enhanced the experience. These included the use of metaphor to challenge them to think more creatively (Stevie: Extract 87). The mountain metaphor had secondary benefits of allowing patients to reflect on past experiences as highs and lows rather than entirely negative (Sam: Extract 18). Despite initial

concerns, the 'ideal friend' was also a great source of support for many (Paul: Extract 97 Robert: Extract 98; Stevie: Extract 99; Stevie: Extract 100).

Individuals offered some recommendations to improve the programme such as more video clips to help stimulate group discussions (Dom & Danny), less homework (Roger and Tom) or removal of the imaginative techniques (Dom). Unfortunately there was little consistency in these recommendations and instead merely appear to reflect individual preferences. It instead highlights the need for facilitators to be flexible and to offer choices wherever possible. In contrast, the subject upon which patients did agree was the perceived negative impact the continuing care ward environment had upon their wellbeing. The following recommendations will therefore centre on suggestions to improve this environment for patients.

8.2   Improvements to the wider hospital

Participants discussed the high volume of patients on the wards making it busy and noisy. This resulted in participants having to block out the excessive noise with the use of headphones when reading. It also meant that patients did not feel that their needs were being met by staff. As a consequence, patients' behaviour appeared to deteriorate in an attempt to gain attention from busy staff. The rebuild of the current hospital site will address many of these difficulties with overcrowding. Wards will be smaller, housing a maximum of 12 beds. There will be a higher staff to patient ratio and separate areas that will allow patients to talk or read without the television. There is also a new resource centre that houses a hospital shop, bank, coffee shop, chapel, GP clinic, garden, woodwork and gym (The State Hospital, 2009b). This may aid the development of a more open community atmosphere within the hospital.

To enhance consistency of care each patient will also remain the responsibility of the same clinical team throughout their admission. Clinical team members may become more accessible, when their offices are re-located to the ward. There will also be an increase in the amount of ward based psychological therapies which aims to increase patient access to interventions (The State Hospital, 2009b).

It appears that the plans for the redevelopment of The State Hospital address many of the concerns raised in this thesis. These improvements to the physical environment need to be mirrored by improvements in the therapeutic milieu. Any mental health system needs to be built on personal and social change rather than control (Pfäfflin & Adshead, 2004). This is

true of any environment, even that of a high security environment such as The State Hospital. There are some significant security concerns that make this goal more complicated within high secure environment, but improvements are still achievable.

The RAP group was a safe environment in which patients could talk about their experiences. This helped them normalise their experiences and improved peer relationships. A variety of ward based groups may enhance the feeling of trust and understanding on the ward. Firstly, reflective open sessions at the end of each day would allow patients to discuss experiences. This would both normalise the daily difficulties faced and promote patient expert roles by sharing beneficial strategies. Secondly, a closed discussion group that allows patients to discuss relevant issues and "think outside the box" (Stevie) would enable patients to develop understanding of each other and develop positive peer relationships.

Patients currently have community meetings in their wards, but this has often become dominated by practical issues regarding the day to day running of the ward. Patients require a more reflective forum to share their experiences. The 'Hearing Voices Network' is a user led service running in the community since 1988 and an equivalent organisation in the hospital would allow patients to further reflect on their experience and develop trust between peers. The group could establish a committee to allow patients to have a greater voice within the hospital setting. This would allow them to develop a sense of self efficacy and further develop the role of patient as expert (Department of Health, 2005). Patients need more opportunities to have meaningful roles and responsibilities in the ward.

Patients also require a more active role in developing their own plans for the future. The patient needs to develop clear goals that are in line with the requirements of the clinical team and progress towards the future. This will require open conversations with patients about the vision they hold of their recovery and what they are aiming for in the future. Action points from The State Hospital Annual Review (2009a) included responding to patients' requests "for more easily understandable information about their condition and treatment." This would allow patients to take a more central role in tribunal processes, annual reviews and goal setting.

A minimum requirement should be that patients are kept informed of decisions affecting their care and treatment. Depending on the cognitive abilities of the particular patient, they may need to be provided in a variety of formats and repeated to them. There should be more immediate access to members of the clinical team in order to raise queries. There also needs to

be a more supportive strategy that encourages confidential whistle blowing for threatening, intimidating or inappropriate behaviour, whether by patients' or by staff.

Goodwin *et al.,* (2003) highlighted the need for clinical teams to act as parental figures to patients, offering them a secure base and modelling appropriate behaviour and compassionate responding. The State Hospital is a demanding environment in which to work. Gilbert (2006) has highlighted that this sort of role can often result in "compassionate fatigue." Developing staff well-being is crucial in ensuring quality of care for patients. There needs to be a secure base for staff, protected allocated time for supervision, suitable breaks and opportunity to have time for reflection with colleagues away from the ward environment.

The re-development of the hospital is an exciting phase, and with some minor changes there is the opportunity to extend the therapeutic milieu of the RAP programme to the entire hospital.

9   EVALUATION OF THE STUDY

9.1   Limitations of the study

The current study involved interviews that collected retrospective accounts of the participants' experiences. A significant length of time had elapsed between participants finishing the programme and being interviewed. For Tom and Roger approximately two years had passed. This was in part due to the researcher being off work on long term sick leave. Despite this time lapse most participants spoke in-depth about their experiences.

The study was also conducted at one specific time point. It would have been useful to evaluate the change in beliefs over the course of the programme, rather than the participants' retrospective perceptions of their personal development.

The study also provides very little information in terms other treatments the participants have received. As this is a qualitative evaluation the researcher acknowledges the impact that other factors such as medication may have, but is interested in gaining an accurate portrayal of participants' opinions on their experience, rather than an unbiased account of cause and effect.

A final criticism of the study is the researcher's dual role as the researcher and facilitator of the programme. In some cases the researcher also had a third role as the participant's therapist or

ward psychologist. The researcher was initially concerned that this may affect the information that patients provided or may bias the analysis. The range of both positive and negative appraisals that were provided in relation to both the group and the wider hospital suggest that participants provided open and honest answers. Furthermore IPA was chosen as an approach as it accepts that analysis involves an interaction and is therefore not unbiased. The researcher has ensured transparency throughout the analysis to allow for this issue (Brocki & Wearden, 2006). During the research process it was discovered that the dual role was in some ways also a strength of the study. The patients seemed to be more at ease during the interview, due to the rapport that had been established during the group. The researcher's knowledge of the programme also allowed her to recognise when participants became confused and began discussing a different group intervention in the hospital. Further strengths of the research will be discussed in the following section.

9.2 Strengths of study

This is an in-depth IPA study of participants' experience of attending a Recovery After Psychosis programme. It complements the quantitative evaluation of the programme (Laithwaite *et al.*, 2009) in that it provides an interpretation of the process of change that led to the positive clinical outcomes that were reported, and provides further evidence that CMT is suitable for patients in forensic populations.

The study revealed patients' perspectives on a range of experiences, both before their admission and during their stay within the hospital. Their views on the hospital environment come at a vital time to influence the development of a positive therapeutic milieu within the hospital redevelopment. This allows patients' views to influence the future of the hospital, which is consistent with current government priorities (Department of Health, 2001).

The current study also employs a larger sample of participants than is usually recommended for doctoral projects (Dallos & Vetere, 2005) allowing greater breath of participant views.

9.3 Future research

Future research could involve a qualitative study of the concept of recovery from the clinicians' perspective. The 'empowerment model' (Andresen *et al*, 2003) highlighted the need for clinicians to believe in positive outcomes for their patients and to foster hope. Sam discussed the disparaging comments of many clinicians regarding his future plans (Extract 28).

A study into clinicians' perspectives of recovery may either highlight further training needs or display positive views that will help to dispel the ongoing negative stigma regarding the chance of recovery for these patients.

To further assess the programme a 'Randomised Control Trial' (RCT) is planned in Ayrshire and Arran by Christine Braehler. This RCT in association with Laithwaite *et al.* (2009) and the current study will offer a comprehensive assessment of the programme. In an attempt to improve the quality of psychological interventions, further research is also necessary into which aspects of the programme produced both positive change and aided the retention of material.

An assessment of the effectiveness of peer support groups and discussion forums within a forensic setting was recommended in section 8 and is currently being planned by the author.

10   CONCLUSION

In conclusion the following sections will directly and succinctly answer the aims of the thesis outlined in section 4.6:

A. What was the patients' experience of the RAP programme?

In response to the main research question this evaluation has provided an in-depth evaluation of participants' experiences of attending a 'Recovery After Psychosis' programme. Patients' narratives complement the results of the quantitative evaluation of the programme and describe the process of change that led to these positive clinical outcomes (Laithwaite *et al.*, 2009). The patients generally found the experience of attending the RAP programme to be positive. Patients felt that the positive atmosphere of the group was supportive and empathic. The group normalised their experiences of mental illness and made them feel more positively about themselves in relation to others. This allowed them to develop trust and form relationships in the group.

B. What is the patients current understanding of the following core programme modules?

The study fulfilled subsidiary research objectives and provided insight into patients' experiences' of the core elements of the programme: psychosis; recovery and compassion

i.   Psychosis

Participants described a lack of trust in both themselves and others as a common defining element of their psychoses. They viewed this lack of trust in others as a consequence of both their paranoid symptoms and their past experiences of maltreatment, betrayal and stigma. Participants also described a lack of trust in the ability of their own mind to make decisions and distinguish between reality and delusions. Participants attempted to reduce distress by avoiding thoughts of the past or the future and concentrating instead on the concrete, immediate and observable. In order to recover patients needed to re-establish connections both to their memories of the past and relationships with others.

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ii. Recovery

As explained above participants were reluctant to talk about the future and this included the idea of recovery. They did, however, explain that recovery is an ongoing process. Most felt recovered in comparison to other group members. Participants highlighted fears that the wider hospital environment was acting as a barrier to change. They explained that the crowded setting of the ward causes them to further isolate themselves and avoid social contact whenever possible. The high demands placed on staff resulted in patients feeling that their needs were not being adequately met, they felt that they lacked control of their future and were unaware of decisions made by the clinical team regarding their care and treatment.

iii. Compassion

There was an absence in patient narrative of any explicit discussions of compassion. Compassion within the group was however implicit throughout the narratives. It was implied within their discussion about the development of trust, the creation of a safe place to talk and increased understanding of both themselves and others.

C. Do patients perceive CMT to be a successful intervention within forensic settings?

The RAP group offered an atmosphere of trust, compassion and safety that was not experienced elsewhere in the hospital. Although compassion was not discussed explicitly there was evidence of empathy and compassion throughout the narratives. Patients benefited from the normalising affect of sharing their experiences. The safety of the group setting allowed participants to develop trust between each other and trust in their ability to cope with a range of thoughts without distress. In this environment they felt adequately supported to trial the CMT techniques taught in the programme. Despite initial anxieties most CMT found techniques were successful in alleviating their distress. Thus in answer to subsidiary research objectives, the present study provides further evidence that compassionate mind techniques are suitable for patients in forensic populations.

D. What improvements can be made to the RAP programme from the patients' perspective?

Obtaining these participants perspectives is vital in terms of making the service more aware of the views of patients. Recommendations such as increased user involvement and patient discussion groups have been put forward in the hope of expanding the positive atmosphere found in the group to the wider hospital environment. It is hoped that these issues will be addressed in the current hospital re-development.

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12 APPENDICES

Appendix 1.   **RAP Ideal Friend Worksheet**

A worksheet provided to participants, during the RAP programme to aid and guide the development of the ideal friend.

Building a Compassionate Image

This exercise is to help you *build* a compassionate image of a **unique ideal friend** for you to work with and develop. Whatever image comes to mind or that you chose to work with, note that it *is your* creation and therefore your own personal ideal – what you would really like from feeling cared for and cared about. However, in this exercise it is important that you try to give your image certain qualities. These will include:

Wisdom, Strength, Warmth and Non-judgement
So in each box below think of these qualities (wisdom, strength, warmth, and non-judgement) and imagine what they would look, sound or feel like.

If possible we begin by focusing on our breathing, finding our calming rhythm and making a half smile. Then we can let images emerge in the mind – as best you can – do not try too hard. If nothing comes to mind, or the mind wanders, just gently bring it back to the breathing and practice compassionately accepting.

Here are some questions that might help you build an image: would you want your caring/nurturing image to feel/look/seem old or young; male or female (or non-human looking – e.g. an animal, sea or light)? What colours and sounds are associated with the qualities of wisdom, strength, warmth and non-judgement? Remember your image brings compassion to you and for you.

How would you like your ideal caring-compassionate image to look/appear – visual qualities?	
How would you like your ideal caring-compassionate image to sound (e.g. voice tone)?	
What other sensory qualities can you give to it?	
How would you like your ideal caring-compassionate image to relate to you?	
How would you like to relate to your ideal caring-compassionate image?	

Appendix 2.   **RAP Ideal Friend Diary Sheet**

During the RAP programme participants were encouraged to make thought records of difficult situations that occurred between sessions. This aided reflection and identified times when their ideal friend could be used.

Thought monitoring and your ideal friend

Triggering events, feelings or images	Beliefs and key thoughts	Feelings	Compassion focused alternatives to negative thoughts	Understanding and change in feelings
Key questions to help you identify your thoughts. *What actually happened?* *What was the trigger?*	*What went through your mind?* *What are you thinking about others, and their thoughts about you?* *What are you thinking about you and your future?*	*What are your main feelings and emotions?*	*What would your ideal friend say to you?* *What alternatives might there be?* *What is the evidence for the new view?* *(How) is this an example of compassion, care and support?*	*Write down any change in your feelings.*

Appendix 3.   **RAP Recovery Plan Template**

Towards the end of the RAP programme participants' reflected on what they had learnt and developed a staying well. The following worksheet was used to help them structure their thoughts.

PSYCHOLOGICAL THERAPIES SERVICE

(PSI-RAP)

RAP Group

Personal 'Staying Well' Plan

Name:

Section 1:

The key problems that led to me coming into this hospital are (include in this offending behaviour as well as psychosis) :-

1.

2.

3.

4.

5.

Things that I know, or have recently discovered, that stress me out and make me vulnerable are:-

1.

2.

3.

4.

5.

The following would be signs that I may be becoming unwell again (i.e. they would be WARNING SIGNS for me). (Please try & identify which are *early* or *late* signs and which are the most important – i.e. which would require you to need <u>IMMEDIATE </u>help).

1.

2.

3.

4.

When I'm feeling unwell or starting to feel unwell, I often use some of the following strategies to help me cope (these are sometimes referred to as SAFETY BEHAVIOURS):

1.

2.

3.

4.

5.

Section 2:

ACTION PLAN & AGREED COPING STRATEGIES

Things I believe might help me when I'm becoming unwell are:

1.

2.

3.

4.

The following are sources of help that I know I can use to help me in the event that I start to become unwell:-

1.

2.

3.

4.

Occasionally we may feel unable to seek help when we need it – e.g. we may feel too unwell (like *things have gone too far*) or we may find it hard to trust someone else. I've therefore identified the following as obstacles that might get in the way of me seeking help when I may need it in the future:

1.

2.

3.

4.

Lastly, having identified these obstacles, things I can do to overcome them are:-

1.

2.

3.

Section 3: Compassionate understanding:

What would my ideal friend say to me to help me understand why I ended up in hospital?

What sense would they try and make of my experiences of psychosis and offending behaviour?

Appendix 4.   **Ethical Approval**

Lothian Ethics board had approved the quantitative evaluation of the RAP programme (Laithwaite *et al.*, 2009). A substantial amendment was then submitted to add a qualitative element to the evaluation. As part of the amendment the authors' name was added as a researcher of the qualitative component. Appendix 4. contains Lothian ethics approval and hospital management approval letter.

Lothian NHS Board

Dr Heather Laithwaite
The State Hospital
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Carstairs
Lanarkshire

Deaconess House
148 Pleasance
Edinburgh
EH8 9RS
Telephone 0131 536 9000
Fax 0131 536 9009
www.nhslothian.scot.nhs.uk

NHS
09 January 2008
Lothian

Dear Dr Laithwaite

Study title	: Recovery After Psychosis [RAP]: A recovery focused programme for patients with psychosis in forensic mental health settings
REC reference	: 06/S1103/76
Amendment number	: 4
Amendment date	: 11/12/2007

The above amendment was reviewed on behalf of Lothian Local Research Ethics Committee 03 by a sub-committee comprising the Chair, Dr Christine West, and Dr Janet Andrews.

Ethical opinion
The sub-committee gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

Approved documents
The documents reviewed and approved at the meeting were:
- Notice of substantial amendment no. 4, dated 11/12/2007
- Protocol, version 4, dated 11/12/2007
- Patient Information Leaflet for Qualitative Interview, version 1, dated 11/12/2007
- Consent Form for Qualitative Interview, version 1, dated 11/12/2007
- Letter to RMO, version 1, dated 11/12/2007

Research governance approval
All investigators and research collaborators in the NHS should notify the R&D Department for the relevant NHS care organisation of this amendment and check whether it affects research governance approval of the research.

Statement of compliance
The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

REC Reference Number	06/S1103/76	Please quote this number on all correspondence

Yours sincerely

Liz Harden
Committee Co-ordinator
Lothian Local Research Ethics Committee 03

Copy to: R&D Department for NHS Lothian

INVESTOR IN PEOPLE

SL32 Favourable opinion of amendment
Version 3, June 2005

The State Hospital

NHS SCOTLAND

Our Ref.: SCY/mm

15 December 2006

Dr Heather Laithwaite
Chartered Clinical Psychologist
State Hospital

Dear Dr Laithwaite

Re: Recovery after Psychosis (RAP): A recovery focused programme for patients with psychosis in forensic mental health settings

Having considered the views of the Research Committee in respect of the above project, I write to advise you that the State Hospital will sponsor your project, and that my name can be inserted in the appropriate section of your COREC form.   Managerial approval to proceed with your project is subject to you obtaining full Ethical Approval and I would be obliged if you could advise me when full Ethical Approval has been obtained.
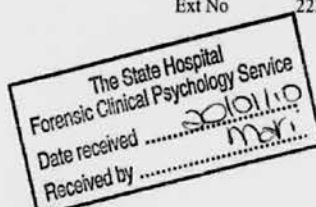
Best Wishes

Yours sincerely

Ms Lucy Abraham | Date | 18 January 2010
Trainee Clinical Psychologist | Our Ref | SCY/aa
The State Hospital | Your Ref |
| Enquiries to | Ann Abernethy
| Ext No | 2221

The State Hospital
Forensic Clinical Psychology Service
Date received ....
Received by ....

Dear Ms Abraham

Re: **Recovery After Psychosis (RAP): A recovery focused programme for individuals with psychosis in forensic settings.**

Having considered the views of the Research Committee and noted that you have obtained Ethical Approval, I write to give you Managerial Approval to proceed with your project. This is subject to you fulfilling the requirements of the Ethics Committee and of the State Hospital Research Committee.

May I take this opportunity to wish you every success in your endeavour.

cc. Jamie Pitcairn, Research and Development Manager.
Dr Lindsay Thomson, Medical Director.

Appendix 5.   **Responsible Medical Officer consent form**

Prior to approaching participants the RMO gave their consent for the participant to be approached. This was to ensure that the participant had the capacity to make an informed decision.

The State Hospital

Date:

Version 1 December 2007

Dr
Consultant Forensic Psychiatrist
The State Hospital

Dear Dr RMO

We have recently completed two Recovery After Psychosis Programmes (RAP) in the hospital and would like to interview patients involved in the programmes. In particular we are interested in finding out, from their perspective, both the positive and negative aspects of the treatment programme so that it can be adapted for future use. If you consent to your patient(s) being approached, they will then be invited to take part in this interview by either myself, or Lucy Abraham, Trainee Clinical Psychologist.

Each potential participant will be given a Patient Information Leaflet and if they agree to take part in the study, they will be asked to sign a consent form. If they participate in the study, they will be interviewed for approximately 60 minutes, on their experiences of being in the Recovery After Psychosis Programme. Each interview will be audio-recorded using a digital recorder. This interview will then be typed up by a transcriber in the psychology department. There will be no patient identifiers on the typed up transcripts, and the digital recorder will not leave the State Hospital.

The findings of this study will contribute to programme and service development in the State Hospital. Furthermore, the results of this study will be written up for publication in a peer-reviewed journal. All patient identifiers will be removed. The results of this study will also be submitted as part of a research thesis being submitted for a D.Clin.Psy to the University of Edinburgh.

-2-
Dr
The State Hospital

We have identified the following patients who attended the RAP group, who we would like to interview. I would be grateful if you could inform me by (date) 2008 as to whether you would consent to Mr .... being interviewed.

Attached is a permission slip for you to complete. I would be grateful if you could return this to ██████ by () 2007.

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Yours Sincerely

Ms Lucy Abraham
Trainee Clinical Psychologist

Dr Heather Laithwaite
Acting Consultant Clinical Psychologist

c.c. Ward Clinical Psychologist

Ms Lucy Abraham
Trainee Clinical Psychologist

Dr Heather Laithwaite

Acting Consultant Clinical Psychologist

I consent to Mr ....being involved in this interview.

Signature ……………………………………………….. Date............................

Name   ………………………………………………..

Appendix 6.   **Participant Information Sheet**

Following RMO agreement that the patient had capacity to give informed, the researcher approached the patients and asked them to consent. Information was provided verbally and in the information sheet that follows.

NHS

SCOTLAND

The State Hospital

Patient Information Leaflet for Qualitative Interview (version 1: December2007)

"Recovery After Psychosis (RAP): A recovery focused programme for people with psychosis in forensic mental health settings." (Rec Ref 06/s1103/76)

Thank you for participating in the Recovery After Psychosis Programme. At the State Hospital we are always revising programmes and adapting them to meet patient needs. We value your opinion on the programmes you attend and we use this to constantly develop the programmes we offer.

Having recently completed the Recovery After Psychosis Programme, we would like to invite you to participate in an interview, where you will be asked to comment on your experiences of the programme.

This interview will be carried out by Lucy Abraham, Trainee Clinical Psychologist.

What is the purpose of this study?

The purpose of this interview is to help us evaluate this programme and for you to provide feedback on your experiences of being a participant in this group. Your feedback is extremely important to us and helps us to shape the services we offer to patients in the hospital.

Why have I been chosen?

You have been selected because you have recently completed the RAP programme. Your RMO has also been asked to consent to us approaching you.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at anytime and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect the standard of care you receive.

What will happen to me if I take part?

If you decide to take part, Lucy Abraham will meet with you for around an hour and ask you about your experience of being in the RAP group. This interview will be audio recorded using a digital recorder, and this will then by typed up by either Ms Abraham or the secretary in the psychology department. After the interviews have been typed up, the interviews on the digital

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recorder will be scrubbed. There will be no identifiers on the typed up transcripts, so no one will know who you are. Typed up transcripts will be kept in a locked cabinet in the psychology department. Dr Heather Laithwaite, Lucy Abraham and our external consultant to the programme, Dr Andrew Gumley, will have access to these transcripts.

Will my taking part in this study be kept confidential?

If you choose to take part in this study, your RMO, ward manager and ward psychologist will be notified. if you disclose information during the interview that causes concern about your well-being, or the well-being of others, this information will be shared with your RMO and Clinical Team. When the study is written up to be submitted for publication, all names and identifiers will be removed so there is no possibility of you being identified.

What will happen to the results of the research study?

The results will be written up for submission to a journal, and the results will be used to develop patient services in the hospital. Lucy Abraham is working towards a Doctorate in Clinical Psychology and the results of this study will be written up and submitted to the University of Edinburgh as part of her thesis. There will be no personal information or identifiers contained in this.

If you have any further questions, please do not hesitate to contact me.

Lucy Abraham
Trainee Clinical Psychologist
Department of Psychology
The State Hospital

Dr Heather Laithwaite
Acting Consultant Clinical Psychologist
Department of Psychology
The State Hospital

Appendix 7.   **Participant Consent Form**

Participants were given a minimum of one week to review the participant information sheet. If after that time they were willing to participate they were asked to sign the following consent form.

NHS

SCOTLAND

The State Hospital

Participant Consent Form for Qualitative Interview (version 1: December 2007)
Rec Ref 06/s1103/76

"Recovery after Psychosis: A recovery focused programme for people with psychosis in forensic mental health settings."

Principle Investigator: Lucy Abraham, Specialist Psychological Practitioner

Name of Participant
(printed)...

(delete as appropriate)
- I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions.   **YES/NO**

- I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason, without my medical care or legal rights being affected.   **YES/NO**

- I understand that sections of any of my medical notes may be looked at by responsible individuals from the Psychosocial Interventions for Psychosis team. I give permission for these individuals to have access to my records.   **YES/NO**

- I understand that the interview is being recorded and will be transcribed.   **YES/NO**

- I understand that if I disclose information that causes concern about my well-being or the well-being of others, that this will be shared with my RMO and clinical team.   **YES/NO**

- I wish to receive a summary of the study results   **YES/NO**

- I understand that anonymised findings will be published (details that identify you will not be published)   **YES/NO**

- I agree to take part in the above study   **YES/NO**

Participant's signature:... Date:....................

Principal Investigator's signature:......................................Date.....................

Appendix 8.   **Semi-Structured Interview Schedule**

The researcher attended a one day workshop on IPA run by Paul Flowers, University of Glasgow. Based on information and advice provided within the workshop and additional reading, a semi-structured interview schedule was developed. This was then reviewed by two supervisors and modified based on comment. The final interview schedule is outlined on the following pages.

Interview Schedule

Thank you for agreeing to take part in this interview to help us understand more the experience of being part of a Recovery After Psychosis Programme. I am interested in finding out your thoughts and opinion on the programme. So, You're here today to take part in a semi-structured interview, so this means that although I've got a list of topics that I'm interested in, that I hope that the interview will be much more like a chat than an actual structured interview, with you doing most of the talking. If I ask you something that doesn't make sense, please just ask me. Sometimes in these interviews people feel that they have been talking too much! Don't worry about that. Because I want to find out about your own personal opinions and experiences, there's not really a right or wrong answer. Sometimes questions might sound a bit obvious or strange, but that is because I'm trying not to take anything for granted and to find our your own opinions. I hope you'll be able to be as honest and open as possible with me I will be recording the interview but anything that you say that might identify you or others will be removed once the interview is typed up. You can stop at any point if you need a break or if you change your mind about being part of the study. If that happens the tape recording will be destroyed. Your typed interview will be kept in a secure place. At the end of the interview I will be happy to answer any questions you might have about the study.

What is your experiences of the Recovery After Psychosis Programme?

What would you tell a friend about the programme?

What worked for you?

What didn't work?

What was helpful or unhelpful?

What did you like or not like?

Did the programme make a difference for you?

If so, what do you think brought about that change?

The group talked about experiences of psychosis a lot, how did you find that?

What was helpful or unhelpful about that?

Do you feel your understanding of psychosis has changed?

If so, what brought about that change?

The group talked about the idea of recovery a lot, how did you find that?

What was helpful or unhelpful about that?

Do you feel your understanding of recovery has changed?

Were people in the group at the same stage of recovery? How did you find that?

If so, what brought about that change?

The group talked about qualities such as compassion and forgiveness a lot, how did you find that?

What was helpful or unhelpful about that?

Do you feel your how you think about compassion has changed?

If so, what brought about that change?

Anything else you feel is important to know about your experience of doing the RAP programme?

What could have been done differently to make it a better experience?

General prompts:

What do you mean when you say.......?

Can you tell me a bit more about that?

Can you give me an example of when that happened?

Why was that?

How?

How did that make you feel?

Looking back now what do you think about....

Appendix 9.   **Example Extract of Participant Transcription**

All interviews were initially transcribed verbatim and were sensitive to the individuals' accent, pauses in narrative and background interruptions. An example of the transcription ids provided on the following page.

200 **So that was something that was helpful. Was there anything**
201 **that you found unhelpful about the group?**

202
203 I didn't much like eh listening to other people talk about their
204 lives... did I? No, there's eh there's there's two points to this. I
205 did and I didn't. Part of me was of my duty here with these
206 people, I don't want to know. But part of it eh, it was
207 interesting and inform informative, and specially for myself
208 because of the way things have been for me since I got here, I
209 actually and because I I I did one or two courses and at group
210 before and that's all, it was interesting and novel and never
211 really heard people speak like this before about their lives. It's
212 very interesting. It's very informative, but on the other side of
213 it, I was saying to myself you know em, - - (2 secs) I don't
214 really want to know.

215
216 **Em. What made you feel you didn't want to know?**

217
218 My peers. The people I went to school with, eh I left in 1993.
219 Eh. After the summer holidays I went to University, got a
220 degree em and then started in the work place and have now
221 been in the work place for ten, fifteen years, so the way I eh
222 measure my life, is with measuring against their lives. So I was
223 sitting there and I said I'm in a psychiatric hospital, I'm in a
224 group full of psychiatric patients, talking about all this horrible
225 stuff, that I wish wasn't relevant to me, and I should be, with
226 my peers, eh freedom in the work place, so I didn't I really,
227 parts of me really disliked it and parts of me thought it was
228 great because it was relevant to me and it did help me with
229 myself.

230
231 **So did it how did that feel, sitting there, with that, with all**
232 **that?**

233
234 First, first of all it was good because it was helpful for me and
235 em, I felt good because, eh, I've only one, two or three groups
236 before, and it was a novel thing for me to be able to be
237 relatively open, and to hear other people who were being
238 relatively open, eh, to get life experience to learn, from life
239 experience.

240
241 **Okay. Did the programme make a difference to you do you**
242 **think?**

243
244 Yes.

245
246 **In what way?**

247
248 In what way? - - - - - - - (7 secs) (patient sighs) - - - - - (5 secs) I
249 learnt about mental illness. I learnt about myself in relation to

Appendix 10.   **Participant Case Studies**

A brief summary is provided below of participants' backgrounds to ensure transparency within the analysis:

Participant One

Participant one (Dom) is an unmarried 48 year old man who currently resides in a continuing care ward in the State Hospital. He had a difficult upbringing involving suspected childhood abuse. He attended school until he was sixteen and left with no formal qualifications. He later gained a City and Guilds qualification whilst in custody and has been in a long term, supportive relationship throughout his detention.

Dom was sentenced to life for a murder carried out in the 1970s. He was released on three occasions, but on each occasion this was revoked due to his behaviour on release. He is reported to have become increasingly unwell whilst in prison, voicing paranoid thinking and delusions of a religious content.

His first admission to psychiatric services was in the mid-nineties when he was diagnosed with paranoid psychosis. He was admitted to The State Hospital as he was deemed a risk to himself in the form of self neglect and was seen as a risk to others due to a history of verbal intimidation and threatening behaviour when ill. Since his admission he has taken part in the following group programmes; 'Drug and Alcohol;' 'Coping with Mental Illness;' and 'Anger Management'. He is not aware of any plans to refer him to local services at the current time.

The researcher first worked with Dom in 2006 as the psychologist based on his continuing care ward. Within this role she conducted a range of risk assessments which required a synopsis of previous file information. Dom disputed the accuracy of this information and the frustration caused him to end any therapeutic contact with the researcher until the commencement of RAP. Despite his reassurances to the researcher that this no longer worried him, there was a sense during interview that he did not want to discuss in detail some topics, particularly his mistrust of clinicians:

> Reflective log, (01 June 2009):
> During the interview [Dom] provided some constructive criticism of the programme. As I was one of the facilitators I think this made it more difficult for him to express this diplomatically. I was conscious of my reaction to the more negative feedback he was providing, as it was difficult for him and I didn't wish to deter him.
>
> He provided areas for improvement such as the use of video extracts to stimulate discussion. He also highlighted concerns that the 'ideal friend' was dangerous and opened your mind to the prospect of mental illness. Overall he felt the group was one of the most important programmes for patients in the hospital. Personally, he felt he

did not get as much benefit as other group attendees. He felt that the group was difficult for him as his psychotic episode was thirteen years ago and he feels it is no longer relevant.

The key themes identified in this participant's narrative were related to the 'fragility of the mind'. He described his experience of psychosis as being the result of trying to make sense of supernatural and religious experiences. There is a sense that these concepts can "blow your mind," (Extract 19), He seemed to perceive the mind to be fragile and unable to cope with some of the strategies employed in the RAP group. He raised concerns that the 'ideal friend' was an "extremely dangerous" (Dom: 449) technique to use with mentally unwell patients. He seemed to believe that once the mind is open to imagination then patients will be susceptible to hearing other auditory hallucinations.

He reported a difficulty verbalising his experiences especially in the form of a letter and a difficulty using his imagination. He reported believing that difficulties with these skills have been present since his childhood (Extract 7; Extract 8; Extract 12).

He reported "mistrust" both of society generally and the medical establishment based on previous experiences (Extract 38). He explained that he would prefer to go to his loved a one in the event of relapse. Despite a lack of trust for authorities he regarded the group as a safe place to talk. It allowed people to find communality and develop understanding of themselves and others (Extract 69).

He believed that RAP would have considerably more benefits for other patients. He did not perceive many personal benefits of attending the programme, nor did he perceive himself to be mentally unwell. Therefore he did not develop the therapeutic skills taught in the programme such as mindfulness, the ideal friend or compassionate responding. Other patients perceived Dom's unwillingness to engage as a sign that he was further behind in his recovery.

Overall he viewed the group as beneficial and one of the most important group therapies in the hospital. The main reason for this is that it provided a "scoring system" (Extract 84) with which he could compare himself to other group members. He was reassured and hopeful as a result of viewing his abilities in comparison to others.

Participant Two

Participant two (Danny) is a single 35 year old man that currently resides on the same continuing care ward as Dom. He was admitted to The State Hospital from prison services in 2006 due to deterioration in mental health whilst serving a life sentence for murder. He has a history of self harm and his symptoms at the time were believed to place him at significant risk to his own health.

Danny described having a good upbringing and was part of a large family. He left school at fifteen with no formal qualifications and embarked on a youth training scheme. His employment history includes a variety of short term manual roles. Danny had two significant relationships in the past and has children but no access arrangements.

The researcher first worked with Danny clinically as his ward psychologist conducting reviews and helping him manage his anxiety. He has also participated in 'Drug and Alcohol', and 'Coping with Mental Illness' programmes. He also commenced 'DBT' following RAP.

> Reflective log (01 June 2009):
> Danny appeared very anxious. As a consequence he would often seek reassurance that he was saying the right thing. He often lost track of the conversation and would ask me to repeat the question. I was aware that the open nature of my questioning was at times quite daunting for him. Despite his initial anxiety, it felt much more relaxed than the previous interview. A major theme in his narrative appears to be the difficulty he had with discussing recovery and planning a future. He has eight years remaining till his liberation and does not feel able to think about life in the community.

Themes in Danny's dialogue centred around mistrust of other people (Extract 35, Extract 37, Extract 40; Extract 45). This appeared to be, in part, related to experiences of peer bullying (Extract 55) and the stigma he has perceived in wider society (Extract 45).

He described anxieties in relation to a variety of aspects of his life including his own thoughts (Extract 21). He was particularly avoidant of thoughts of the future (Extract 24). This seemed to be partly related to the significant period of time that remains till his liberation date.

These anxieties were also a difficulty within the group setting (Extract 7 ; Extract 8). The main benefit of the group from his perspective, was that it increased his confidence and allowed him to tolerate and eventually enjoy sitting in a group situation (Extract 90). The reason for this was the safe environment of the group (Extract 65; Extract 66). Safety was created in the

group setting through the adherence to boundaries and the flexibility of staff to accommodate him. An example of this was being able to arrange the furniture in a way that he felt comfortable in initial sessions. This provided him with an element of control in a situation where he felt anxious. He described significant benefits of talking to other people who had gone through similar experiences (Extract 69; Extract 75; Extract 77; Extract 78). This had a significant normalising effect and made him more hopeful. By the end of the group he was able to talk about a future which he had originally feared.

Participant Three

Participant three (Paul) is a 45 year old man admitted to The State Hospital ten years ago having been found mentally unwell at trial in connection with the murder of a child. He is currently diagnosed with paranoid psychosis and at the time of interview, he was residing on a rehabilitation ward. His first contact with psychiatric services was in 1987 due to depression, self harm and suicide attempts.

Paul is the middle child of five. He reported witnessing domestic violence between his parents who are now deceased. He missed significant periods of his schooling and left without any qualifications. In his adult life he worked in a variety of roles including a job at a steel works, on a farm and in bars. In his personal life he maintained a number of long term relationships.

Since his admission to the State Hospital he has participated in a range of psychological interventions including a 'Coping with Mental Illness' group, 'Drug and Alcohol' treatments; 'Anger Management;' and 'CBT for psychosis'. The researcher had no therapeutic involvement with this patient prior to him commencing the RAP group.

Following the interview the researcher made the following entry in her reflective log:

> Reflective log (08 June 2009):
> There was a sense in this interview that Paul was providing all the answers that he thought I wanted to hear. There was nothing he felt needed improving and nothing he didn't enjoy. Through discussion with the ward psychologist it seems that this group came at the right moment in his recovery. A lot of the interview centred around stage of recovery and he felt that other patients were at a different stage in the recovery process to him. He felt that they were at the stage he was at years previously. As a result he felt that he took the lead in group activities. He felt that the main benefit of the group was to show the clinical team and prove to himself he was capable. The report and positive feedback that he received was perhaps one of the best parts of the

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programme for him. He also really enjoyed the support and communication in the group.

As can be seen in Table 2 Paul spoke very positively about the RAP Programme and felt that it had a significant role in developing his understanding, through sharing common experiences in a safe environment (Extract 61; Extract 74). He differentiated between the group environment and that of continuing care wards. He believed that the atmosphere on these wards was a major cause of depression (Extract 58).

Due to his poor educational history, Paul was initially concerned about his ability to do academic tasks in the group (Extract 5; Extract 9 ; Extract 10). He was initially sceptical of the ideal friend technique, but later found it to be beneficial (Extract 32). By the end of the programme this participant had developed new skills (Extract 97) and was acting as an expert assisting other group members (Extract 91; Extract 92).

In contrast to other group members, he found the group discussions about his past, his future and more abstract thinking very useful and wanted to be part of another reflective group in the future (Extract 19; Extract 27). The researcher hypothesised that this may be a consequence of his stage of recovery and the imminent date for his discharge. This provided him with the confidence to explore these difficult topics. Paul described wanting to do well in the group to illustrate his abilities to the clinical team (Extract 48). This occurred and he was subsequently transferred to other services.

Participant Four

Participant four (Roger) is a twenty six year old man who was admitted to The State Hospital in 2005 from prison services. He has been diagnosed with paranoid schizophrenia and drug induced psychosis. At the time of his admission he had been serving a sentence for culpable homicide and is not due for parole until 2014.

He suffered a violent upbringing witnessing marital violence between his parents and suffering abuse himself. Roger was expelled from school at the age of fifteen due to serious fighting. He left school with no formal qualifications and did not find employment. His intelligence was assessed by the Wechsler Assessment of Intellectual functioning (WAIS IV) and his performance was in the borderline range.

He previously took part in: 'Drug and Alcohol' group interventions; 'Coping with Mental Illness' group treatment and 'CBT for Psychosis'. The researcher had not been involved in his care prior to his participation in the RAP Programme. Following the interview the researcher made the following record:

> Reflective log (16 June 2009)
> This rehab ward is usually viewed as the final step prior to discharge. Another patient on the ward declined to take part in these interviews, because he was so close to being discharged. He saw the interview as having the potential for him "to slip up at the final hurdle." In the interviews carried out on this particular ward, nobody has criticised the programme or made any suggestions for improvements. This could be due to a number of reasons; they may be feeling that they are still being assessed and don't want to say anything negative in case it affects their chances of being discharged. Alternatively it could be that they are in a more positive frame of mind because they can see progress. During the interview with Roger he was very anxious and gave very brief answers. Prior to the interview he had been unsure whether he could remember enough about the group to talk with me and this seemed evident in the interview. The interview was very short in duration.

As highlighted above, Roger reflected a great deal on the limited cognitive resources he had as a result of his upbringing. He regularly commented on his inability to remember despite being able to make a lot of relevant comments (Extract 2). He also described himself as an isolative individual and as a result found it difficult sharing information during initial group sessions (Extract 3).

A major theme for Roger was the restrictive nature of The State Hospital (Extract 47). He reported that his motivation to participate in psychological groups was a result of threats and incentives given by staff in relation to his future plans (Extract 49; Extract 51 ; Extract 52). He described the lack of control and the monotony of life within the hospital (Extract 52). As a result of these factors he believed that 'recovery' was impossible within the hospital environment (Extract 47).

He also spoke very positively about the programme, particularly the safe and supportive environment that it provided for talking with other patients and sharing experiences (Extract 71 ; Extract 79). Roger explained that the programme illustrated the benefits of sharing his concerns with others (Extract 95).

Participant Five

Participant five (Tom) is a 34 year old man admitted to the hospital two years ago for the purposes of assessment. At the time of admission he was serving a life sentence for attempted murder. His first contact with psychiatric services was in 2001. He immigrated to the UK prior to his index offence and states that he is still married to a woman in his country of birth. There is a scarcity of accurate file information about this participant as a result of his recent immigration. The researcher had not been involved in the care of this patient prior to his participation in the RAP programme. He commenced the RAP programme group in March 2007 but had a good recall of material. Following the interview these notes were made in the Researchers reflective diary:

> Reflective log (08 June 2009):
> Tom's speech was difficult to understand at times and the interview was therefore difficult to follow. He had surprisingly good recall of a group that he had participated in a number of years ago. He was generally positive about the programme. The sharing of experiences and forming of friendships was central for him especially as he is someone that is generally outcast and ridiculed. He is scared to return to prison in the future for this reason. He discussed the cycles of recovery/relapse and with hindsight I should have asked about how this felt when he returns to the beginning of a cycle. He also commented on how well the programmes offered within the hospital work together. He had done 'Coping with Mental Illness' first as a purely psycho-educational programme. This was followed by individual CBT and then the group discussions involved in RAP. I felt I was talking more in this interview perhaps this was due his linguistic abilities. He made a lot of hand gesture and nodded to communicate in the interview.

Key themes in Tom's narrative were in relation to difficulties in The State Hospital environment. He described early abusive experiences that made him fearful of recalling the past. He described bullying in the ward environment, that triggered memories of his childhood abuse (Extract 15). Tom greatly appreciated the trust and safety of the RAP group setting where, in contrast to the ward, he felt equal to his peers (Extract 72). The programme provided important information about the different paths to recovery (Extract 80). Tom felt that in comparison to other group members he was progressing well in his recovery (Extract 87).

Participant Six

Participant six (Robert) currently resides on a continuing care ward in the hospital. His first contact with psychiatric services was in 1992. He has received diagnoses of paranoid schizophrenia, schizo-affective disorder and drug induced psychosis. In 1997 he was found guilty of killing his partner during a psychotic episode and was admitted to The State Hospital from court.

As a child, Robert reports being rejected by his mother. He spent significant periods of his childhood in borstal care and children's homes. There are also reports of physical abuse. He attended school until the age of sixteen and left with no formal qualifications. He gained unskilled manual employment. He was married at the age of 25 and had four children from three different relationships. Robert continues to have contact with his mother and brother, but is denied contact with his children.

Robert previously engaged in group interventions for: 'Drug and Alcohol' issues; 'Anger Management; 'Problem Solving Skills Training;' 'Relationship Group; and 'CBT for psychosis'. The researcher did not work with this patient prior to the RAP programme:

> Reflective log (17 June 2009)
> The interview was short in duration and felt heavily structured by the researcher. Staff working with this patient therapeutically have frequently remarked on the feelings and emotions that are evoked during interactions. His eye contact is usually held for longer and more intently than is the norm. His index offence was against a female as he 'saw the devil in her eyes'. He tended to avoid providing too much information that was of a personal nature. This may be due to concerns about disclosure affecting his future transfer. Alternatively it may have been a genuine difficulty verbalising his experiences. There were discussions of paranoia and delusions, but he provided no details of what these experiences were like for him personally.

Robert explained in the interview that he was encouraged to take part in the group, due to the suggestion made by staff that it would help his chance of discharge. Once he attended the group he said that he found it beneficial (Extract 50). When he was unwell, prior to entering the hospital, he described feelings of mistrust which resulted in isolative behaviour (Extract 46). In contrast, he found, that trust developed in the group as a result of shared experiences (Extract 62; Extract 63; Extract 64).

Participant Seven

Participant seven (Stevie) is a 47 year old man currently residing on a rehabilitation ward within the hospital. He has had sporadic contact with services since 1997 and whilst in prison his mental health deteriorated further. His index offence was a suicide attempt involving a gas explosion of proportions that endangered the lives of others.

Stevie reported an uneventful upbringing, but he suffers significant gaps in his long term recall. Reports from third parties indicate some difficulties in his early development. He left school at the age of sixteen with no formal qualifications. He gained unskilled employment and then progressed to a responsible engineering role.

Stevie engaged in 'Drug and Alcohol' programmes and 'Coping with Mental Illness' prior to commencing RAP. He also engaged in CBT for psychosis work with the researcher.

> Reflective log (12 July 2009)
> This interview was extremely positive. The participant was enthusiastic about the group and the progress he has made. He explained a clear process of change through attending the group. There were, however moments in which his description of the ideal friend was so vivid that I can relate to the concerns of the other participants. Hearing such vivid descriptions may lead some clinicians to wrongly suspect relapse. Given the difficulty of diagnosis in schizophrenia this is a real concern.

Stevie described the distressing nature of thought. He was trapped in thoughts of the present and observable. He avoided thoughts of the past (Extract 16), he had difficulty distinguishing reality and delusion (Extract 22) and he was fearful of contemplating the future. He felt "stupid" for believing his illness, but the group normalised this experience (Extract 75). He was initially sceptical of the imaginative techniques, but once he tried them he found them to be very beneficial. Techniques of mindfulness and the 'ideal friend' helped him to begin to contemplate his past, make sense of the present and be confident in planning a future (Extract 99). He took a role of patient expert and was so pleased with the benefits of these techniques that he tried to share them with other patients (Extract 93).

Participant Eight

Participant eight (Sam) is a 39 year old man who was admitted to the hospital from another high secure setting in 2006. His first contact with services was 1994. He described developing schizophrenia at a young age. Sam is an only child and has a good relationship with his parents. He became ill whilst at college studying for A' levels. He described a boy at college manipulating him to kill, at a time when he was vulnerable due to his mental illness and his lack of social support. He was found guilty of murder and entered the prison system, where he was later diagnosed with paranoid schizophrenia and transferred to a special hospital.

Sam was enthusiastic about taking part in the interview and spoke at length about his experiences:

> Reflective log (19 June 2009)
> The opportunity to talk with others both in the recent interview and the RAP group was important to Sam and he wished for this to continue in the future. He contrasted the feeling of safeness and confidentiality that allowed open expression in RAP with the feeling on the ward and within prison. I was surprised to hear him chastise himself, for not seeking help from someone in the hospital earlier. He explained that staff were available, but he didn't feel able to approach them. He felt that his therapeutic experience has only just begun in the hospital and this raised questions for me: How as clinicians we can ensure that therapeutic experience commences earlier? How do we build a greater feeling of trust throughout the hospital? How do we engage people when they do not have the ability to approach staff themselves?
>
> Sam also raised the issue of shame and stigma particularly in the prison environment. It is only now that he is well that he is able to look back and recognise his exposure to stigma and intolerance. Through the discussions of compassion and forgiveness within RAP he was able to recognise the stigma of the past. I reflected post interview on whether this is really a good thing. I wondered how he had framed these experiences previously?

Sam was very articulate during interview and he discussed all of the themes highlighted in this study. The researcher found the themes described above in the reflective log particularly salient; the lack of support (Extract 39), his difficulty seeking appropriate support and the stigma that he felt he had experienced (Extract 44) were particularly moving. He continued to request help within the hospital, but believes it is difficult because of the demands of a busy environment.

Sam also differs from other participants in a number of ways. He described a positive relationship with his parents (Extract 36) and high hopes for his future (Extract 28). He

described becoming frustrated when staff suggested that he may not attain specific future goals. As a result of his upbringing he too perceived himself to be different to other patients in the hospital. He described not wanting to form relationships with other patients because he fears he may be "contaminated" by others (Extract 43). He appeared to have made some progress by the end of the group, in that he felt safe talking to others in the group and he had begun to see the benefits of talking to them (Extract 60 ; Extract 76).