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Exploring Therapeutic Endings and the Role of Therapeutic Relationships in Promoting Recovery for Secure Inpatients; an Interpretative Phenomenological Analysis Study and a Systematic Review and Narrative Synthesis.

by

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Thesis for the degree of Doctorate in Clinical Psychology

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University of Southampton

Abstract

Faculty of Environmental Life Sciences

School of Psychology

Doctorate in Clinical Psychology

Exploring therapeutic endings and the role of therapeutic relationships in promoting recovery for secure inpatients; an IPA study and a systematic review and narrative synthesis

by

Sophie Rose Collingwood

Research suggests that Therapeutic Relationships (TRs) are important across disciplines and can improve outcomes. This is also true for secure care, where there is an increased risk of attachment difficulties and experience of trauma. Yet there is little research on the role of TRs in promoting recovery. Secure inpatients may also experience several therapeutic endings, such as ending therapy, moving wards, staff leaving or a change in care team. Given the importance of TRs and the attachment difficulties experienced by secure inpatients, and the volume of endings experienced, it is important to understand the experience of therapeutic endings for this population.

Chapter 1 is a systematic review of the qualitative literature around patient perspectives of recovery and TRs in secure care, to understand the role of TRs in promoting recovery. 11 papers were quality assessed and analyzed using thematic synthesis. This produced two overarching themes of *Promoters*, highlighting how positive TRs can promote recovery and *Barriers*, highlighting how difficult TRs can become a barrier to recovery. Results aligned with previous reviews regarding recovery in secure care.

Chapter 2 is an empirical paper exploring low secure inpatient experiences of therapeutic endings, using Interpretative Phenomenological Analysis (IPA). Three Group Experiential Themes were identified from an IPA of interviews with eight participants: *The Flow of Power, Endings Through Time and Coming to Terms with the Loss of Connection.*

Results of both chapters are discussed in line with the current literature and clinical implications, strengths and limitations, and directions for future research are considered.

Table of Contents

Table of Contents 3
List of Tables 6
Table of Figures 7
Research Thesis: Declaration of Authorship 8
Acknowledgements 9
Definitions and Abbreviations 10
Chapter 1 The Role of Therapeutic Relationships in Promoting Recovery in Secure Services. A Systematic Review and Narrative Synthesis ... 11
Journal Guidelines 11
Title Page 12
Abstract 13
Introduction 14
Aims 18
Materials & Methods 18
Eligibility Criteria 19
Search Strategy 19
Identification and Screening of Papers 19
Quality Appraisal 20
Results 21
Data Synthesis 21
Quality of Included Studies 22
Themes 22
Discussion 31
Clinical & Research Implications 37
Strengths & Limitations 39
Conclusion 40
Acknowledgements 41
Declaration of Interests Statement 41
Data Availability Statement 41

References **41**

Supplementary Material 1 – Definitions of Secure Care **48**

Tables **49**

Table 1 – Eligibility Criteria 49

Table 2 – Data Extraction Table 50

Table 3 – Theme Summary & Prevalence 53

Figures **54**

Figure List 55

Chapter 2 Experiences of Therapeutic Endings for Low Secure Inpatients. An Interpretative Phenomenological Analysis **56**

Journal Guidelines **57**

Title Page **58**

Abstract **59**

Introduction **60**

Study Aims 64

Materials & Methods **65**

Ethical Approval & Considerations 65

The Unit 65

Recruitment 65

Participant Demographics 67

Data Collection 67

Data Analysis 68

Quality Assurance 69

Validity 69

Results **70**

Group Experiential Theme 1 – The Flow of Power 70

Group Experiential Theme 2 – Endings Through Time 73

Group Experiential Theme 3 – Coming to Terms with the Loss of Connection 79

Discussion **88**

Strengths & Limitations 93

Future Directions 95

Conclusion 95

Acknowledgements **96**

Declaration of Interests Statement **96**

Data Availability Statement **96**

References **96**

Chapter 2, Supplementary Material 1 – Interview Schedule **102**

Chapter 2, Supplementary Material 2 – Reflexive Summary **104**

Tables **108**

Table 1 – Summary Demographics 108

List of Tables

Chapter 1 – The Role of Therapeutic Relationships in Promoting Recovery in Secure Services. A Systematic Review and Narrative Synthesis.

Table 1 – Eligibility Criteria................................. **Error! Bookmark not defined.**

Table 2 – Data Extraction Table .... **Error! Bookmark not defined.**

Table 3 – Theme Summary & Prevalence................ **Error! Bookmark not defined.**

Chapter 2 Experiences of Therapeutic Endings for Low Secure Service Inpatients. An Interpretative Phenomenological Analysis

Table 1 – Summary Demographics......................... **Error! Bookmark not defined.**

Table of Figures

Chapter 1 – The Role of Therapeutic Relationships in Promoting Recovery in Secure Services. A Systematic Review and Narrative Synthesis.

Figure 1- PRISMA 2020 flow diagram for new systematic reviews which includes searches of databases, registers and other sources……………………………………………………………55

Research Thesis: Declaration of Authorship

Print name: Sophie Rose Collingwood

Title of thesis: Exploring therapeutic endings and the role of therapeutic relationships in promoting recovery for secure inpatients; an IPA study and systematic review

I declare that this thesis and the work presented in it are my own and has been generated by me as the result of my own original research.

I confirm that:

1. This work was done wholly or mainly while in candidature for a research degree at this University;
2. Where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated;
3. Where I have consulted the published work of others, this is always clearly attributed;
4. Where I have quoted from the work of others, the source is always given. With the exception of such quotations, this thesis is entirely my own work;
5. I have acknowledged all main sources of help;
6. Where the thesis is based on work done by myself jointly with others, I have made clear exactly what was done by others and what I have contributed myself;

None of this work has been published before submission

Signature: ....

Date: 23/08/2024

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Definitions and Abbreviations

CHIME............................Connectedness; Hope and optimism about the future; Identity; Meaning in life; and Empowerment (model of recovery for general psychiatric services).

CHIME............................Connectedness; Hope and optimism about the future; Identity; Meaning in life; and Empowerment (model of recovery for general psychiatric services).

CHIME-S…………………..Connectedness; Hope and optimism about the future; Identity; Meaning; Empowerment; Safety & Security

IPA ....Interpretative Phenomenological Analysis

Meaning in life; and Empowerment; Security & Safety (model of recovery for secure services.

MHA................................Mental Health Act (1983)

MoJ..................................Ministry of Justice

NHS.................................National Health Service

PRISMA...........................Preferred Reporting Items for Systematic Reviews and Meta-Analyses

REC.................................Research & Ethics Committee

Secure Care ....Secure hospitals support people with mental health difficulties, who due to either a risk to themselves or others, cannot be cared for under general psychiatric services.

Therapeutic Endings.........Patients moving ward, service or to the community, staff leaving, care team changing, end of therapy.

Chapter 1 The Role of Therapeutic Relationships in Promoting Recovery in Secure Services. A Systematic Review and Narrative Synthesis.

Journal Guidelines

This paper has been prepared for the Journal of Forensic Psychology Research and Practice. Guidelines for submission can be found on the following in Appendix A and the following webpage: https://www.tandfonline.com/action/authorSubmission?show=instructions&journalCode=wfpp21

Title Page

The Role of Therapeutic Relationships in Promoting Recovery in Secure Services. A Systematic Review and Narrative Synthesis.

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Abstract

Although there has been increasing research on recovery in secure care, there has not been a specific focus on the role of therapeutic relationships. This paper systematically reviews the qualitative literature around recovery and therapeutic relationships in secure care, from patient perspectives, to understand the role of these relationships in promoting recovery. The review was pre-registered on PROSPERO (CRD42023475411) and followed PRISMA guidelines. 11 papers were retained from searches of six databases and hand searches of citations and reference lists. Papers were quality assessed and analyzed using thematic synthesis. This produced two overarching themes of *Promoters*, highlighting how positive therapeutic relationships and connectedness can promote recovery and *Barriers*, highlighting how difficult therapeutic relationships and disconnectedness can become a barrier to recovery. Themes and subthemes aligned with previous reviews regarding recovery in secure care. Results are discussed with reference to current literature and clinical implications including models of care are discussed. (150/150 words)

Keywords: recovery, therapeutic relationship, forensic, secure inpatient, review

Introduction

The current paper offers a qualitative systematic review and narrative synthesis of the role of the therapeutic relationship in promoting recovery, using the views of secure inpatients. Throughout this paper, those accessing secure care will be referred to as “patients”. This is in line with recent research (Priebe, 2021) that suggests that the term patient is favored more by those using services than other terms such as ‘service user’ or ‘consumer’.

Therapeutic Relationships

Therapeutic relationships are seen as the primary vehicle of change, over any specific approach and external factors (Lambert & Barley, 2001). Therapeutic relationships, or alliances, were defined by Norcross as “the feelings and attitudes that therapist and client have toward one another and how these are expressed” (Norcross, 2010, p. 114). They are often reported in terms of psychological therapy, but are applicable to other disciplines such as occupational therapy (Evatt & Scanlan, 2022), nursing (Zugai et al., 2015) and psychiatry (Priebe & Mccabe, 2008). Safe and effective therapeutic relationships should be adapted to the needs of the person, adapting the relationship for culture, preferences and attachment style has shown promising effectiveness (Norcross & Lambert, 2018). Therapeutic relationships are particularly important for secure inpatients (Drennan et al., 2012), who spend most of their time with staff and have few opportunities for relationships outside of hospital (Mezey et al., 2010).

Therapeutic relationships can be negatively impacted by attachment difficulties (Mann et al., 2014) and relational trauma and abuse (Jordan, 2010). Developing and maintaining safe and effective therapeutic relationships with secure inpatients can be challenging, as they are also more likely to have experienced trauma over the lifespan (McKenna et al., 2019) and are much more likely to be insecurely attached when compared to the general population (Adshead

& Moore, 2022). Research suggests that patients hold therapeutic relationships in high esteem, and may view staff as attachment figures, acting as their secure base (Adshead, 2002).

Due to these difficulties with attachment and often negative experiences of care, for example, with non-attuned parents, secure inpatients might have indirect ways of communicating emotional needs (Aiyegbusi, 2009). This may result in their needs not being met, and as a result they may feel staff are also unattuned and unavailable, in the same way as their caregivers in childhood. Within this cohort particularly, it may mean that perceived unavailability of care leads to them displaying care-eliciting behaviors which are inherently linked with risk to self and others, such as self-harm, violence and aggression towards staff and peers, in order to get their needs met (Olsson et al., 2015). Therefore, seeking care in this manner could affect progression from services because risk behaviors could lead to further restrictions, such as loss of leave. Within secure settings, there also needs to be acknowledgement of the gatekeeping role of staff, and the power imbalance that exists within this relationship (Tomlin et al., 2020). Given this gatekeeping role and power imbalance, there is likely to be an impact on the therapeutic relationship, but also progression through services and assessment of risk.

Recovery

Stronger therapeutic relationships have been posited to both increase well-being and linked to how recovery orientated patients feel psychiatric inpatient services are (Osborn & Stein, 2019). The concept of recovery in mental health is presently considered as living *with* mental health difficulties with new meaning and purpose (Anthony, 1993) and historically in a medicalized

way as the reduction or of absence of symptoms. This idea encompasses personal recovery (Slade, 2009) and moves away from recovery viewed as just clinical, functional and social. Personal recovery includes not only the individual, but the system around them, including the social environment and identity enhancing relationships, which promote the person as more than their illness (Slade, 2009). Leamy et al. (2011) suggest there are five personal recovery processes: Connectedness; Hope and optimism about the future; Identity; Meaning in life; and Empowerment (CHIME). For those from Racially and Ethnically Minoritised (REM) backgrounds, two further themes included culturally specific facilitating factors and collectivist notions of recovery (Leamy et al., 2011).

A systematic review of secure patient's experience of recovery, suggested that sense of self and connectedness, to both staff and the wider network, were the two most important factors in recovery to this group (Clarke et al., 2016). The role of positive staff relationships in developing the sense of self is also important to note and is further supported by another review, which reports relationships as having a vital role in recovery (Shepherd et al., 2016). Secure settings need to further consider the role of risk and safety, in relation to offending, but also to the restriction and control placed upon patients, who may experience stigma related to their mental health and risk (Drennan & Wooldridge, 2014). This stigma could present a barrier to recovery (Mezey et al., 2010).

Senneseth et al. (2022) updated the CHIME model for recovery in secure care; the CHIME-S, to include safety and security, and acknowledge the difficulties for secure patients in maintaining hope. The model also incorporated the importance of the quality of relationships with staff specifically related to secure services, due to the length of admission and further identified the role of staff in coming to terms with experiences of trauma and offending in relation to patients' identity. CHIME-S also suggests the importance of rupture and repair of relationships in secure settings, and how this can support with recovery, perhaps as a way of

supporting secure service users to cope with ruptures, given the attachment difficulties described above. One final addition to the model, (Senneseth et al., 2022) is about developing mutual collaboration and having a shared understanding of goals, whilst working with the person to achieve them. The therapeutic relationship could be the way of achieving collaboration. The model also separately states unique barriers for secure service users, which are both relational and environmental.

International guidance on promoting recovery in secure services suggests that the therapeutic relationship is one of the key factors in recovery focused practice; “A therapeutic relationship is essential to supporting recovery in which partnership working and hope is promoted”, (Le Boutillier et al., 2011, p. 1474). This review of guidance demonstrates the importance of therapeutic relationships in recovery and suggests that services should be attending to therapeutic relationships in order to promote recovery.

There have been several systematic reviews examining recovery generally in secure care and personality disorder services (Clarke et al., 2016; Senneseth et al., 2022; Shepherd et al., 2016) but to date a review has not been carried out to understand secure patients’ perspectives of the role of therapeutic relationships in promoting recovery. Hence, the current study aims to add to the research, looking at the role of therapeutic relationships specifically in secure inpatient populations and from patients’ perspectives. Patients are experts by experience; therefore the current study uses the views of patients as opposed to staff, or observational and clinical data gained through quantitative studies. It is important to understand how patients experience services as well as understanding their experiences through the lens of staff (Holley et al., 2020).

Aims

The present study aims to provide a narrative synthesis of qualitative studies exploring patient experiences of personal recovery in secure care, in relation to therapeutic relationships. More specifically answering the following question: What is the role of the therapeutic relationship in the personal recovery of those experiencing secure care?

Materials & Methods

The current paper will systematically review qualitative papers using thematic synthesis (Thomas & Harden, 2008) to provide a synthesis of both primary and secondary data on secure inpatient experiences of the therapeutic relationship and how this is linked to recovery. A scoping search was completed to check for suitability of the review topic and a protocol was subsequently registered on PROSPERO (International Prospective Register of Systematic Reviews, CRD42023475411) and follows the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) (Page et al., 2021). The synthesis is approached from a constructivist perspective and utilizes a hybrid inductive and deductive approach (Proudfoot, 2023), by initially inductively developing themes grounded in the data, and then deductively applying these to two existing reviews based on recovery in secure care by Clarke et al., (2016) and Senneseth et al., (2022) when developing analytical themes, as per the third stage in thematic synthesis (Thomas & Harden, 2008). Although Barnett-Page and Thomas (2009) argue that thematic synthesis could be approached from a critical realist perspective, they also suggest that the epistemological position is unclear in Thomas & Harden's original paper. A social constructivist approach; however, suggests that learning develops existing knowledge, and an individual can understand this knowledge in novel ways (Taylor, 2018), which is why this approach is used within the present synthesis. As such, this paper takes a relativist position

(Willig, 2012), putting importance on the meanings constructed by participants in research and adopts reflexivity to understand one's own position in this sense making, utilizing discussions within research supervision to understand this.

Eligibility Criteria

Eligibility criteria are outlined in table 1 below.

[Table 1 here]

Search Strategy

A full search was completed in October 2023, to identify papers for the current review, using the following databases: PsycINFO, MEDLINE, EMBASE, CINAHL, BNI and ProQuest Dissertations & Theses. Reference lists and cited article searches were then conducted by hand. The search strategy included the words: Therap* relationship OR therap* alliance OR staff relationship AND Recover* AND Low secur* OR medium secur* OR high secur* OR forensic OR secure inpatient. Use of the terms with asterixis allowed for synonyms and truncations, which was supported by all of the databases used.

Identification and Screening of Papers

The PRISMA flow diagram (Page et al., 2021) of the search and review process is depicted in figure 1. A total of n = 273 papers were identified from the initial search. These were entered into Rayyan to remove duplicates and screen titles and abstracts. Rayyan is a tool to support systematic reviews, allowing identity-hidden rating between multiple authors (Ouzzani et al.,

2016). N = 103 items were removed as duplicates. The 160 unique returns were independently rated by the first author and a second rater (NM), using identity-hiding software, to reduce bias. Initially, there was conflict with eight articles; however, these were all resolved through discussion and refinement of the inclusion and exclusion criteria. This resulted in 8 full text articles, of which, 25% (2 articles) were reviewed by a second rater (NM). There were no discrepancies in titles to be excluded and included at the full text stage. Following review at full text, the reference lists and citation searches of included articles was conducted by hand and revealed a further n = 3 articles for inclusion, from n = 979 papers.

Quality Appraisal

The quality of the research included in the present study was appraised using the Critical Appraising Skills Program (CASP, 2018) for qualitative research. Given the vulnerability of this population, it is important to take into account how researchers have managed the ethical problems associated with research in this area (Sheldon et al., 2011). This is particularly pertinent for issues around informed consent, whereby those detained in secure hospitals may say ‘yes’ to being involved in research to be seen in a positive light, or may feel inclined to be involved in research facilitated by their therapist (Sheldon et al., 2011). Therefore, when assessing quality in the present review, particular attention was paid to how informed consent was obtained. The CASP tool was used to create a score, with each question answered yes, being given a score of 1, providing a score out of ten.

Results

Data Synthesis

Of the 11 papers included in the review, nine were conducted in the United Kingdom, one in Canada, one in Australia and contained a total of N=142 patients. See table 2 for a summary of study characteristics. A hybrid inductive and deductive thematic synthesis (Thomas & Harden, 2008) was used to analyze the data, which proposes a three step analysis, first creating descriptive codes, second, developing these into descriptive themes and, third, creating analytical themes from this data. Thomas and Harden (2008) suggest there is overlap between these stages. This allows themes to stay close to the data, whilst also building upon the descriptions provided in the primary studies, to generate new data (Maeda et al., 2022). The method was designed to allow the synthesis of qualitative data for systematic reviews, based on the principles of thematic analysis (Braun & Clarke, 2006). The primary researcher kept a reflexive journal to help ensure analysis was grounded in the data and to check assumptions brought to the process, analysis was conducted with authors CC, MH and PL.

In order to answer the research question, primary and secondary data related to therapeutic relationships with staff and principles of recovery for secure patients from both direct quotations and author interpretations was analyzed with thematic synthesis. Recovery was as defined in the CHIME-S framework (Senneseth et al., 2022) and the principles generated in the review by Clarke et al. (2016), namely connectedness, coming to terms with the past, sense of self, freedom, hope, and health and intervention. These definitions of recovery for secure patients were used to guide the analysis related to the therapeutic relationship with staff. The use of reflexive journals alongside the development of initial codes inductively, with any codes related to the staff relationships included. This process included going back and forth between the data, ensuring that any codes that overlapped were collapsed and refined, and new

codes were generated as needed to account for the data. NVivo 13 (International, 2020) was used to support the line by line coding and then grouping into themes.

Following this, descriptive codes were created by visually clustering similar codes. Finally, themes and codes were displayed visually and analytical themes generated about patients' views and experiences of therapeutic relationships deductively, using two systematic reviews detailing principles of recovery for secure service users to identify a framework to map the themes onto (Clarke et al., 2016; Senneseth et al., 2022). An excerpt from the code workbook can be found in Appendix B

Quality of Included Studies

All of the studies scored above 8/10 or above, indicating good quality. Of the lowest scoring studies, there were difficulties with ethical considerations, one did not report having gained ethnical approval for the study (Barsky & West, 2007), several did not consider how the relationship between researcher and patients would have affected the study (Bennett & Hanna, 2021; Nijdam-Jones et al., 2015; Walker et al., 2023). Of the others there needed to be more discussion around how patients were recruited (Baker, 2017; Bennett & Hanna, 2021). On the whole, most studies considered ethical issues when working with this population and discussed issues of privacy, confidentiality and obtaining informed consent (O'Connor et al., 2021).

[Insert Figure 1 here]

[Insert Table 2 here]

Themes

Two overarching themes captured the role of therapeutic relationships in recovery: "*promoters*" and "*barriers*". "Promoters" has five subthemes, supported by 6-11 of the papers and describes how therapeutic relationships promote recovery. 'Barriers' describes how

difficulties in therapeutic relationships can hinder, and be a barrier to, recovery and has three subthemes, supported within 6-11 of the papers. Sub-themes were constructed through the lens of two earlier reviews (Clarke et al., 2016 & Senneseth et al., 2022). Patients in the studies reported feeling cared for in good therapeutic relationships, and care appeared to be a marker of a relationship which promoted recovery, thus supporting patients to overcome the identified barriers to recovery, such as disconnection or overcoming shame. See table 3 for a summary of how many papers supported each theme.

[Insert table 3 here]

Promoters

Promoter 1 – Moving toward the future with meaning

Therapeutic relationships inspired patients to have hope for the future (Clarke et al., 2017). Having hope can support patients to feel like their preferred future is in reach, but can be lacking in secure services (Budge, 2016). Furthermore, staff relationships supported patients to find meaning by preparing for life outside hospital and to make progress:

> *In the other places you don't make a bond and that like I said because it's easier. Here… you-You gotta make a bond, some sort of bond and that to get some sort of working relationship you know in order to get leave and go out and stuff like that, progress - Mark* (Mitchell, 2023, p. 85)

Relationships were seen as an essential part of moving on from services and into the community, whether that be to do psychology work, which was not always by choice (Baker,

2017), or influencing advancement through “the system” through to lower security settings, or the community (Budge, 2016).

Promoter 2 – Developing Identity and sense of self

Staff relationships facilitated a move towards non-patient identities, with “people being treated like people” - Bob (Baker, 2017, p.87). Patients’ sense of being viewed as humans also supported them to develop their sense of self and worth, and feel as though they were treated equally and mattered:

> *When I was unwell I never had any kind of, any support from anyone, I was totally alone . . ...now I’m here it is important to have recognition and support by people because it helps . . . . . . it makes you feel that you deserve something, that you’re recognized as a person for who you are, not as something to be, uh, ridiculed against or something negative . . . it makes you feel have self-worth and that means you matter rather then not mattering at all* - Participant number or pseudonym not reported (Mezey et al., 2010, p. 690)

Patients described the importance of developing relationships, which enabled self-discovery and that within this process, it was important to learn from experiences in the past (Laithwaite & Gumley, 2007). This process was described as helpful, but could also be difficult for patients to deal with (Clarke et al., 2017); however, “coming to terms” with the past, or offending history, with the support of staff to reframe and understand the offence in context, helps ensure the past is not repeated (Nijdam-Jones et al., 2015). Coming to terms with their offences, and letting down barriers within the relationship allowed patients to feel accepted (Mitchell, 2023) and worthy (Mezey et al., 2010) and meant their identity became more than the roles defined

for them by services (such as offender and mental health patient), which was important to foster hope (Clarke et al., 2017).

Promoter 3 – Empowerment

Patients felt empowered through learning skills, from staff within the therapeutic relationship, for self-management of their mental health difficulties (Bennett & Hanna, 2021). These skills allowed patients to remain in control, and obtain their preferred method of support from staff (Bennett & Hanna, 2021), with staff providing the "tools" and "direction" (Gavin in Clarke et al., 2017, p. 68) to allow patients to keep well (Clarke et al., 2017). Furthermore, relationships helped patients cope with being detained in hospital, often for long periods of time (Mezey et al., 2010; Nijdam-Jones et al., 2015).

Patients were further empowered by having a say in their care (e.g., Walker et al., 2023), with staff collaborating *with* patients important to achieve this (Baker, 2017). This form of mutual collaboration gave patients a say in their care (O'Connor et al., 2021), balancing the power between patients and staff and allowing them to move from the "darkness to the light" (Clarke et al., 2017), as highlighted by the quote below:

> *Because you get involved in your care, you're not in the dark, you're um, in the light, what's going to happen to you, um and um, your goals set for you, and um, you get some direction, um, you get to have your say.* - John (Clarke et al., 2016, p. 67)

Promoter 4 – Safety & Security

Relationships can provide safety and security in both the felt sense, in the form of feeling safe (Baker, 2017; Mezey et al., 2010) and secure (Budge, 2016) by asking "'what's wrong?" - Kyle

(Bennett & Hannah, 2021, p. 934); and the physical sense, by managing risk, using the relationship to de-escalate aggression or other incidents and prevent the use of seclusion and, or promote self-management of risk, by offering reflection on risk incidents (Budge, 2016). Feeling emotionally and physically safe was an important factor for feeling cared for by staff (Baker, 2017):

> *One thing is the care that we get. Nobody sees what goes on behind the scenes, just to keep me here. Keep me safe, keep me fed, keep me warm* - Alfie (Baker, 2017, p. 86)

Staff were able to manage risk by flexibly applying the rules, which was appreciated by patients (Bennett & Hanna, 2021). Staff completing risk assessments with patients appeared to contribute to this feeling of safety and allowed them to feel like there was a safety net in place in the event they experienced a deterioration in mental health, or showed signs of risk (O'Connor et al., 2021). Talking with patients and understanding risks, means the relationship acts as a vehicle for "getting to the bottom" of feelings (Mezey et al., 2010), which is done through staff becoming acquainted with patients and their needs (Walker et al., 2023). Patients reported benefitting from this approach and felt like staff were there for them and able to help (Barksy & West, 2007).

Promoter 5 – Connectedness

This theme was the most prevalent in the data and pertains solely to the importance of patients' relationships with staff. Support from professionals, over time, can help patients develop relationships with family (O'Connor et al., 2021) and repair ruptures (Budge, 2016). Trust and respect in relationships with staff are an important tool that the relationship cannot flourish without (e.g., Barksy and West, 2007), and are vital for recovery (Bennett & Hannah, 2021).

Trust is developed over time, and benefits from the 'consistency' of staff in being there for patients (Budge, 2016; Laithwaite, 2007). Patients described unconditional support from staff, with "continued care" provided, despite threats, or abuse which helped develop a meaningful, good quality, special connection (e.g. Bennett, 2021).

> *All the team, the whole team, from the doctor down to domestics. They've all supported me in times where I've been unwell or uncooperative* - James.
> (Bennett & Hanna, 2021, p. 931)

For some patients, this type of relationship was unique to one member of staff and was built up over time (Nijdam-Jones et al., 2015). Staff were seen to have qualities that boosted the relationship, such as finding the positive (Clarke et al, 2017), being "down to earth", generally personable (e.g., Walker et al, 2023) and empathetic (Bennett & Hanna, 2021, Budge, 2016).

Patients reported that support within therapeutic relationships and therapy, helped them to appraise the meaning of their past relational trauma, such as experience of abuse, or surrounding their offence and manage their illness (Clarke et al., 2017; Mezey et al., 2010). This supports personal recovery and development of new non-patient or offender identities. Establishing therapeutic relationships with staff takes time, and the investment of time was important to patients *"they seem to want to spend more time with you and develop those relationships"* Daphne (Budge, 2016, p. 96) and contributed to patients adapting to the hospital environment (Laithwaite & Gumley, 2007).

Barriers

Barrier 1 – Disconnectedness

This theme depicts the ways in which patients feel disconnected from staff and their wider network, such as feeling unable to trust staff, and therefore unable to benefit from the

therapeutic relationship (e.g. Bennett & Hanna, 2021). Patients saw this as having a knock-on effect on their behavior (Barksy & West, 2007), with mistrust of staff meaning patients felt unable to communicate their psychological and emotional needs, thus increasing risk of incidents of violence or self-harm (Budge, 2016). Some patients reported that it was difficult to build trusting relationships with staff (e.g., Laithwaite & Gumley, 2007), either due to their mental health difficulties and experiencing paranoia, or because their therapeutic relationships were informed by their previous negative experiences of care growing up. This is indicated by a patient in Budge's paper (2016*) "it was quite hard because I've always had, like, trust issues"* - Daphne*.* (Budge, 2016, p. 95).

It is further supported by P11, in Laithwaite and Gumley's study (2007), who described feeling rejected by his mother as a child and never good enough and stated:

> *I see myself as worthless and not good enough, and . . . I am nervous about carrying on a conversation with someone in case I say the wrong things, or I say something that is stupid, so I will go into my shell and that is how I deal with things.* – P11 (Laithwaite & Gumley, 2007, p. 308)

Social interaction outside of secure settings was limited, due to the limitations of secure care (Mezey et al., 2010) and this could "*perpetuate feelings of frustration, loneliness and sadness*" (Nijdam-Jones et al., 2015, p164). In addition, patients described feeling let down and disappointed in the past by staff, or by the system itself (Baker, 2017; Clarke et al., 2017) which acted as a barrier to building new relationships and good quality therapeutic relationships, because staff might be kept at arm's length for protection.

The loss of therapeutic relationships acts as a barrier to recovery because it further diminishes the amount of people a patient has meaningful connections with (e.g. Mitchell, 2023). Patients described taking a long time to form connections with staff (Nijdam-Jones et

al., 2015). As such, if familiar staff then leave, this could act as a barrier to patients accessing support, as patients felt they could 'talk to' staff they had known a long time and felt safe to disclose, in a way they did not with unfamiliar staff (Budge, 2016; Mitchell, 2023). Given the limited opportunities for building relationships outside of hospital, and the increased length of stay in hospital, patients described becoming dependent on staff support. P05 in Walker et al.'s study (2023) described the feeling of institutionalization "*it's a sad thing to say, but the regime of the place. To get institutionalized is wrong, but I've been, this section I've been in 15 years, I'm institutionalized"* - P05, (Walker et al., 2023, p. 9). The researchers (Walker et al., 2023) described this institutionalization as:

> *Patients adapted to having structure and being told what to do, developing a reliance on others, potentially associated with a loss of skills. The system and structure designed to support patients to manage their mental health conditions can leave them ill-equipped to move on and progress*. (Walker et al., 2023, p. 9)

This could act as a barrier to freedom, by patients not having the skills needed to move on, as they are reliant on staff.

Barrier 2 – Disempowered and Ashamed

Patients described feeling disempowered through mistreatment (e.g. Barksy & West, 2007; Bennett & Hannah, 2021) and abuse of power by staff (e.g., Clarke et al., 2017), resulting in a lack of autonomy and collaborative care. Furthermore, patients felt "done to" (Mitchell, 2023) or neglected, and feeling as though staff are present, but unavailable to meet their needs (Nijdam-Jones et al., 2015).

Shame and self-loathing were described as barriers to recovery, and patients reported that some interactions within relationships with staff evoked these feelings:

> *if you make a request which is reasonable and you get . . . an abrupt response or someone treats you badly in that interaction, it affects the way you feel about yourself as a person, is it just me they're doing it to, is it something that I've done, or something that is wrong with me. – Participant number or pseudonym not reported* (Mezey et al., 2010, p.692)

Patients felt as though staff did not want to spend time with them (e.g. Baker, 2017), which acts as a barrier to having good quality therapeutic relationships. High staff turnover also meant patients felt they were unable to build relationships with staff (Walker et al., 2023). Some felt that relationships were conditional and *a "are a commodity, bought through the currency of 'good' behaviour'"* (Budge, 2016, p. 118). Inconsistency of staff responses was seen as a barrier because it affected trust within the relationship, and left patients not knowing where they stood (Budge, 2016). Patients made sense of a lack of therapeutic relationships as sad (Mezey et al., 2010), but also as negatively affecting "*quality of Life, health, wellbeing, and progress"* (Walker et al., 2023, p.10), and thereby recovery. This theme also identified the divide patients felt between themselves and staff, labelled as the "us versus them" dynamic (e.g. Clarke et al., 2017).

Barrier 3 – Perpetuating stigma though dehumanization

Patients reported that relationships wherein they felt seen as their mistakes (Clarke et al., 2017) were dehumanizing and led to patients feeling *"morally judged"* and that this offered justification for staff to treat patients poorly (Baker, 2017, p.78). Viewing and treating patients in this way was viewed as unhelpful:

I mean sometimes I feel they don't look at us as people, sometimes I feel they look at us as objects, like it's their job, that they come in and they have to do it ...they're just here, they're just doing their job and they want out of here and that doesn't help. - Participant number or pseudonym not reported (Mezey et al., 2010, p. 692)

Relationships that are de-humanizing and do not promote individuality are in conflict with recovery and supporting people to develop non-patient and non-offender identities. Some patients felt as though staff did not convey an "understanding of mental health problems" which was also detrimental to patients feeling understood (Barksy & West, 2007, p. 9).

Discussion

The present systematic review explored how patients viewed therapeutic relationships and their role in promoting recovery through thematic synthesis of the data. Given that patients are the experts by experience in this setting (Tapp et al., 2013), it is important that their views are heard. After reviewing and going through the stages identified in the PRISMA guidance (Page et al., 2021), 11 studies met the inclusion criteria for this study. This identified two overarching themes pertaining to the role of therapeutic relationships in promoting recovery: "Promoters" and "Barriers". Within these main themes, there were eight sub-themes, with the barriers often being the opposite of the promoters e.g., connectedness and disconnectedness. The descriptive themes generated in stage two of the analysis, mapped well onto the CHIME-S model (Senneseth, 2022), which incorporates many aspects of the factors generated in Clarke et al.'s review (2016).

Facilitating Recovery Through Connection

Patients in all studies described the importance of connection and relationships with staff in promoting recovery and making them feel safe and cared for. Walker et al., (2023) suggest that it is this closeness that denotes the strength of the therapeutic relationship and for patients with limited opportunities for external relationships (Bennett & Hannah, 2021), staff act as family. The complex attachment histories of clients in forensic services (as described by patients in Laithwaite & Gumley, 2007), can be reenacted in their relationships with staff (Mann et al., 2014) . Caring relationships can feel restorative, and challenge these views (Mitchell, 2023). The role of staff relationships, also facilitated relationships with the wider network (such as family), which allows and sense of connection, but also a motivator for growth (Gillespie et al., 2021).

Showing care seems to be a way of supporting patients to move past potential barriers to recovery, but secure patients frequently feel uncared for (Hörberg et al., 2012). Care appears to be a key indicator of the quality of therapeutic relationships and a challenge to "pessimistic views" of relationships (Mitchell, 2023, p. 91). Although feeling 'cared for' was noted by Clarke et al.'s 2016 review, under the title of connectedness, and seen as "central" to recovery in the wider literature (Drennan & Wooldridge, 2014), this was not included in the updated CHIME-S framework (Senneseth et al., 2022). Promoting a caring environment was found to be possible through the use of connecting on a human level, with an understanding of past trauma for forensic inpatients (Sollied et al., 2023).

The importance of therapeutic relationships to secure patients in promoting their recovery was clear, and this is consistent with staff qualitative data (Marshall & Adams, 2018; McKeown et al., 2016). Alliance is identified as a supporting process through which interventions enable recovery, with staff attitudes moderating this relationship (Winsper et al.,

2020). This suggests that the therapeutic relationship is both a standalone concept for promoting personal recovery, as per Slade (2008), but also enables the success of interventions and can predict the effectiveness of treatment, more linked to clinical recovery (Horvath, 2000).

Disconnectedness as a Barrier

Given the importance of care and connection within the relationship, it would be expected that *dis*connectedness would act as a barrier for forensic recovery (Senneseth et al., 2022). Lack of trust in staff increased risk of violence and self-harm (Budge, 2017) and felt antagonistic for patients (Barksy & West, 2007), therefore this lack of trust becomes a barrier to recovery by increasing the chances of delayed discharge, or increasing restrictions placed on the patient. The lack of opportunities for relationships external to the ward environment was also noted as a barrier for connection. Forensic inpatients are more likely to have their social contact restricted (i.e. not having leave to the community, or having stipulations about who can visit and when) to support with risk management, where patients have previously presented as a risk to others, but this also means opportunities to connect are limited to staff (Joyes et al., 2021). So when there is difficulty building trust with staff (e.g. Bennett & Hanna, 2021), this can result in the absence of many meaningful connections at all.

Experiencing previous relational trauma and attachment difficulties was described as one of the barriers to developing meaningful therapeutic relationships with staff and increasing a sense of disconnection (e.g. Laithwaite and Gumley, 2007; Clarke et al., 2017). Attachment difficulties are high in this population (Adshead & Moore, 2022), with a study in a high secure setting reporting around 86% of patients were insecurely attached (Marin-Avellan et al., 2005). Another study found 100% of forensic inpatients had experienced trauma over their lifespan, with 75% occurring in childhood (McKenna et al., 2019). These experiences might make it more likely secure inpatients have difficulty building relationships, given that in data from non-

forensic samples, adverse childhood experiences predicted interpersonal difficulties (Poole et al., 2018). Speaking with staff was found to be a helpful way of coping with and appraising previous trauma for forensic inpatients (Cartwright et al., 2022b); however, relational difficulties may act as a barrier to this. This shows the need for an understanding of trauma within secure services, that moves outside of the person and into the system. The instability of patient's mental health was also seen to impact the therapeutic relationship and contribute to the barrier of 'disconnectedness' (e.g., Laithwaite & Gumley, 2007; O'Connor et al., 2021). For instance, increased symptom severity could negatively impact the quality of therapeutic relationships on admission to psychiatric inpatient settings (Bolsinger et al., 2020), which could be due to difficulties building trust when experiencing paranoia, or because patients feel unsafe as in Laithwaite & Gumley (2007) and therefore staff are unable to understand the needs of patients who are acutely unwell, or display signs of trauma. Given that trauma can be triggered by many environmental factors, including receiving care (Kimberg & Wheeler, 2019), it is integral that staff are trained in a trauma informed model of care, in order to support staff to be attuned to patient's needs and for patients to feel heard and safe.

Identity

Building of non-patient/offender identities and sense of self, via the therapeutic relationship, promoted recovery (e.g. Mezey et al., 2010).The importance of being seen as a human was noted throughout the studies (e.g. Mitchell, 2023). This is supported by the literature, such as the "personal recovery framework" (Slade, 2009, p. 90), with personal recovery encompassing both personal (view of the self) and social identity (how you are viewed by others) (Slade, 2009). Forensic patients might face difficulties in building a sense of meaningful, pro-social,

occupation outside hospital (Drennan & Wooldridge, 2014), so might need to rely on staff to support them to develop new identities. Therapeutic relationships with staff support the development of both personal and social identities. For forensic inpatients, Dorkins and Adshead (2011) argue there may need to be a move towards an updated sense of identity for the patient, using the therapeutic relationship, which acknowledges both the illness and offence, and future possibility of risk of harm to others. This highlights the need for patients to understand the consequences of offending and come to terms with what this means for their life now and in the future (Simpson & Penney, 2018) and any associated trauma (Soh et al., 2023) in order to move forward. Maruna (2001) describes how supportive relationships with staff who believe in their ability to change and move past offending, helps patients create a "redemption script", which allows them to appraise their past as preluding their present, non-offending life, in which they have control and can contribute to society.

Conversely, relationships that left patients feeling de-humanized perpetuated stigma around offending (e.g., Clarke et al., 2017), as per the barriers to recovery identified as *"dehumanized and perpetuating stigma".* This stigma acts as a barrier to recovery (Senneseth et al, 2022) as does viewing patients as a sum of their received diagnoses and risk (Dorkins & Adshead, 2011).

(Dis)empowered & Ashamed

Studies showed patients felt empowered when given autonomy, choice and were collaborated with in their care, which was facilitated by the therapeutic relationship (e.g. Bennett & Hanna, 2021; Clarke et al., 2017). This linked to the findings of the Senneseth et al., (2022) review, where they highlighted the importance of mutual collaboration for increasing personal recovery. This sense of collaborating with patients is an important factor within the therapeutic relationship (Shattock et al., 2018). Empowerment has been found to be an important concept

within the recovery literature, both for secure (Tapp et al., 2013) and general psychiatric populations (Leamy et al., 2011).

It therefore makes sense that feeling disempowered through mistreatment, lack of availability and abuse of power was a barrier to recovery, as seen in the theme, *"disempowered and ashamed".* Senneseth et al. (2022) identified that, in addition to the power difference between staff and patients, patients feeling neglected by staff was another way of feeling disempowered. Abuse from staff has been cited elsewhere in the literature (Marklund et al., 2020), with staff trying to exert power over patients. Patients in the reviewed studies described how negative interactions increase their sense of shame (e.g. Mezey et al., 2010). This increased sense of shame is associated with criminality (Svensson et al., 2017), but also moral injury, whereby distress follows the enactment of behavior which violates ones' moral code. Moral injury is associated with a wealth of difficulties and can influence risk (either to others or the self) and recovery (Roth et al., 2022).

Hope and Freedom

The theme "moving toward the future, with meaning" identified how the therapeutic relationship supported hope (Clarke et al., 2017) and a move towards freedom, by supporting with meaningful activities outside of the ward, such as leave (Barksy and West, 2007). Vogel-Scibilia et al., (2009), put forward a psycho-developmental recovery model which parallels the theory of human development by Erikson (1963). It posits that recovery initially requires dependence on others, but that moving through shame and fostering hope can be done within supportive relationships, to support independence and decreasing shame, with the aim of "living well with" mental illness, rather than living well without. The opportunity to prepare for discharge through learning new skills was identified by Senneseth et al. (2022). In a non-forensic sample in China, perceived hope was found to mediate the negative impact of self-

stigma on recovery as perceived by patients (Huang et al., 2024), which could suggest that relationships that foster hope could also support stigma reduction. However, it is important to note the cultural differences in perceptions of shame and self-stigma in a Chinese sample and the predominantly western views of the studies reviewed. Another recent review also suggested the importance of meaningful activity for forensic service users (Humphries et al., 2023). Staff and services can act as a secure base in which to explore from (as per Mann et al., 2014), which could mean patients are more likely to engage with meaningful activity away from the ward, in the same way a child uses a parent as a secure base from which to explore their surroundings (Mann et al., 2014).

Safety & Security

The safety and security sub-theme detailed the ways in which therapeutic relationships promote safety and security, either in the felt or the physical sense. These in turn help promote a supportive environment. This was an addition to the initial CHIME framework (Leamy et al., 2011), and was identified as a necessary recovery process for forensic inpatients (Senneseth et al., 2022) and included feeling protected from others and by the presence of staff. This is in line with research in general psychiatric services, whereby staff relationships support a sense of safety (Gilburt et al., 2008).

Clinical & Research Implications

The present review indicates the importance of therapeutic relationships in promoting recovery, through offering connection and meaningful relationships that are difficult to access elsewhere in secure care (Bennett & Hanna, 2021). Therapeutic relationships have the power to nurture a sense of empowerment through collaborative care (Clarke et al., 2017), supporting the development of a non-patient/offender identity (Mezey et al., 2010), a meaningful life (Barksy & West, 2007) and feeling safe and secure (Baker, 2017). The implication of this is that

therapeutic relationships should be promoted and held in high esteem in order for secure inpatients to benefit from them (Cartwright et al., 2022a).

Shame acts as a barrier to recovery, and is influenced by attachment insecurity (Adshead & Moore, 2022) as well as past experiences of trauma (Cartwright et al., 2022b). In light of this there is an importance of having attachment informed environments (Bucci et al., 2015). Staff would benefit from training around shame, particularly in the implementation of 'trauma informed care', to make this 'shame-sensitive' (Dolezal & Gibson, 2022) to get the best out of the model of care. A trauma informed care model places patients in the context of systems, understanding the there are several ecological systems that exist around the patient (Bronfenbrenner, 1986), where trauma needs to be considered. Secure services in particular, would benefit from this model (Seitanidou et al., 2024), which goes further than the interactions between staff and patients and considers the system around the patient. Staff may also benefit from training on the role of shame within relationships and how this can result in a 'push-pull' relationship with staff, creating relational safety with staff is important to overcome this. Putting the therapeutic relationship as a priority, is a systemic need that must be prioritized from the top down when it comes to funding, and expectations of staff time (Kingston & Greenwood, 2020). Adapting the therapeutic relationship for culture, preferences and attachment style is suggested to show effectiveness (Norcross & Lambert, 2018).

Care may be needed to attend to relationships following restrictive practices, for example physical restraint (Moyles et al., 2023). Given that staff in forensic settings experience a high-level of burnout, which could lead to difficulty using effective coping skills used (Kriakous et al., 2019), it is important staff feel supported to manage burnout, as this can lead to compassion fatigue in healthcare professionals (Kartsonaki et al., 2023). This could be in

the form of reflective practice, clinical supervision, or improving well-being and self-care (Marshman et al., 2022), as well as increasing self-compassion and maintaining professional boundaries, which can be supported by training in these areas (Pirelli et al., 2020).

Barriers to recovery were identified in poor or abusive therapeutic relationships, where patients described feeling dehumanized, disempowered and disconnected. Forensic mental health services should work in an attachment informed way in order to best support the client group (Bucci et al., 2015). Given the high level of studies where patients reported abuse from staff, and felt they were present, but not engaged, services should consider their recruitment processes and support staff experiencing compassion fatigue. For instance, utilizing values based interviews and decreasing reliance on agency staff by increasing staff retention, whilst understanding the impact of restrictive practices, which may be perceived as abusive by forensic inpatients (Askew et al., 2020).

This review has identified that more research is needed on the impact of trauma informed care, training and relational ways of working on therapeutic relationships. It would be important to capture both patient experiences as well as quantitative data on the impact of this, in order to secure further funding for this type of training. The Lammy Review (Lammy, 2017) identified that Racially and Ethnically Minoritised (REM) groups are more likely to have poorer relationships with staff in other sectors of the justice service, such as prison, therefore it would be pertinent to explore the experiences of minoritised groups in secure settings, to ensure needs are being met.

Strengths & Limitations

Strengths of the present study include the use of identity-hidden rating of titles and abstracts, to reduce bias. Having more than one reviewer for this process added to the validity of the

present review. Grey literature was also included, which could make the review more comprehensive, offer a more balanced view and lessen "publication bias" (Paez, 2017). This review did not exclude non-English language studies; however, no relevant papers were identified in the initial search.

It was not possible to assess the impact of ethnicity on patient's experiences related to recovery in the present paper, as it was often not considered, or reported on within the papers within the review. The views of REM groups would be pertinent to address in future research. The original CHIME model (Leamy et al., 2011) included references to culture, such as the importance of spirituality; however, this was neglected in the updated review by Senneseth et al., (2022). Females were underrepresented in the sample from included papers in the present review, although this may reflect the gender differences across forensic services (Tomlin et al., 2021).

Conclusion

In summary, the present study identified that collaborative therapeutic relationships could provide care, safety and affirm non-patient humanizing identities, which promote recovery. Conversely, relationships where patients feel unheard, misunderstood and dehumanized act as barriers to recovery. Therapeutic relationships fit in with existing models and reviews of recovery for secure care, such as the CHIME-S model identified in Senneseth et al.'s review (2022) and Clarke et al.'s review of recovery in secure care (2016).

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Declaration of Interests Statement

The authors report there are no competing interests to declare.

Data Availability Statement

The data that support the findings of this study are available from the corresponding author, [SC], upon reasonable request.

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Supplementary Material 1 – Definitions of Secure Care

What is secure care?

Secure hospitals support people with mental health difficulties, who due to either a risk to themselves or others, cannot be cared for under general psychiatric services. Some may also be on a forensic section of the Mental Health Act (MHA, 1983), which means they have committed a crime and have received a hospital order or have been transferred from prison to receive secure inpatient mental health care. For some, this means lengthy stays in highly restricted services, with limited opportunities to access the community.

Tables

Table 1 – Eligibility Criteria

Table 1

Eligibility Criteria

Inclusion Criteria	Exclusion Criteria
Exploring patient perspectives of recovery, including therapeutic relationships with staff.	Staff only views / papers where staff views are not delineated from patients if mixed and no mention of recovery or therapeutic relationships
Adult Secure inpatient settings (i.e., high, medium, or low secure hospitals)	Not from an adult secure inpatient setting
Qualitative methods	Non-original papers such as systematic reviews (due to replication of data) and opinion pieces
Original research papers	Papers about specific conditions that are not routinely treated in forensic inpatient settings (e.g., severe anorexia) Therapy specific papers

Table 2 – Data Extraction Table

Table 2

Data Extraction Table

Reference	Sample	Setting type & location	Methods	Quality assessment*	Summary of Findings
Baker, 2017	6 participants (males, aged 23-44, White British/ African Caribbean Ethnicity)	Forensic personality disorder and Serious Mental Illness Wards	semi-structured interview; IPA	9	Three superordinate themes: 'disempowered, dehumanized', 'coming back to life', 'the struggle'.
Barsky & West, 2007	6 participants (males, age and ethnicity not reported)	Long-stay medium secure wards, North England	Semi-structured interviews & analyzed with thematic content analysis.	8	Six main themes: Activities , freedom on the ward, Access off the wards and the security wall, atmosphere on the ward, Staff, positives of high-secure care.
Bennett & Hanna, 2021	30 participants (males, aged 23-61, ethnicity not reported)	One high, medium and low secure hospital, in the United Kingdom	semi-structured interviews; reflexive thematic analysis	8	Five main themes: 'Respectful and reciprocal relationships between patients and staff', 'Working with and empowering patients within a restrictive environment', 'Keeping themselves to themselves', 'a disinterest in Authoritarian relationships' and 'the perceived over- exertion of power ?over? their patients'.
Budge, 2016	8 Participants (All Females, age and ethnicity not reported)	Low and medium secure units, England	in-depth interviews; thematic analysis	10	Five Domains; 'Nature of therapeutic relationships', 'reason for and function of violence and aggression', 'lived experience of violence and aggression', 'impact of violence and aggression on therapeutic relationships' and

Reference	Sample	Setting type & location	Methods	Quality assessment*	Summary of Findings
					'management of violence and aggression'. This encompassed 20 themes
Clarke et al., 2017	6 participants (males, aged 32-59, 1 black British, 5 white British)	Adult low-secure (two male and one female ward), South England	semi-structured interviews & analyzed with Interpretive Phenomenological Analysis (IPA)	10	Five over-arching themes identified: 'journey', we're vulnerable in here, 'loss', 'Relationships with staff' and 'hope'
Laithwaite & Gumley, 2007	13 participants (12 males and 1 female, Aged 22-60, ethnicity not reported)	State hospital, maximum security (serves Northern Ireland and Scotland)	Semi-structured interviews and analyzed with a social constructivist revision of grounded theory	10	Relationships and a changing sense of self, held 2 themes: past experiences of adversity (with 4 categories) & recovery in the context of being in hospital (with 6 categories)
Mezey et al., 2010	10 participants (2 females 8 males, aged 24-56, 4 white, 6 participants from different racially and ethnically minoritised groups)	Medium secure unit, 4 wards, London, England	Open ended and semi-structured interviews, grounded theory and direct content analysis	10	Three main themes: definitions and understandings of recovery, What helps to bring about recovery, Impediments to recovery,
Mitchell, 2023	8 participants (males aged 50-83, ethnicity not reported)	4 wards, 3rd sector mental health provider, North of England	Semi-structured interview; IPA	10	Four Overarching group experiential themes: 'Relational power of staff members in secure care', 'the experience of living with other patients with forensic and mental health needs', 'the additional stressors of being an older adult in secure care', and 'coping'.
Nijdam-Jones et al., 2015	30 participants (24 males, 6 females, mean age 40 (SD = 11.1) 26 white, 4 not specified)	Forensic mental health hospital, British Colombia, Canada	Semi-structured interviews; thematic analysis	9	Five themes emerged: 'involvement in programmes', 'belief in rules and social norms', 'attachment to supportive individuals', 'commitment to work-

Reference	Sample	Setting type & location	Methods	Quality assessment*	Summary of Findings
					related activities' and 'concern about indeterminacy of stay'.
O'Connor et al. , 2021	8 participants (5 male and 3 female, aged 30-51, ethnicity not reported)	Forensic Step Down Rehabilitation Unit (FSDRU, still inpatient), Adelaide, Australia	Semi-structured interviews and experiential thematic analysis	10	Five main themes: Mental Health Management, Relationships, Court Influence, Resident Journeys and Forensic Step Down Rehabilitation Unit
Walker et al., 2023	17 participants** (total sample age *M = 59.8 SD = 3.9,* total sample 92% male, total sample 81% white, 16% Black, African, Caribbean, Black British, 3% mixed or multiple ethnic group)	Inpatient (high medium and low) and community forensic health services (N.B only data from inpatients used) across England	Semi-structured interviews; inductive thematic analysis	9	Two 'global' themes: "Enablers" and "Obstacles", which were further split into three organizing themes – "The environment", "The relationships" and "The person".

*NB CASP Quality rating was calculated by giving each 'Yes', a score of 1.

**from inpatient only settings, 10 further participants were from community settings, their data was not included in the present review

Ethnicity Data is reported where it is included in the papers.

Table 3 – Theme Summary & Prevalence

Table 3

Theme Summary, and Prevalence for Each Theme.

Reference	Promoters					Barriers		
	1. Moving towards the future with meaning	2. Development of identity and sense of self	3. Empowerment	4. Safety and security	5. Connectedness	1. Disconnectedness	2. Disempowered & ashamed	3. Dehumanized, perpetuating stigma
Baker, 2017	√	√	√	√	√	√	√	√
Barsky & West, 2007	√	x	x	√	√	√	√	√
Bennett & Hanna, 2021	x	√	√	√	√	√	√	√
Budge, 2016	√	√	√	√	√	√	√	x
Clarke et al, 2017	√	√	√	x	√	√	√	√
Laithwaite & Gumley, 2007	x	√	√	x	√	√	√	x
Mezey et al., 2010	x	√	√	√	√	√	√	√
Mitchell, 2023	√	√	√	√	√	√	√	√
Nijdam-Jones et al., 2015	x	√	√	x	√	√	√	x
O'Connor et al. , 2021	x	√	√	√	√	√	x	x
Walker et al., 2023	√	√	√	√	√	√	√	x

Figures

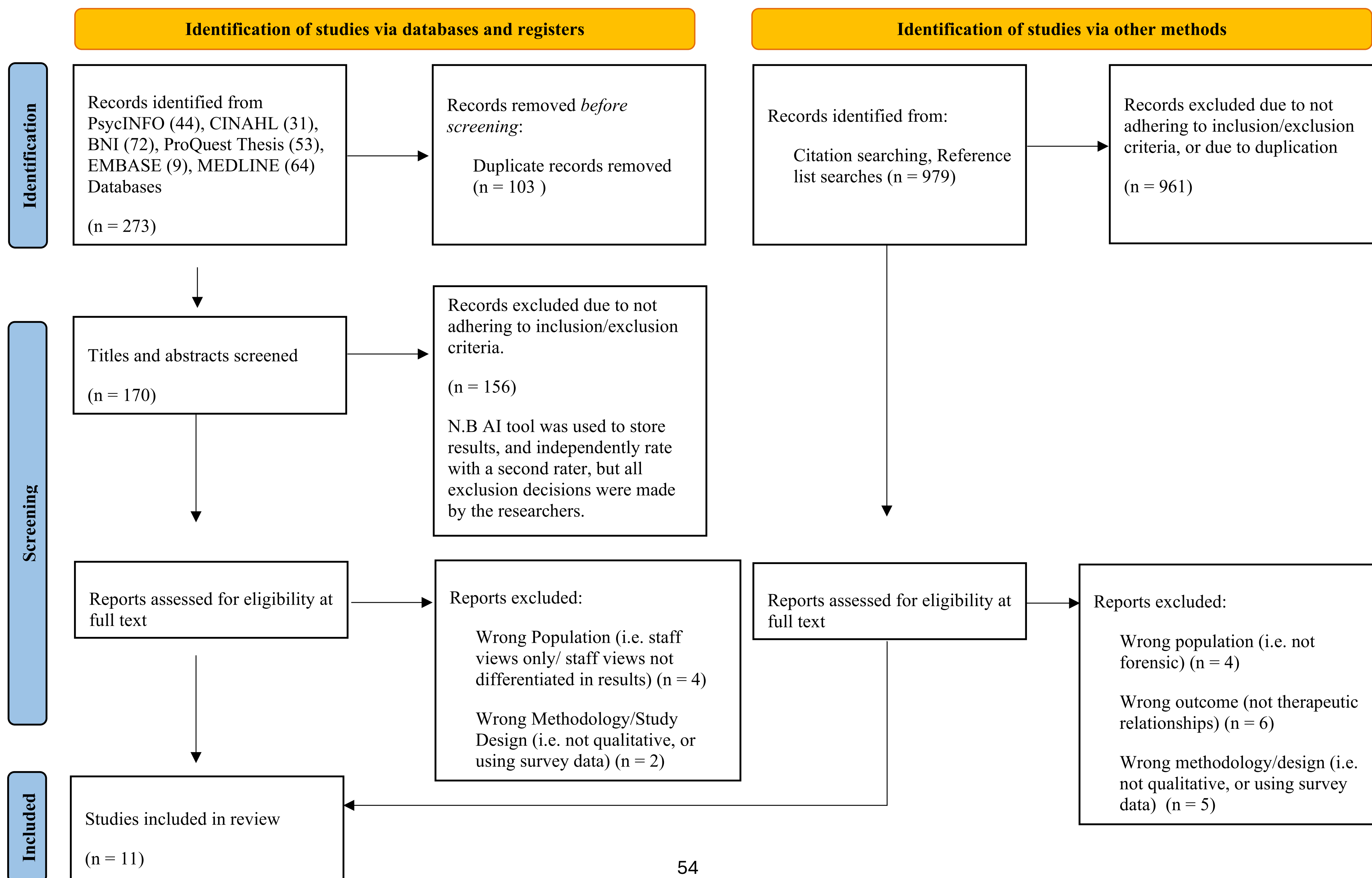

Figure List

Figure 1

PRISMA 2020 flow diagram for new systematic reviews which includes searches of databases, registers and other sources

Chapter 2 Experiences of Therapeutic Endings for Low Secure Inpatients. An Interpretative Phenomenological Analysis

Journal Guidelines

This paper has been prepared for the Journal of Forensic Psychology Research and Practice. Guidelines for submission can be found on the following in Appendix A and the following webpage:
https://www.tandfonline.com/action/authorSubmission?show=instructions&journalCode=wfpp21

Title Page

The Experiences of Endings for Low Secure Inpatients. An Interpretative Phenomenological Analysis.

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Abstract

Secure inpatients may experience many therapeutic endings, defined in the present study as staff leaving, or moving wards, ending therapy, or patients transitioning between wards or hospitals. Given the attachment difficulties experienced by the population, it is likely that attachment plays a key role in these endings, activating patterns of attachment from early childhood. In light of this, the present study aimed to explore low secure inpatient experiences of therapeutic endings, using Interpretative Phenomenological Analysis (IPA). Three Group Experiential Themes were identified from an IPA of interviews with eight participants: *The Flow of Power, Endings Through Time* and *Coming to Terms with the Loss of Connection.* These are discussed in line with the current literature, which indicates the importance of attachment informed care models within secure services. Clinical Implications, strengths and limitations, and directions for future research are considered. (139 words)

Keywords: Therapeutic endings, secure inpatient, forensic, low secure, IPA, qualitative

Introduction

Population

Secure inpatient settings are hospitals that support people with mental health difficulties under the Mental Health Act (1983), who present as a risk to themselves or others, which requires management in a secure setting. Secure inpatients experience many endings, including therapeutic endings, defined in the present study as staff leaving the service or ward, patients transitioning between services or wards and ending therapy, in which attachment plays a key role (Bucci et al., 2015).

Attachment

Bowlby's attachment theory describes attachment as "intimate emotional bonds between individuals" such as caregiver and child (Bowlby, 1988, p. 120) . He suggests that the drive for these bonds are innate and seek protection, closeness and survival, and that a child's treatment by their caregiver has an influential effect on their development. Attachment in both children and adults has been conceptualised as broadly coming under four different styles: secure, anxious/preoccupied, avoidant and disorganised (as discussed in Levy et al., 2011) . Those with non-secure childhood attachment styles may have difficulties in relating to others, or believing they can be relied upon or are safe (Levy et al., 2011). This has implications for the therapeutic relationship, in which the therapist is viewed as an attachment figure by patients acting as their secure base from which to explore difficult themes in therapy or the relationship (Haggerty et al., 2009).

Attachment in Secure Settings

Inpatients in secure settings, will have more likely experienced adverse child experiences than the general population (McKenna et al., 2019), which are linked with both aggression and

criminality, and can also impact the capability to form attachments and succeed in secure environments (Stinson et al., 2021). Secure inpatients are less likely to have a 'secure' attachment style than the general population, with over 86% of a forensic sample being insecurely attached (Marin-Avellan et al., 2005) and as such, services can meet the needs of patients with attachment difficulties by providing a secure base, continuity, and being available and flexible, in order to facilitate more secure attachments (Bucci et al., 2015). Building relationships in and of itself can be a challenge for patients in secure care, as creating emotionally safe relationships is affected by the childhood experiences of care as frightening and abusing, which is common in this population (Mann et al., 2014). People in secure settings have limited opportunities for building connections outside hospital (Bennett & Hanna, 2021) and see staff and other patients through the same lens they see their family (Walker et al., 2023), given the high incidence of these being traumatic relationships, insecure attachments and unhelpful re-enactments are expected. Attachment figures could also be victims of index offences (Adshead & Aiyegbusi, 2014), which is likely to disrupt the attachment relationship, along with admission to services. Furthermore, moving on from hospital could also be viewed as rupturing the attachment relationship formed between staff and patients (Liddiard et al., 2019), as the relationship with staff ends with their time in the service and could be linked with feelings of abandonment. Moving on from psychiatric inpatient settings could also signify the loss of staff as a safe base for patients (Berry & Drake, 2010).

Current Research About Endings

Most research has focused specifically on the end of psychological therapy in community or inpatient settings, as opposed to the other endings that occur in inpatient settings such as a change in care team, staff leaving, or patients transitioning between wards or security levels. Endings are important to both the patient and therapist in terms of understanding what is next, and how this can be managed (Beattie et al., 2019; Råbu & Haavind, 2018; Webb et al., 2022).

A systematic review from both secure and general psychiatric populations found ending therapy elicited strong emotions and was often perceived as a loss, particularly given that therapeutic relationships are contextualised by providing a safe secure base in which to share experiences (Webb et al., 2019). Research from a high secure unit, also emphasised the significance of facilitating endings, in which patients feel informed and prepared for their next steps with opportunities for continued contact with staff, due to the worries highlighted by participants about ending relationships and starting new ones when moving from high to medium secure (Madders & George, 2014).

There is an importance in viewing endings of therapy through an attachment lens, with the ending of these relationships initiating attachment patterns, which can result in maladaptive coping strategies if not well managed (Marmarosh, 2017). The end of the therapy has been reported to have similarities with the mourning process (Wachtel, 2002). Quintana's "termination as loss model" (1993), suggests that endings do include elements of loss, but also transformation, with the element of loss being more applicable to 'unsuccessful' therapy (Quintana, 1993). Therapists have spoken about the importance of preparing for endings as to not contribute to a sense of abandonment that can come from ending relationships (Burke et al., 2016). It has also been reported that marking the ending can be a helpful way of managing the feelings that understandably arise (Webb et al., 2022).

Relationships within secure settings are extremely important and have been reported by patients to be an pivotal factor in moving on, with trusting relationships with staff and those around them leading to feelings of safety (Tapp et al., 2013). It has been theorised that it is this feeling of safety that contributes to recovery in secure settings (Senneseth et al., 2022). A recent review found that positive therapeutic relationships promote recovery in secure care, by providing a sense of connection, safety, hope, supporting with developing new non patient/offender identities, finding meaning and empowering people in secure services to be involved in their care (Collingwood et al., Pre-publication)Relationships were an important

factor for people in secure settings to feel they were worth something and treated with humanity (Mezey et al., 2010). Relationships can also support the reduction of risk, whether this be through upskilling and psycho-education (Bennett & Hanna, 2021), or through belief that someone can ‘make good’ of their offending identity (Maruna, 2001). Maruna (2001) suggests that, with support, those who offend can rewrite their past using a ‘redemption script’, that supports them to understand their past as a ‘prelude’ to a different life, whereby they can contribute to society and have control over their own future. Here, the relationship stands as a way to promote self-worth and belief in the fact there is a possibility outside of offending. This could suggest that if a key relationship ends, either when the patient moves on or the staff member leaves, this could have an impact on the person’s sense of safety and recovery, as well as their sense of identity, if not well managed.

Secure inpatients can experience multiple endings during their time in hospital. The admission itself can signify the loss and ending of a life before hospital and can also lead to the loss of relationships (Nijdam-Jones et al., 2015). Parents are likely to lose contact with non-adult children upon admission to secure services, and victims of their index offence are more likely to have been a child or family member than non-parents in secure care (Argent et al., 2018).

The experience of loss then tends to be frequently repeated, as the considerable rates of staff burnout in forensic inpatient settings (Elliott & Daley, 2013) can impact staff turnover (Kinghorn et al., 2022), which can affect the ability of patients to build trusting and supportive relationships with staff (Holley et al., 2020). Despite the multiple staff endings this population may experience, there appears to be a gap in the literature on patient experiences of endings more generally within secure inpatient settings.

Attachment & Endings

Endings should be considered as part of attachment informed services and is an important consideration to admission and progress within inpatient settings (Adshead, 2001). The significance and relevance of attachments within mental health services has become more recognised over the last 20 years, with an increasing focus on attachment and relationships, due to the risk of violence within relationships, but also because of the importance of them to therapy and the secure inpatient environment (Adshead & Moore, 2022).

Much of the research in secure care focuses on rates of recidivism, treatment or quality of life (Holley et al., 2020), although there have been advances in research on patient perspectives, there is presently no research from the perspective of secure patients on therapeutic endings. Given that the time spent in secure services can be long term (Hare Duke et al., 2018), with some patients spending time in child and adolescent secure units before transitioning to adult services, it makes sense that services themselves and the care giving staff, act as a secure base (Mann et al., 2014). As such, endings, could activate attachment patterns to attempt to seek safety, leading to dysregulation or care eliciting behaviours, which could lead to prolonged admission times and potentially transfer to higher secure services.

In light of the above research, it appears that the experiences of those using secure settings around endings both inside and outside psychological therapy have been neglected, and since patients in low secure settings will have likely experienced multiple endings through moving services, or preparing for discharge, staff team changes and engaging in multiple therapies, it is pertinent to seek their views on this topic.

Study Aims

As such, the present study aims to:

Explore the lived experience of therapeutic endings such as; staff leaving the service or ward, patients transitioning between services or wards and ending therapy, within a low secure service and explore the meaning that might be given to these experiences.

Materials & Methods

This study is qualitative in nature, to explore the experiences of secure inpatients in great detail (Silverman, 2015). Data will be collected via semi-structured interviews and then analysed using Interpretative Phenomenological Analysis (IPA) (Smith & Fieldsend, 2021). IPA fits with the aim to explore the lived experience of endings; since it is an experiential method, which aims for an idiographic exploration of the sense participants make of their world, including the meanings ascribed by participants to their experiences (Smith et al., 2022), whilst also seeking to find patterns of similarity and difference across the data. It acknowledges the role of the researcher in interpreting the experiences of participants as they make sense of them, both by becoming 'experience close' and attending to what is being said, using empathic hermeneutics, but also using questioning hermeneutics to get at what is left unsaid and why this might be (Eatough & Smith, 2017).

Ethical Approval & Considerations

The present study received ethical approval in May 2023, by the North of Scotland Research and Ethics Committee (REC) and the Health Research Authority for IRAS ID 322445. REC Reference: 23/NS/0048. A letter of access was awarded in June 2023, by the local trust. See appendix C for ethical approval.

The Unit

The setting used is a low secure unit forming part of an NHS (National Health Service) forensic mental health service with three wards for adult male and female patients.

Recruitment

Participants were recruited using purposive sampling to allow for a homogenous population to explore the research question (Willig, 2013).

Clinical teams provided permission to approach patients who were deemed to have capacity to consent. All patients meeting this requirement were offered the opportunity to take part, the study was advertised through community meetings, posters and information sheets were available on the wards. Due to the nature of secure services, which use restriction to keep people safe, there is an inherent power imbalance, so obtaining informed consent is of upmost importance (Völlm et al., 2017). Any patients who expressed an interest, were given an information sheet ahead of the study and had the opportunity to discuss the research and ask questions before giving informed consent. Participants were also given the opportunity to meet the primary researcher ahead of the study, again to support with informed consent.

Participants were informed that their participation would in no way affect the care they receive, and was not linked to their treatment, and the researcher was not working at the hospital. Participants were also informed about their right to withdraw and right to anonymity as well as the bounds of confidentiality. Recruitment was stopped when no more volunteers came forward for the study. Participants were all assigned pseudonyms, which are used throughout. See Appendix D for research materials used.

Of the participant pool, N=8 volunteered to take part in the study, N=3 declined to take part and N=1 was unwell on the day of interview and could not be rearranged. N=2, were determined not to have capacity to take part currently. Eight participants is within the 6-10 participants that is suggested for IPA, which uses small samples in order to achieve the idiographic exploration of participants' experiences in the depth required (Pietkiewicz & Smith, 2014).

One participant knew the primary researcher from their previous role as an assistant psychologist within the service, and another had taken part in preparing materials for the research (information sheet and poster Patient and Public Involvement, PPI), another was known to the researcher from a previous admission, so there was some awareness of context

for these patients. All participants were known to the second and third authors, all other authors are independent to the service.

Participant Demographics

Participants were asked to give their gender and ethnicity as free text, as well as select their ethnicity from a list (NHS Digital, 2022), in order to account for those whose gender is different to the sex they were assigned at birth, and for those who do not identify with an ethnicity from the list. Due to the small population sample, only summary characteristics will be provided here, in order to protect participant identities, see table 1.

[Table 1 here]

Data Collection

Data was generated through the use of semi-structured interviews, a commonly used data collection tool for IPA (Pietkiewicz & Smith, 2014). A copy of the interview schedule can be found in supplementary material 1, which was developed in line with guidance for IPA (Smith et al., 2022), and reviewed with PPI, by an individual who had experienced secure care and was paid for their time. The schedule was further refined within the research team. The interview was piloted with the first participant, and no changes were made.

All interviews were conducted in person, by the primary researcher, in a private room off the ward between September and November 2023. All interviews were securely audio recorded and transcribed verbatim by the primary researcher or by a secure third-party transcription service. They lasted between 20 and 50 minutes. Participants were offered £20 in either cash or voucher for their time. In line with the information sheet and consent form, participants were informed they had the right to end the interview or take a break if things got too much and would be offered support as appropriate.

Data Analysis

IPA considers the participant as the "experiential expert in the phenomenon of interest" (Eatough & Smith, 2017, p. 9), therefore the researcher is aiming to interpret what sense is made by participants on the phenomenon of therapeutic endings, as they make sense through the interviews. Data was analyzed using the six steps in Smith et al., (2022), from the epistemological position of relativism, but the ontological position of realism; this does not demote the view that meanings are socially constructed within the current paper, but also acknowledges that IPA is asking about lived experience (Willig, 2016). This is summarized as a 'critical realist' position (Fryer, 2022). In order to become immersed within the data, the transcripts were repeatedly read alongside listening to the audio recordings from interviews, before making initial exploratory noting on descriptive, linguistic and conceptual elements of the data, to think about what is being said, how and why. This information was then taken, alongside quotes from the transcript in order to remain close to participants' experience, given their expert position (Eatough & Smith, 2017), to create experiential statements, which offer a deeper level of interpretation. Experiential statements were then mapped and clustered visually, alongside their associative quotes, before being refined to come up with Personal Experiential Themes (PETs). A case level summary using this process was completed for each participant, before moving onto the next, an example of this can be found in Appendix E. Once all eight transcripts were analysed, a similar clustering and refinement process took place of all the PETs (including quotes), as part of a cross-case analysis, looking for convergence and divergence across the data in order to create higher order Group Experiential Themes (GETs). The GETs and rationale were explored within research supervision, to allow for discussion and refinement of the GETs and support with phenomenology (Husserl, 2001).

Quality Assurance

There is a recognition that bias is inevitable within IPA, given the double hermeneutic, and it is important to use ongoing questioning of your own beliefs, assumptions and biases in order to meaningfully engage with the analysis (Eatough & Smith, 2017). It is argued that quality can be upheld in IPA through reflecting, being reflexive and the use of a journal (Vicary et al., 2017). The primary researcher kept a journal, both reflecting on experiences at each stage of analysis, and thinking about how their own thoughts, experiences and judgements may have shaped the interpretation and meaning making, as per the double hermeneutic of IPA (Smith et al., 2022). Furthermore, findings were discussed within the research team to allow for further reflexivity. For context, the researcher is a white female, who had previously worked in the service and has an interest in attachment and endings. The assumptions that came with this were checked throughout, in order to bring reflexivity and a reflexive summary is provided in supplementary material 2.

Validity

To support with validity, an audit of two sub-themes was completed, whereby one of the researchers, not involved with the analysis was given randomised quotations for two sub-themes and asked to sort these according to theme. Initially, the audit revealed one quotation matched to a different theme than the first author, but the auditor expressed uncertainty about this quote. Due to this uncertainty, the GET titles were given in addition to the sub-themes and subsequently all quotes were matched with the themes identified below. An expert by experience also reviewed all quotations and themes, and his feedback was that the quotes made sense with each theme, and also resonated with his experiences of secure care.

Readers of this paper can further examine its quality and validity and decide if it meets the standard for "field specific criteria" (Emery & Anderman, 2020). Prevalence of themes are

also reported for the current study, where all sub-themes are supported by at least half of the participants (Smith et al., 2022).

Results

Participants shared their experiences of therapeutic endings in the context of secure care. Three group experiential themes were created. The first, "Flow of Power", displays participants experiences of power within the relationship and the ending. The second, "Endings Through Time", which has three sub-themes – *Clarity, Expectation and (Un)certainty, Marking the Ending* and *New Beginnings*, describes the journey of endings in secure care. Finally, "Coming to Terms with the Loss of Connection", has two sub-themes, *"Professional Friends"? Defining the Relationship* and *You Know it Was Worth it When it Hurts*. This theme explores how relationships are understood by secure inpatients, and how they experience the loss of these relationships, as well as how they recover.

Some were able to articulate their experiences more clearly than others, therefore some participants are more represented within the quotations presented below. They did contribute to both the PETs and final GETs, please see table 2 for themes and prevalence.

[Table 2 here]

Group Experiential Theme 1 – The Flow of Power

This theme describes the experience of power in relation to endings within relationships and psychological safety, which is captured by five participants. It discusses the flow of power through participants and the endings they experience. Jocelyn and Aaron both described feeling as though staff or the Ministry of Justice (MoJ) held all the power over their future and therapeutic endings had a complex interplay with this. For Aaron, he felt his psychiatrist moving wards meant his progress was delayed *"er I was trying to get um, er um get like out and get like*

my, then my consultant psychiatrist left. Then it got left" (Aaron, 114-117), which he perceived as a barrier to discharge. Throughout his transcript, Aaron makes reference to the power of his psychiatrist, either through wanting others to communicate with them *"I was hoping talking to her might make her talk to my consultant psychiatrist"* (Aaron, 107-108), or through the psychiatrist being at odds with his narrative. For Jocelyn this power looked like moving her without notice, and being 'exiled' to another unit:

> *Uh I was always scared that they were gonna, you know, just send me over there, umm which is what they did, they they didn't actually prepare me, because [Oh ok] they knew it would stress me out so much, so it wasn't until the morning of you know, they actually then told me er and then, I was then moved over to the low secure.* (Jocelyn, L 58-66)

Jocelyn describes the powerful as "they", which suggests she views staff as a collective, and signifies the distance she feels between herself and them, which reinforces the narrative widely spoken about in secure care of "us and them" (Barsky & West, 2007). Jocelyn seems to reflect that not knowing in advance may have been in her best interests, but she seems conflicted with the lack of power to prepare for the ending.

Moira seemed to indicate that she did not have the power to end relationships with staff or peers as she pleased:

> *But these kind of environments are a false kind of environment because you have to placate people to stop arguments and to stop bitchiness and stuff, so you have to try and be everyone's friend even when you're not. It's a very false environment, you know. I don't like it too much. (Moira, L 525-532)*

Moira's description of the environment as false, and then the repetition of this, speaks to the scrutiny she might experience around her relationships, as her interactions will be judged by staff and conflict perceived as risk, which could delay discharge. Moira sounded resigned in the last sentence, like she was left with no other option. Aaron echoed the lack of choice in relationships, and he felt stuck and disempowered when not allowed to change his consultant:

> *Yeah, before he actually changed wards I asked to change doctor and I had that, put that formal process. So, um but the doctor that would have taken over came and saw me and said he didn't want to, and so I have to stay with my current doctor.* (Aaron, L182-187)

This disappointment for Aaron was tied up in the notion that his current psychiatrist did not see his point of view and could not see him outside of his diagnosis of mental illness. This highlights lack of power to end what he perceived as an unhelpful relationship, as well as powerlessness in a perceived blocking of a desired therapeutic ending of moving services or into the community.

Although patients often felt powerless, for Jocelyn and JJ, they also felt they had some choice in their ending, as described by Jocelyn below:

> *Uhh and then um, one day, umm, the place that I was at before, it became unbearable and I decided that I'd had enough and I said yeah, please send me here* (Jocelyn, L125-129)

For Jocelyn, the sense is that she felt empowered to make the decision to leave, so it was on her terms, meaning that this ending was perceived therapeutically.

Group Experiential Theme 2 – Endings Through Time

This theme describes how participants move through therapeutic endings, from a sense of anticipation, expectation or inevitability about the ending, the relationship or the work and the feelings these bring, through to how endings are marked and celebrated and finally shifting to what comes next.

Clarity, expectation and (un)certainty

This sub-theme highlights the difficulty for participants of knowing staff are going to leave through experience, yet still feeling uncertain, and at times uncontained by a lack of clarity about what this looks like and when it might happen.

Alexis, Aaron, JJ and Jocelyn, all felt that endings need to be communicated in advance so *"it's not sprung on them"* (JJ, L 141), giving the opportunity to make sense of the ending, For Jocelyn, although she laughed as she described just how many staff she had seen leave services over the years, this appeared to be more of a humoured disbelief and she still felt unprepared for the end. This appeared to be determined by the quality and closeness of the relationship.

> *Uhh you know, where was, when um you know you've got somebody that you're close to that does leave, umm, you know you're not prepared for it, you're not. As much as you probably know what's coming, you know, it you're not prepared and you're not able to sort of process it in your head. (Jocelyn, L355-363)*

It seems as though Jocelyn has an internal conflict between the known sense of how difficult the end might be versus the actual experience of living it. Jocelyn uses "you" language throughout this passage, which could refer to a collective sense of the experience, but it could

also be a way of reflecting back on her own experience and creating a distance from the pain and overwhelm she experienced. The repetition of 'you're not', seems to speak to just how unprepared Jocelyn felt when she was reflecting on her experience of staff leaving. For five of the participants having more clarity around the end, including a sense of time it would occur, helped them understand what to expect, but this appears to have occurred in various degrees. Moira reflected on her experience of time and notice:

> *now I'm just floating off like I don't really care". You know, it's that kind of feeling [mm]. Even though you know they do care, but it's just ease us into it, you know. Don't be so starch about it [mm] and matter of fact about it, you know. 'Oh, I'm off next week'. 'Oh, right, where are you going? On holiday?' 'No, I'm going.' 'What?!' you know [mm], that's a bit… a bit much. So, prior warning, forewarning. Forewarned is forearmed, as they say.* (Moira, L422-437)

Moira here, shares the dissonance between known and felt senses - knowing staff care about her, but their "floating off" seeming to indicate and evoke feelings they do not care. She reflected on her ability to arm herself from loss and hurt, through forewarning. Moira seems to illustrate her frustration in staff's nonchalance and lack of insight into what the end might be like for her, and her "what?!" gives a sense of the disbelief she has felt when she has not been told about endings. Aaron reflected on his own experience of this lack of warning, which conveyed disbelief about the lack of communication around the ending:

> *I was a bit up in the air about what was happening [ah ok]. I didn't know whether she was having more sessions, but it did just end by her like saying to staff on the ward, 'Oh, we're not going to do that anymore'. She didn't say it to me. She didn't say, 'Oh, you've only got one'. She just like stopped coming. (Aaron, L820-822)*

Aaron seems to have a sense of betrayal in the suddenness of the ending, but also that he wasn't told this personally, leaving him with a sense of uncertainty and not feeling grounded, but "up in the air". His repetition of the word "just", in relation to the ending, appears to indicate his shock that the work had finished. He describes later in the transcript how his hopes for the work were not actualised, and his expectation of what he would get out of it were not achieved *"But yeah, just hoping and missed hope basically, because it was just disappointment it didn't happen"* (Aaron, L842-844). Whilst Aaron's uncertainty appears to centre around the meaning of the end of the work and ultimately what this means for his freedom, Jocelyn appeared to be more concerned about who was next and whether they would live up to the person who had left:

> *It wasn't nice, um cause you know like the next ward round there's gonna be somebody different you know [ok, yeah]. And who knows that might person might be better than the one before [yeah], you just never know, but you know in your mind, umm that person that's leaving is always you know, the best.* (Jocelyn, L423-431)

Jocelyn described the passing of time and her use of the words "who knows" and "never know", seem to suggest that it's up to fate, and the nature of loss and replacement can be uncomfortably uncertain, as to whether they will live up to expectation. In her mind, any replacement will never live up to the person she connected with, so there is a sense of anticipation and comparison, and a difficulty letting go of the 'best' staff member, as they will be a big perceived loss to Jocelyn.

Marking the Ending

This subtheme looks at the experiences of five of the participants and demonstrates the importance of marking the end, particularly for staff endings, through either celebration, or through spending time together. For some participants there was recognition of getting to do *"normal" activities* such as going out for coffee, which was described by Penelope, Spencer and JJ, which seemed to also signify a link to societal norms from the 'outside world'. Although

Spencer seemed to value the normality, going for coffee outside the unit appeared to give him a deeper sense of connection with the staff member who was leaving, showing him the relationship was more than just the work.

> *"It's just nice, you know, just to sit there and have a cup of coffee and chat about different things. We'll be chatting about books and TV and films" (Spencer, L326-330)*

Furthermore, being out in the community gave Spencer a chance to develop his non-patient identity, with the support of someone he trusted. For JJ, going for coffee was a chance to be in a *"different environment"* (JJ, L186) outside of hospital, but also this form of ending felt *"nice and special"* (JJ, L38). Both of these extracts illustrate the importance and meaningfulness of accessing the outside world. For Penelope, *"Just getting out of this place and spend some quality time together"* (Penelope, L350-351), appeared to be her favoured way of marking the ending, highlighting the importance of giving time to mark the ending. The extracts from the three participants allude to the meaningfulness of an individual ending that's 'just for me', as an opportunity to celebrate the relationship and savour the last times together.

Four of the participants (JJ, Twyla, Spencer and Alexis) also spoke about leaving parties and described the use of cultural traditions such as "picky food" and coming together as a having a dual purpose, described in this quote:

> *Yeah, it was really nice because we all got together and we got to celebrate and remember the person that's left and wish them well in their future (Alexis, L366-369)*

For Alexis, leaving parties seemed to serve the same purpose as a wake – both in memory and celebration and an opportunity to say goodbye. There was a sense across all four participants

who spoke about parties that they were communal and signified a coming together of the ward to say goodbye to people. For Spencer, *"It's nice to show your appreciation for good people"* (Spencer L128-129), highlighting that the good ones are worth celebrating and having a party communicates your appreciation at a collective level. For Twyla, her preferred way of showing gratitude was on an individual level, "*with cards, chocolate and flowers"* (Twyla, L139-141), which appeared important to her:

> *What would it mean to me? Umm. It would just make me feel a lot better that I'm giving them something to say thank you really [yeah]. It's a nice way to end things. (Twyla, L 148-152)*

For Twyla, it seemed important for her to acknowledge that she had got something from the relationship and her use of the word "nice" suggests that ending in this way feels positive for her.

Twyla and JJ also appeared to note the significance of the opportunity to mark the endings and preferred this to when staff "*just leave and don't tell you*" (JJ, L95-98), the reference to "just leave" in this sentence appears to denote the shock JJ felt when staff are there one minute and gone the next. This seems to link with Aaron's experiences of uncertainty and unmet expectations described in the previous theme, whereby not marking the ending, leads to uncertainty and confusion. This was supported by Twyla, who described the lack of ending *"they've just left it unknown… it's not really nice"* (Twyla, L185-186), and her pause could denote her own processing around what it means for her.

New Beginnings

This sub-theme, illustrated by four of the participants (Spencer, JJ, Alexis and Moira) described endings as moving onto the next stage, whether this be the community, more work with someone else, or recovery itself. This idea of the next chapter was described metaphorically by Moria.

…showing the patient that it's not the end, it's just the beginning, you know. With one ending comes a different opening. I always look at life like chapters in a book, you know. Life is the book itself and we have many chapters, and one closes, but as soon as one closes a new one opens. (Moira, L647-654)

Moira's description of endings as not the end, serves as a way of protecting herself from loss, but also a reminder of the bigger picture, that the end of the relationship is not the end of your story, which gives insight into Moira's views about needing to progress through services and onto the next "chapter". Whilst some were hopeful for the future, and looking forward to working with new people, for others, the prospect was more difficult without staff support, particularly the moves down security levels or into the community. Alexis described her worries in relation to the differences between low secure and the outside.

Yeah. With no rules. Things like that. And it's going to be different" (Alexis, L220-221)

This appeared to be in relation to institutionalisation and having lived under the rule of others for a long time, Alexis' use of 'no rules' is interesting here, as it highlights the difference between hospital and the community, with hospital as restrictive and controlling, yet finding an element of safety in knowing what to expect. This was supported by Moira, who shared concerns about moving to the next phase:

Then I was to move from there to here, where I am now, which is a low-secure unit. And it was stark difference and I was a little bit nervous and worried and I said, you know, the level of care is going to be different and the level of what's expected of me is going to be different (Moira, L38-45)

This again speaks to the expectation of participants in the next stage of their journey, and the mismatch of expectation and potential reality causing anxiety. This is also an acknowledgement that despite all the positivity around moving on and moving forward, it is exciting *and* difficult.

Spencer, Alexis and Moira also thought of the ending as a way of appraising the skills you had learnt on your journey, which Alexis described as a way to *"prove that we've turned a corner"* (Alexis, L155). This highlights the need to prove yourself as worthy of the next step, as your future is determined by others, such as the responsible clinician or the MoJ. For Spencer, hospital was an opportunity to do all of the work possible to prepare for the future:

> *I think the more work you can do while you're in hospital helps, 'cause it helps you learn coping strategies and all that sort of stuff. (Spencer, L410-413)*

Further on his transcript, Spencer spoke about the dual role of interventions, which he noticed once they had ended:

> *Nothing to do. Time drags, you know, and you're not being productive, really. Just sitting in front of the TV. Yeah, and that's when my voices and my anxiety and my depression can get worse [mm], you know, because I've got nothing to occupy myself with (Spencer, L428-434)*

It seems interventions not only allowed him to learn strategies, but also to spend time with others doing something "productive", with both the skills learnt and the activity in general acting as a distraction supporting him to manage his mental health in the longer term.

Group Experiential Theme 3 – Coming to Terms with the Loss of Connection

This theme picks up on the common thread that was discussed by all of the participants – connection. It tracks the connection from its inception through the sub-theme of *"Professional Friends"? – Defining the Connection*, which speaks to the processing that goes on for

participants around what the relationship means to them, before moving on to thinking about what it means to experience connection and lose it in *You Know it was Worth it When it Hurts*. For most participants, this risk is worth the reward, but divergence and ways of coping with the feelings that arise are also discussed.

"*Professional Friends"? Defining the Relationship*

This theme was supported by five participants and illustrates the complexity of relationships in secure care. Moira, appeared to experience caregiving from staff as parental and viewed the staff and other patients as her *"extended family"* (Moira, L231), and gave them roles:

> *You've got the staff that come in like parentals, and then you've got all of us who are like kids together. You know, some are mature kids and some are real kids, and it's just, I don't know, it it… harnesses a kind of a *pause* a family feel. It's like an extended family, like everyone's step this and step that. (Moira, 325-332)*

Moira seems to acknowledge that alongside the caregiving role, there is also the role of enforcer of rules and boundaries, and her pause suggests that she is reflecting in action that actually these people are like family for her, but she then appears to add distance, using the term "extended family". This could be Moria's way of distinguishing the difference between additions to the family and birth family, or because she acknowledges the diversity in personalities and a coming together of people as in hospital, as being more akin to a blended family, than a nuclear one. Penelope described defining the current relationship through the lens of her past, in terms of attachment difficulties, stating:

You just count down the days until they're going and like, because I've got EUPD, I have attachment issues. [Okay.] So, when I get close to someone, if they leave it really upsets me. (Penelope, L 104-109).

For Penelope, this highlights her need to get close and stay close, in order to not feel abandoned, as this links to her own experiences and feelings of close relationships. It suggests that Penelope views the ending as inevitable, as based on her past experiences, everyone leaves, so there's a sense of her just waiting for this to happen and "counting down the days" until she experiences that familiar sense of pain and loss. Alexis also seemed to reference staff as attachment figures or people she shared a "bond" with, but for her these were time limited, and crossed the boundary into friendship. She shared that staff relationships meant that you *"get a bond with these people for the time that they are here, and you make friends that way."* (Alexis, 70-72). What is interesting to note about Alexis' quote, is that it seems as though the bond for her is limited to the time staff are there, suggesting they are context dependent. Pulling on what Alexis said about friends, Jocelyn seemed to have conflicting feelings about the felt sense of friendship, as someone you share with versus the cognitive sense of the impossibility of being friends with staff.

It's not that, obviously, you're not friends with them, but you build up this rapport with these people you know [Yeah]. Uhh, so you know it is like losing, sort of, you know the other half, because like, um you know they know things that probably that a lot of other people don't know about you. (Jocelyn, L139-146)

This quote feels evocative and powerful and really highlights the strength of the bond Jocelyn feels to staff with the words "losing… the other half", and that when she forms bonds with staff they form part of her. Her use of "obviously" in relation to staff not being friends suggests that despite it being an unwritten rule and a professional boundary, it still *feels* like friendship. There is also a sense that in endings too, staff are in a different realm of existence, which would not be the case if a friend moved:

you know, you'd like to be able to, well I, for me I'd like to be able to meet them in outside of hospital, [ok], and you know, [yeah], and see what they're like outside of the hospital environment [ok], so you know, it, it's very difficult, because I can't really explain [mm]. It's just, like telling somebody, your deepest secret and then you know, and then, that person going. (Jocelyn, L 181-190)

This lack of mutual vulnerability and the recognition that staff have a life outside of the unit, leads to a curiosity about whether the relationship would survive the outside world and whether staff would be the same. There is also a reference to the relationship ending after Jocelyn had shared her "deepest secret", which could indicate a difficulty appraising this ending, after something so personal was shared. It is perhaps best summed up by Moira's reference to staff as *"professional friends"* (Moira, L167), recognising the limits of closeness in the following quote:

I've been in the services [over 20 years] and I've seen a lot happen, you know... I've made a lot of professional friends [mm] and I get close to them, not close-close, but close enough [mm]. You know, close enough to be telling people about my problems and worries that I wouldn't even tell my best friend. (Moria 164-172)

Moira's experience of services has shaped her view of staff relationships, and she makes the distinction that safety to disclose is a unique aspect of the relationship, but the lack of mutuality and shared vulnerability is what adds the professional element to friendship.

You Know it Was Worth it When it Hurts

Throughout the transcripts, all eight of the eight participants spoke about the connection with staff and some shared the enormous sense of loss when these relationships end, although some were more descriptive about this than others. Despite this loss, relationships continued to be made, and the benefit of the closeness, connection, power and associated safety was worth the risk. Due to this loss, participants attempted to cope in different ways, divergence across this

theme is also noted. The importance of the role of staff was supported by all participants represented in this theme. For Twyla, the sadness of the loss of staff was related to their helping, caring role and their consistency, and they fulfilled a connection that peers could not.

> *Umm I guess for peers, you can get peers that are unwell and stuff so you can't create that massive bond or however. Umm, but, with staff they're just constantly there and they're well and they take care of you. (Twyla, L71-76).*

Jocelyn went further and described the role of connection as a "lifeline":

> *as much as it's probably, you know difficult for staff to leave, you know, I think it's a lot more difficult for patients when staff do leave umm, because you know at that time, when you're with that person that person is almost like your lifeline [mm], you know to either getting out of hospital [yeah], or you know to changing your life around so I do think as much as it is hard for staff, I do think patients find it a lot harder. (Jocelyn, L495-506)*

Jocelyn's use of the word lifeline speaks to the sheer gravity of the loss, as much more than just the relationship, but her connection to freedom, recovery and safety. Jocelyn's words imply a need for connection, based on more than attachment but speaking to that helping role staff play and the power they have to support her in achieving her goals. She acknowledges the differences between her world view as a collective of patients, and that of staff, which could suggest that being left is more difficult than leaving. Moira suggests that process of loss is akin to *"bereavement"* (Moira, 605-608) for some patients. She also felt that staff were unaware of the impact they had on patients:

They don't realise the impact they have, you know, because they're all we have. And you know, They're all we have and they're all we see and they're all we know (Moira, L418-421)

For Moira, the world outside of hospital did not exist for her, in the same way it does for staff, and it shows a sense of dependency on staff, who play a large role in her world.

Moira, Penelope, Jocelyn all shared the notion of the loss of staff relationships meaning the loss of their confidante. For Penelope, she acknowledged that it was hard for her to build trusting relationships, so when she did, she wanted to spend all her time with that person, to feel safe and supported:

Because with me, I find that I put all my eggs in one basket and I don't spread them around. So, when that person leaves, I'm like, "Oh, I've got no one, shit, I've got no one to talk to". (Penelope, 140-144).

This loss of connection gave Penelope the shocking realisation that she had lost 'her one person', and that talking was part of the connection. When "that person" leaves, Penelope is left feeling alone and out of options. This notion is further echoed by Moira, who reported feeling a *"there is a part of you inside that you can't let out anymore and you feel a little bit more constricted"* (Moira, L 205-8), as a result of key connections being lost. Moira depicts the connection with staff as an outlet for her, without which she cannot "open up". Jocelyn, spoke of the unique insight she had given staff into her experiences, which then led to feelings of insecurity and panic about whether that would be possible again:

they know things that probably that a lot of other people don't know about you [mm OK] so, when they actually go, you think 'oh my god' you know, they know everything [mmm], how am I ever gonna be able to, you know get that rapport back with anybody else. (Jocelyn, L144-151).

The use of the words "*how am I ever" and "anybody else",* highlights the unimaginable loss for Jocelyn, with it being difficult to even think about the same level of connection with someone else. There is a specialness about relationships where you connect on a level where you can share things about yourself that are not shared with others, with being let into the circle of trust having its benefits as well as risks. It suggests that connections with others are something worthwhile to lose.

For Spencer, it seemed as though the depth of the connection allows the relationship to work for him.

> *It's good because she, I've got autism and ADHD and she made things for me and she'd write on there, you know? I like visualising things as well. You know, on pieces of papers and things with a circle there going out there and why that happens, this happens, that happens. (Spencer, L 449, 455).*

Without this connection, the therapist would not be attuned to Spencer's needs and would not be able to provide him with accessible therapy; because Spencer felt safe enough to communicate his needs, he was able to feel more understood. This was shared by Jocelyn, who felt that the connection allowed her to feel understood.

> *You know I think people have got sort of empathy, [ok] you know [yeah], and they actually sort of understand and mean [ok] and mean what they say. You know there's no good somebody that doesn't understand really what I'm saying, cause, you know how can they feel what I'm, well I know they can't feel it, but how can they empathise with you, you know if, you know if they don't, if they don't know what you're talking about [mm], sort of thing. (Jocelyn, 246-258)*

For Jocelyn, her connection with staff allowed them to almost feel what she was feeling and sit with her in the emotion, she could communicate her needs and they would be heard. It is this that makes reward worth the impact of the loss. It seems for most of the participants, there were positives gained from the relationships with staff, making the pain caused when they leave as worth the risk.

Not all relationships were seen as a loss though. Jocelyn and Aaron both described feeling hopeful that some therapeutic endings were an opportunity for new connections, with Aaron saying he was "glad to get another one" (Aaron, L180), and Jocelyn stating the following.

> *I've had a few where I've been glad that *laughs* the, therapeutic ending has happened [shared laughter], because you know, you don't either agree with them, [Mmm], or you know, you don't like them. (Jocelyn, L45-51)*

This suggests that not all relationships result in the same felt sense of loss and that it is in our human nature not to like everyone. Jocelyn's laughter here suggests a softening of the fact she was glad the relationship had ended, as though she may have expected that every ending should be difficult.

Jocelyn acknowledged that sometimes, you need to understand the function of the ending to understand what this means for you, and although it's hard to leave the people you have developed connections with, it might be worthwhile and necessary:

> *And like I say, I left like my primary nurse that I'd had there and um, the manager that was the manager of the ward, was lovely as well. Er so, I found it quite hard to, you know sort of leave those. But you know, you have to, to move so soo… otherwise I would've still been there now, probably. (Jocelyn, L80-88)*

For Alexis; however, she felt as though her own personal resilience meant she found it easier to manage therapeutic endings:

> *Yeah, it's been fine. I've, I've got no attachment issues or anything, so I'm happy for people to come and go as they please.* (Alexis, L104-107).

This distancing from the attachment narrative seemed to be a way for her to avoid distress and sadness about the ending, which she also did through positivity *"It was kind… of sad, but it was good for them."* (Alexis, L62-63). Twyla shared this way of coping, using positivity to cope with loss:

> *Just think 'nooo!', but then you just look forward to them opening their new chapter. You can be sad, but it's all positive really isn't it? (Twyla, L85-88)*

There is a juxtaposition here in the way the no is said, in an almost dramatic way, with the extended "nooo!", highlighting the depth of the loss and the fact this is immediately followed with the suggestion that sadness is a choice with the use of the words "can be". For Aaron, his way of coping was to focus on new relationships which offered him hope and left him feeling *"encouraged"* and *"optimistic"*. (Aaron, L414-419).

Spencer noted being glad for staff who moved on, but it seemed as though, for him, it was the sense of achievement in the work, that allowed him to cope with the loss of a trusted ally and moderated the sadness he felt.

> *Umm I'll feel quite positive because all the work we've done. I mean, when I had my MDT yesterday, I got a gold star for all the hard work I put into my therapy [ahh well done!] So, quite positive, but quite sad that she was leaving, you know, and I wanted to carry on with it. (Spencer, L178-184)*

Penelope found it harder to cope with loss of relationships and she was able to link not being able to share her internal experiences with staff to a need to access care by any means, which was through incidents.

> *Yeah. Because I find if I only talk to that person and I've got no one to talk to… I build everything up in my head [yeah, OK]. And then when it gets too much, I have an incident and then I've got to talk to someone. (Penelope, L206-211)*

There seemed to be a process for Penelope whereby her feelings and thoughts became overwhelming, as she had lost her outlet for sharing these, and this sense of overwhelm, led to care eliciting behaviour in the form of incidents. Penelope felt that she had learnt from this cycle in order to cope with future losses, by expanding her trusted circle to "*talk to more people"* (Penelope, L 179). Penelope was reflective about her learning throughout her journey in secure care.

> **long pause* I don't know... Probably… don't leave on a bad note. [Yeah] Because I've done that to a couple of people where on the last session, I haven't spoken to them and I've ignored them and then when they're gone, I think 'what are they thinking?' (Penelope L222-228)*

Penelope felt that ignoring the person who had moved wards, would subsequently avoid any negative feelings about this loss, or avoid the ending all together, on the contrary it left her wondering about what they were thinking and whether she was in their thoughts. By not leaving on a bad note, Penelope is able to leave less to the unknown and have a clear cut end point and offer an opportunity for her to appraise the relationship and its meaning.

Discussion

This study aimed to explore low secure inpatients' experiences of therapeutic endings, using IPA. Therapeutic endings were defined as the end of any relationships with staff involved in patient's care and service endings, not only ending therapy, in order to capture the full spectrum

of endings within secure care. This has extended the literature, because previous studies have looked at ending therapy only, in non-secure settings (e.g. Webb et al., 2022) and did not use IPA.

Three main Group Experiential Themes (GETs) were created; '*Flow of Power'*, '*Endings Through Time'*, and '*Coming to Terms with the Loss of Connection'*. Interestingly, most participants thought of therapeutic endings in the context of personal losses or gains and described how the communication and marking of endings affected them. Relationships with staff had a profound impact on participants, emotionally, and or practically, and there was often a sense of deep loss when these relationships ended. The impact of power on therapeutic endings was also discussed by participants. Clinical implications are discussed in relation to each theme.

The influence of power on endings was reported in both staff relationships and through higher powers such as the MoJ, for some, this meant delay in their desired therapeutic ending, or resulted in dissatisfaction within the relationship. This is supported by research around risk assessment in secure services, which found the MoJ as being an 'unseen' higher power with control (Gray et al., 2021). It links with the view that staff act as gatekeepers to recovery and desired therapeutic endings (Tomlin et al., 2020) The "us and them" narrative created is prevalent within the forensic inpatient literature (e.g. Barksy & West, 2007, Clarke et al., 2017). Conversely, some patients felt empowered in their endings and felt it was their choice, allowing cooperation and involvement that is valued in relationships and provides a better quality of life (Walker et al., 2023) and is important for recovery (Senneseth et al., 2022). This is consistent with Marklund et al. (2020) who found that empowering patients by involving them in their care and explaining decisions around their care, such as therapeutic endings, supported patients to feel listened to and involved in their recovery.

The importance of involving patients within their care, including when care is ending, was prevalent within the GET endings through time, where participants described needing certainty and clarity around therapeutic endings, experiencing anxiety when this did not happen. This supports the findings of Tetley et al. (2010), who noted the importance of preparation when transitioning between services. Furthermore, the importance of marking therapeutic endings for secure inpatients, with things such as parties or going out for coffee, is consistent with the findings around ending treatment from community personality disorder services (Webb et al., 2022). Accessing the community, by leaving the unit for the ending, can feel especially meaningful for secure inpatients (Farrell et al., 2024), which could indicate the importance of accessing the community as a way of marking the ending and offering a sense of normality, which was highly valued by participants in the present study. This supports people to feel included in the outside community and develop their sense of non-patient identity, as well as a way to feel connected to staff. Participants in the current study highlighted how they were both hopeful about the future, but also concerned about what the ending would mean for them, which echoes the views of participants being discharged from a high secure service to lower security (Madders & George, 2014). Having hope for the future and an 'ordinary life', is shown to support recovery in secure care (Senneseth et al., 2022), therefore secure inpatients may benefit from having therapeutic endings framed as a move towards this life and increasing hope for the future.

The most prevalent GET was making sense of the loss of connection, which was spoken about explicitly in all of the transcripts. Participants viewed relationships in different ways and this set the context for how the ending was experienced. For some, staff were seen as like "extended family" and this notion is supported by the findings of Walker et al., (2023). Bonds with staff were strong, and participants described attachment relationships with staff. This

population are more likely to have experienced disrupted attachment and insecure patterns of attaching to care givers (Adshead & Moore, 2022) and up to 75% of secure inpatients will have experienced an adverse childhood experience (McKenna et al., 2019), which may affect how they relate to staff and their environment. Environments themselves can act as a 'safe base' and given the difficulties with attachment and experiences of trauma throughout childhood, secure environments might be the first place secure care patients have felt safe (Adshead and Moore, 2022).

Given the level of attachment insecurity within secure populations, as described above, it would make sense that attachment style would impact patient's response to and appraisal of therapeutic endings. Bowlby's theory (1988) suggests that attachment informs internal working models of the self and others, which last into adulthood. Fahlberg (1994) posed that responses from attachment figures to seeking care or getting their needs met, further informs our beliefs, with anxiously attached individuals developing beliefs that they need to keep attachment figures close to avoid abandonment and avoidantly attached individuals believing that others cannot be relied upon. Within therapeutic endings, this provides context for the findings around endings being difficult, or appraised differently for different relationships, as it may trigger feelings of abandonment, or confirm beliefs that others cannot be relied upon. Bowlby (2005), suggests that even the threat of losing someone can trigger anxiety, with loss causing grief and anger too. This again highlights the needs for attachment to be considered within endings, in order to best support patients (Bucci et al., 2015) acknowledging the large role staff had to play for patients in the present study and the impact attachment has on beliefs, and emotion regulation (Girme et al., 2021).

Viewing of relationships and the environment through an attachment and trauma lens has implications for therapeutic endings, given that these may re-enact attachment trauma, and lead to patients feeling abandoned, neglected or mistrustful of staff (Adshead and Moore, 2022). Therefore services would benefit from being mindful of attachment and ensure

attachment principles are applied in secure care (Bucci et al., 2015; Procter et al., 2017), paying particular attention to therapeutic endings, in which attachment patterns may be activated (Marmarosh, 2017). In addition, staff may benefit from training in Trauma Informed Care (TIC) (Procter et al., 2017) to support with improved relationships and increased compassion for the difficulties faced by this population. There is an importance in understanding a patient as more than an individual, and placing them within the context of a system and relationships, both of which could act as a trigger for previous trauma (Kimberg & Wheeler, 2019). By using a TIC model, it addresses the environment, by increasing empowerment, understanding and compassion, with all staff groups considering the impact of trauma, which has shown to be effective in secure care (Seitanidou et al., 2024).

Another finding related to the state of confusion around staff being friends, with one participant suggesting staff were like professional friends, whereby they act as a confidante, but there is also a limit to the relationship, defined by professional boundaries. Given there are limited opportunities for people in secure services to have pro-social relationships outside hospital (Bennetts & Hanna, 2021), it is no wonder staff are viewed as friends in the present study. Whilst maintaining professional boundaries is important, the ability of staff to show some vulnerability supports a connection with patients that has been shown to aid de-escalation of risk incidents (Johnston et al., 2022). In light of this, patients may benefit from support to build relationships and connect with the community, as well as flexibility from staff, this is also indicated by the Boundary See-Saw model (Hamilton, 2010).

Participants shared how staff were their "lifeline" and "all they knew", therefore it is unsurprising that therapeutic endings signified a great loss for patients. This is supported by Mezey et al. (2010), who reported that for secure inpatients, discharge can be seen as a loss of companionship, safety, and other positive activities in their life. This suggests the importance of staff and the leading role they play in patients' lives, as such their exit can play a large role

too and needs to be considered by services and staff. Participants stated the difficulty they had when staff "just left", and this shows how meaningful therapeutic endings can be (Webb et al., 2022). Endings can also trigger attachment patterns in both patients and staff (Marmarosh, 2017), which can subsequently activate strategies to cope with this disruption, due to emotional distress (Mann et al., 2014). One of the ways of coping in forensic services is linked to risk to self and to others (Bagshaw et al., 2012), as insecurely attached individuals may use violence as a way of externalising their pain (Adshead & Moore, 2022). This could also be viewed as a way to elicit care and proximity seeking, particularly when a patient has experienced a therapeutic ending. Connectedness also has a large role to play in recovery, particularly in secure care (Clarke et al., 2016; Senneseth et al., 2022). Therefore, whilst it is important to foster good therapeutic relationships, these will inevitably be seen as a loss, with the benefits of the relationship outweighing the loss for many of the participants in the current study. This again highlights the importance of attachment informed care within secure services (Bucci et al., 2015), given the large role staff play in patients' lives.

Strengths & Limitations

The current study has several strengths and limitations. A key strength is that it has provided a narrative of how secure inpatients are experiencing therapeutic endings and identifies potential options for improving this process to support recovery and improve outcomes. Strengths were including views of an under-represented, often marginalised group (Holley et al., 2019). The small sample size allowed for homogeneity of the sample, which is a good fit for IPA (Smith et al., 2022). Using IPA meant that the interpretation was grounded in participants' experiences, allowing for the double hermeneutic (Eatough & Smith, 2017). This closeness to the data also increases the validity of the study. The reflexive process allowed consideration of researcher influence on the findings.

There was an uneven gender split within the sample, with the majority identifying as female, which does not reflect the demographics of the secure population nationally (Tomlin et al., 2021), but does reflect the gender split of the service. This gender difference may account for some of the divergence within the themes. The present research was based on a sample who identified as White British in the majority. Older research suggests that Black people are more likely to be admitted to secure services (Coid et al., 2000) and Racially and Ethnically Minoritised (REM) groups are more likely to be involuntarily admitted under the Mental Health Act (1983) than white individuals (Barnett et al., 2019). Therefore, the ethnic identities of individuals in the present research may not reflect forensic services nationally. The present study did not consider how ethnicity or culture may have affected patient experience of therapeutic endings, but research from the wider justice sector, suggests that REM groups report poorer therapeutic relationships, which could affect experiences of endings (Lammy, 2017).

Some voices were missed in the write up of the study, as their quotes were often short and lacked depth which may reflect a difficulty in disclosing to a stranger, or difficulty mentalising and communicating what is going on for them (Mann et al., 2014) or due to ineffective interviewing. The power imbalance and viewing the researcher as a staff member, may have meant participants did not feel able to share their true feelings regarding endings, for fear of consequence, or impact on their care (Völlm et al., 2017). Offering the opportunity to preview questions ahead of the interview may have supported participants to be able to clearly think of examples of therapeutic endings. It may have also been interesting to collect data on the participants' attachment styles, to see how this corresponded with their views on therapeutic endings, which was not done in the present study.

The present study has used attachment theory (Bowlby 1988); however, this could be criticized for being too individualistic and can place the problem within the individual (Luyten et al., 2021). In the present study, the meaning that was made from therapeutic endings, was dependent on the relationship, both between individual, but also with services. Luyten et al.,

(2021) suggest that attachment is not within people, but within their interactions with those around them and their context socially, therefore, attachment style is important, as it will inform how patients may adapt to their environment, giving them the best chance to survive.

Future Directions

It could be helpful to further understand the barriers and facilitators to providing secure inpatients with therapeutic endings that meet their needs, which may be gleaned by doing further qualitative research with staff. Given the implications of the current research, including the suggestion for attachment and trauma informed care, future research could focus on secure services that have implemented such models of care, gaining patient views on what has worked well, with a focus on therapeutic endings. Those who have left secure care and now reside in the community may also have valuable insights into therapeutic endings, so future research could focus on this population. It may also be helpful to understand the role of therapeutic endings in incidents and risk, using a quasi-experimental approach looking at incident data at each stage of therapeutic endings, from finding out, to the end. This may support understanding about how best to manage risk at times of instability, using the lens of attachment. It would also be important to explore the views of Racially and Ethnically Minoritised groups, to ensure their views are captured in research.

Conclusion

In summary, the present study has highlighted the importance of relationships to low secure inpatients, with therapeutic endings being experienced as a great loss, complicated by attachment patterns and history of trauma. This also demonstrates significance of therapeutic endings in secure care and how these need clarity and care with a parity shown between fostering a relationship in order to support recovery (Clarke et al., 2016; Senneseth et al., 2022)

and the importance of the end of these relationships, both with services and staff. When done mindfully with attention paid to attachment difficulties, and what has been gained from the relationship, endings could hold the dialectic of not only loss, but also growth (Quintana, 1993).

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Declaration of Interests Statement

The authors report there are no competing interests to declare

Data Availability Statement

The participants of this study did not give written consent for their data to be shared publicly, so due to the sensitive nature of the research supporting data is not available.

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Chapter 2, Supplementary Material 1 – Interview Schedule

Interview Schedule

The interview will start with me explaining to the participant what the definition of therapeutic endings is for the purpose of this study and allow time for questions to form a shared understanding. "I really want to learn about your experiences of therapeutic endings and I will ask some questions about this, but ideally this will work best when you do the talking and I say very little."

It will describe therapeutic endings covered – so therapy with psychology (maybe an assistant psychologist), 1:1 OT or physiotherapy, staff member leaving or care team changing such as change of primary nurse, psychiatrist moving wards or moving between hospitals or from hospital to the community

Questions:

1) Could you describe what therapeutic endings mean to you?

2) Can you tell me about your experience of therapeutic endings whilst in secure care?

3) How, if at all, have therapeutic endings affected you personally?

Prompt – Emotions, thoughts, outlook

Follow-up - What was your experience of finding out the ending was going to happen?

4) In what way, if any, have therapeutic endings affected the care you receive?

5) In what way, if any, have therapeutic endings affected your recovery?

6) If you were writing a book with advice about how to give someone a helpful therapeutic ending what would you focus on? Prompt – What might the ideal ending look like for you?

7) We discussed this earlier, but I'd like you to tell me again, what therapeutic endings mean to you, this can be different to what we discussed earlier.

General prompts

Can you tell me any more about that?

What was that like for you?

How did you feel when that happened?

What sort of thoughts were you having about it?

How does that affect you? – be more open in what way did it affect you, if any?

Why?

Asking for more information

Can you tell me what you meant by that?

Chapter 2, Supplementary Material 2 – Reflexive Summary

Reflexive Summary – Experiences of Endings for low secure inpatients

This is a reflexive summary of journal entries over the course of the research, from data collection and through the stages suggested by Engward and Goldspink (2022), mapped over Smith et al.'s (2009) six steps of the analytic process. The remainder of this summary will be written in the first person.

I am a trainee clinical psychologist, and I previously worked in the low secure service, as an assistant psychologist. The idea for the research came when I was ending work with people on my caseload, either as they prepared to move on, or because the work had ended and when I turned to the research to think about what might be helpful, I just could not find what I was looking for. I found plenty on the termination of therapy, thinking about skills and blue prints, but nothing on how endings were experienced and what would be most helpful in terms of notice, or what was most remembered. I knew from supporting with another doctoral project that Interpretative Phenomenological Analysis seemed like the best fit for this area, and so I banked the idea and knew if I got on the doctorate, that would be my research area. Wearing my attachment hat and reflecting on the client group's previous experience with endings, I could see their importance – often people had left patient's lives, leaving them feeling abandoned and rejected, or through ruptures, where the relationship felt so intolerable it was pushed away. I had a strong sense that I did not want to do this and hoped that I could offer a template for endings that was ultimately not harmful. I reflected on my own views of the service whilst working there, and my opinions of how therapeutic endings had been managed. As an assistant, I did not feel I owned much power, and so although I suggested that leaving with a day's notice was perhaps not the most helpful, I still saw it happen.

My previous experience in the service meant I was really mindful of thinking about how this relationship would affect consent for the present research, whilst also giving potential participants a chance to chat and ask questions about the research. I knew some of the patients from previous admissions, or from designing materials for the study, which meant for some I was a familiar face. During data collection, I felt out of my depth, and entries in my journal reflect this, such as "Did I ask in enough depth, should I have asked more follow up questions?", this was mixed with reflections about how I could learn from the participants,

and topics that seemed pertinent for them. There were words that struck me, such as 'blue moments' or little gems such as "professional friends", that I felt at the time were going to be important later. At times during the interviews, I felt as though I didn't want to push, because some participants shut down questions with short answers, so I think with my therapeutic hat on, I push where it moves, and it felt like pushing at that point would not have been helpful. This was one of the main challenges throughout the interviews, in that I was not acting as their therapist, so I had to think about what was interesting to explore and pull on important threads regarding therapeutic endings. There was a feeling a sadness in some of the interviews, when thinking about staff members who had left, which brought up feelings of sadness in me, as I was one of those people that left, which is when guilt also arrived. It was important to me to bring myself back to the interviews themselves and be present for the participants and not hold on too tightly to my preconceptions of therapeutic endings from my own experience of them from working in secure care.

Becoming immersed in the data was overwhelmingly sad sometimes, as participants spoke about their raw emotions and how much staff meant to them, the sadness came from a place of empathy, that I knew they had no one else. There was a quote one of the transcripts that said that it was 'ripped out of me' when the relationship ended and another who felt she had no-one when staff left, and it highlighted the power of relationships. I felt as though I really wanted to do the data justice, and it seemed like there was some real pearls in the data. I found that because I could imagine the participants speaking when I was re-reading the data and it was close enough to data collection for the interviews to be fresh in my mind, that I felt close to the data.

Data analysis felt never ending, and brought up a lot of feelings of incompetence, I felt I had to check myself to think about what I was leaving out and what I was making more of. There were times, particularly when participants were saying very little, but the tone sounded sad, or dismissive, that it felt like there was something there, but I had not explored things enough, that it was my fault participants did not feel comfortable enough to disclose and this came from a place of anxiety about not doing it right. When I had made experiential statements with very short quotes, I had to check my assumptions and think about the double hermeneutic and how balanced it was. I also knew about the histories of some of the clients, which gave more context than I had for others, and this in addition to my knowledge about the impact of attachment and trauma meant I needed to catch myself in assumptions of what relationships

looked like and whether it was making the data ‘stretch’ with the lens I was viewing it through. I wanted to ensure I was remaining close to the data and not getting tied to my interpretation, which mostly left me with the overwhelming sense of ‘am I doing this right?’. I think because I wanted to know what would be helpful, maybe I pulled on that thread harder than others. Reading forums and discussing with peers at this stage really helped me move past these feelings of incompetence, at least until the next stage.

I had to check my assumptions when making the Personal Experiential Themes (PETs), ensuring that I wasn’t making themes because I held topics in high esteem and not from the participants and think about staying close to the data and the story it told. My dining table was over-run and there were lots of tears, because I just wanted to do a good job. Sometimes I felt I had ‘got it’ and then when I would relook, something did not make sense and needed to be changed. When it came to looking for patterns across cases and making Group Experiential Themes (GETs) I felt unsure I knew what I was doing and I had to go back a revise the work I had done on my PETs, as I realised that some did not quite make sense together and were together by a matter of circumstance and not because they truly belonged together, like a bad relationship. I moved from the dining table to the floor and spread the data around me, looking for patterns like frantic detective with string from person to place to clues. If I am honest, at times it felt like detective work – staying close to the evidence, or data in my case to explore participant’s narratives, and think about how they made sense of their experiences and in turn how I was then making sense of this. As with any good detective, I used the team around me, and supervision was a helpful tool to keep me grounded at this point and explaining my theories of how the data was linked helpful me realise where it needed some work. I thought about the data lodgers, what was lingering and what it meant, and held onto these as I wrote up my analysis. Hermeneutics came up quite a lot when I was in the analysis stage, I had to continuously hold in mind the hermeneutics of empathy – stepping into participants’ shoes, but then using questioning hermeneutics to go further and interpret and think what does this actually mean?!

In summary, I had to stay mindful of how my previous experiences of secure care and the participants in the study affected my interpretation of how they made sense of endings, to continue to hold the double hermeneutic and not just over-interpreting a very raw experience for some. I mostly felt incompetent throughout the analysis and ‘the book’ (Smith et al., 2022) became my aid and my reflections my outlet, they filled pages of notepads and seeped into my voice memos as I thought aloud about how the data was linked. I am now at a stage where I

feel I can reflect on the experience in a helpful way and am just so grateful to the participants who took part in the research.

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Tables

Table 1 – Summary Demographics

Table 1

Summary Demographics

Participant Characteristic	Range of Answers
Age	26-57
Self-Identified Gender	6 Female, 2 Male
Self-Identified Ethnicity	White British, British, English & Dual Ethnicity
Selected Ethnicity	Dual/Mixed Ethnicity, White British
Sections of the Mental Health Act (1983)	37, 37/41, 3
Time spent in secure services	2-38 years

Table 2 – Group Experiential Themes

Table 2

Group Experiential Themes and subthemes, with prevalence data.

Group Experiential Theme	Sub-theme	Prevalence
The Flow of Power		N=5 Moira, Aaron, Jocelyn, Spencer, JJ
Endings Through Time	Clarity, expectation & (un)certainty	N=5 Jocelyn, JJ, Moira, Aaron, Alexis
	Marking the ending	N=5 Twyla, JJ, Alexis, Spencer, Penelope
	New Beginnings	N=4 JJ, Alexis, Spencer, Moira
Coming to terms with the loss of connection	"Professional Friends"? Defining the Relationship	N=5 Jocelyn, Alexis, Moira, Spencer, Penelope
	You know it was worth it when it hurts	N=8 Jocelyn, Alexis, Aaron, Spencer, Penelope, Twyla, Moira, JJ

Appendix A – Journal Submission Guidelines, Journal of Forensic Psychology Research & Practice

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- Open Access
- Peer Review and Ethics
- Preparing Your Paper
    - Structure
    - Word Limits
    - Style Guidelines
    - Formatting and Templates
    - References
    - Taylor & Francis Editing Services
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- Using Third-Party Material
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- Data Sharing Policy
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- Copyright Options

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- Bruce Arrigo

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Authors are further encouraged to cite any data sets referenced in the article and provide a Data Availability Statement.

At the point of submission, you will be asked if there is a data set associated with the paper. If you reply yes, you will be asked to provide the DOI, pre-registered DOI, hyperlink, or other persistent identifier associated with the data set(s). If you have selected to provide a pre-registered DOI, please be prepared to share the reviewer URL associated with your data deposit, upon request by reviewers.

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Queries

If you have any queries, please visit our Author Services website or contact us here.

Updated 28th February 2024

Appendix B – Example Codebook Extract (Systematic Review)

Table 1

Codebook Extract

Name	**Description**
Barriers to recovery	Overarching Theme
Barrier 1 - Disconnectedness	This analytical theme depicts the ways in which patients feel disconnected from staff and their wider network and therefore not able to benefit from the therapeutic relationship, such as not feeling able to trust in staff. It thinks about how the loss of therapeutic relationships impacts on loneliness and trust in staff, with a lack of time to develop relationships acting as a barrier to connection.
Descriptive Theme: It's hard to trust people	This descriptive theme shows the difficulty building trust for participants and thinks about why this might be and the impact it has on the relationship.
Code: difficulty building trust	Example Quotes *“suggesting this is part of daily life as a forensic inpatient, characterised by fear of punishment and can lead to a sense of mistrust towards staff”* (Bennett & Hanna, 2021, p. 936) *“When I first came here it was sort of like terrible, um, it sort of like unsettled me very very much, um, and I'd reluctantly speak to the staff, I was very angry (long pause) and I like didn't like really like sort of like trust or like the staff. It was a sort of process”* – Grace (Budge, 2016, p. 95)
Descriptive Theme: Relying on a limited circle	This descriptive theme describes the limited opportunities for connection both in and out of hospital, and how staff can facilitate connections outside of hospital (such as with family), but this may mean they are relied upon, with little other options.

	Example Quotes for codes:
Code: familiarity with staff supports relationship	*"When you become used to staff ... you know who they are and you know you can talk to them"*. – Sid (Mitchell, 2023, p. 85).
Code: limited opportunities for other relationships	*"the absence of other affirming relationships in the community and the physical and social dimensions of the forensic hospital that perpetuated feelings of frustration, loneliness and sadness"* (Nijdam-Jones et al., 2015, p. 164)

Appendix C – Ethical Approval

ERGO II – Ethics and Research Governance Online https://www.ergo2.soton.ac.uk

Submission ID: 78579
Submission Title: The experience of therapeutic endings for low secure service users: An Interpretive Phenomenological Analysis. With therapeutic endings encompassing the end of therapy, staff endings and service endings.
Submitter Name: Sophie Collingwood

The Research Integrity and Governance team have reviewed and approved your submission.

You may only begin your research once you have received all external approvals (e.g. NRES/HRA/MHRA/HMPPS/MoDREC etc or Health and Safety approval e.g. for a Genetic or Biological Materials Risk Assessment).

The following comments have been made:

-
- Thank you for making the suggested changes.

  OID - Please update Linda's job title at the following

  - **Section 18** Authorised on behalf of Sponsor by: Linda Hammond, Head of Research Ethics and Clinical Governance and put today's date.

Once external approvals are received you must upload your final document set and approval letters to ERGO using the *Upload External Approvals* button if your project is sponsored by University of Southampton.
If your project is sponsored by another institution, please ignore this request as you will already have provided these documents.

Miss Sophie Collingwood

Email: approvals@hra.nhs.uk
HCRW.approvals@wales.nhs.uk

30 May 2023 (Re-issued 18 July 2023)

Dear Miss Collingwood

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**The Experience of Endings for Low Secure Service Users: An Interpretive Phenomenological Analysis. With therapeutic endings encompassing the end of therapy, staff endings and service endings.**
IRAS project ID:	**322445**
Protocol number:	**N/A**
REC reference:	**23/NS/0048**
Sponsor	**University of Southampton**

I am pleased to confirm that HRA and Health and Care Research Wales (HCRW) Approval has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The standard conditions document "*After Ethical Review – guidance for sponsors and investigators*", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **322445**. Please quote this on all correspondence.

Yours sincerely,
Libby Williamson
Approvals Specialist

Email: approvals@hra.nhs.uk

Copy to: *Mrs Linda Hammond*

List of Documents

The final document set assessed and approved by HRA and HCRW Approval is listed below.

Document	*Version*	*Date*
Copies of materials calling attention of potential participants to the research [Research Advertisement Poster]	5	19 May 2023
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Insurance University of Southampton]		05 April 2023
Interview schedules or topic guides for participants [Interview Schedule Draft]	2	19 January 2023
IRAS Application Form [IRAS Form 03052023]	322445/1617142/37/574	25 April 2023
Letter from sponsor [Letter from Sponsor]		05 April 2023
Non-validated questionnaire [Demographics Questions]	2.0	24 March 2023
Organisation Information Document [OID]	2	28 April 2023
Other [Debrief Form]	3	28 April 2023
Other [NHS to NHS confirmation pre-employment checks]		05 April 2023
Other [Insurance Legal Liability]		01 August 2022
Participant consent form [Consent Form]	4	03 May 2023
Participant information sheet (PIS) [Participant Information Sheet]	6	19 May 2023
Research protocol or project proposal [Research Protocol]	5.0	19 May 2023
Response to Request for Further Information [Response to HRA assessment queries]		28 April 2023
Schedule of Events or SoECAT [Schedule of Events]	2	24 March 2023
Summary CV for Chief Investigator (CI) [Sophie Collingwood]		28 April 2023
Summary CV for supervisor (student research) [Pete Lawrence]		06 February 2023
Summary CV for supervisor (student research) [Melanie Hodgkinson]		06 February 2023
Summary CV for supervisor (student research) [Caroline Clarke]		28 April 2023

IRAS project ID	322445

Information to support study set up

The below provides all parties with information to support the arranging and confirming of capacity and capability with participating NHS organisations in England and Wales. This is intended to be an accurate reflection of the study at the time of issue of this letter.

Types of participating NHS organisation	Expectations related to confirmation of capacity and capability	Agreement to be used	Funding arrangements	Oversight expectations	HR Good Practice Resource Pack expectations
Research activities and procedures as per the protocol and other study documents will take place at participating NHS organisations.	Research activities should not commence at participating NHS organisations in England or Wales prior to their formal confirmation of capacity and capability to deliver the study in accordance with the contracting expectations detailed. Due to the nature of the activities involved, organisations will be expected to provide that confirmation to the sponsor - Within 35 days of receipt of the local information pack - After HRA/HCRW Approval has been issued. If the organisation is not able to formally confirm capacity and capability within this timeframe, they must inform the sponsor of this and provide a justification. If the sponsor is not satisfied with the justification, then the sponsor may escalate to the National Coordinating Function where the participating NHS organisation is located.	An Organisation Information Document has been submitted and the sponsor is not requesting and does not expect any other agreement to be used with participating NHS organisations of this type.	Study funding arrangements are detailed in the Organisation Information Document	A Local Collaborator should be appointed at participating NHS organisations.	Where an external individual will be conducting any of the research activities that will be undertaken at this site type then they would be expected to hold a Letter of Access. This should be issued be on the basis of a Research Passport (if university employed) or an NHS to NHS confirmation of pre-engagement checks letter (if NHS employed). These should confirm Occupational Health Clearance. These should confirm standard DBS checks.

Other information to aid study set-up and delivery

This details any other information that may be helpful to sponsors and participating NHS organisations in England and Wales in study set-up.
The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN Portfolio.

Southern Health
NHS Foundation Trust
Recruitment Department
Hawthorn Lodge
Moorgreen Hospital
Botley Road
West End
Southampton
SO30 3JB

Tel: 023 8047 5160

www.southernhealth.nhs.uk

Sophie Collingwood

28th June 2023

Dear Sophie

Letter of access for research – The experience of Therapeutic endings for low Secure Service Users.

I am pleased to offer you an honorary research contract in Southern Health NHS Foundation Trust. I should be grateful if you would sign the attached three contracts, keep one yourself and return the other two to the above address. We will send a copy of the contract to your substantive employer.

In accepting this letter, each participating organisation confirms your right of access to conduct research through their organisation for the purpose and on the terms and conditions set out below. This right of access commences on 28th June 2023 and ends on 27th June 2024 unless terminated earlier in accordance with the clauses below.

As an existing NHS employee you do not require an additional honorary research contract with the participating organisation(s). The organisation(s) is/are satisfied that the research activities that you will undertake in the organisation(s) are commensurate with the activities you undertake for your employer. Your employer is fully responsible for ensuring such checks as are necessary have been carried out. Your employer has confirmed in writing to this organisation that the necessary pre-engagement checks are in place in accordance with the role you plan to carry out in the organisation(s). Evidence of checks should be available on request to Southern Health NHS Foundation Trust.

You have a right of access to conduct such research as confirmed in writing in the letter of permission for research from this organisation. Please note that you cannot start the research until the Principal Investigator for the research project has received a letter from us giving the organisation(s) permission to conduct the project.

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

While undertaking research through Southern Health NHS Foundation Trust, you will remain accountable to your employer greater Somerset NHS Foundation Trust but you are required to follow the reasonable instructions of your nominated manager Dr Peter Phiri in each organisation or those given on her/his behalf in relation to the terms of this right of access.

OUR VALUES

Partnership

Respect

Trust Headquarters, Sterne 7, Sterne Road, Tatchbury Mount, Calmore, Southampton SO40 2RZ

University of Southampton

Appendix D – Research Materials

Participant Information Sheet

Study Title: The experience of therapeutic endings for low secure service users. With therapeutic endings encompassing the end of therapy, staff endings and service endings.

Researcher: Sophie Collingwood **ERGO number:** 78579 **IRAS:** 322445

<u>Summary</u>

- This study aims to explore your experiences of therapeutic endings, such as ending therapy (like Psychology, OT or other therapy), staff in your care team leaving/changing, or you moving hospital or ward. During your time in secure services.
- You **do not have to take part** and you can change your mind any time. It will not affect the care you receive.
- It will take up to an hour to do a face to face interview (which will be audio recorded) and complete a short questionnaire about yourself.
- After the interview, the recording will be typed up and will not use your name, or any other information that can be related back to you (anonymised), then the recording will be deleted.
- You can choose what you answer and talk about – it is up to you what you feel comfortable sharing and you can say if you *do not* want to talk about something.
- The interviews will be carried out by Sophie Collingwood (Researcher) at *service name removed for anonymity* Low Secure Unit in an off-ward quiet room.

- Doing this interview will not affect your care, and any information from the interview will not be shared, unless someone is at risk of harm.

- The anonymised typed up interviews will be analysed and then made into a final report and submitted as part of the researchers' doctorate degree at the University of Southampton. Once the research is written up, it will not have any personal information that can be linked back to you (for example, we will make up names to go with any quotations we use).

- You can request a copy of the research, after it has finished. A summary will be available.

- After informing the nurse in charge, you will get £20 voucher of your choice or cash for taking part.

- If you are feeling worried or distressed after the interview, the researcher will support you to access support from the ward staff.

You are being invited to take part in the above research study. To help you decide whether you would like to take part or not, it is important that you understand why the research is being done and what it will involve. Please read the information below carefully. You can ask questions if anything is not clear or you would like more information before you decide to take part in this research. You may like to discuss it with others but it is up to you to decide whether or not to take part. If you are happy to participate, you will be asked to sign a consent form. This document refers to the research team throughout, this includes Sophie Collingwood (Researcher) and three supervisors, Dr Caroline Clarke, Dr Melanie Hodgkinson & Dr Pete Lawrence, who are all Clinical Psychologists.

What is the research about?

This study hopes to gain understanding about the experiences of therapeutic endings of people living in secure hospitals. Especially your experiences of ending therapy (such as psychology, or OT), staff in your care team leaving the service, or moving between or out of hospital, whilst living in secure services.

University of Southampton

Appendix D – Research Materials

This study is being carried out by Sophie Collingwood, a trainee clinical psychologist as part of a Doctorate in Clinical Psychology. Sophie would like to help improve future endings of people living in secure settings, as she is feels it is important to improve the experience of being in hospital. This study is being sponsored by the University of Southampton to take place within Southern Health NHS Trust.

Why have I been asked to participate?

You have been invited to take part in this project as you have experienced a therapeutic ending, such as someone in your team leaving, ending a therapy, or changing service (i.e. from medium to low secure) and you live in a secure hospital. The researcher hopes to find 6-8 people who have experienced this type of ending, during their time in secure services, from the XX people in *service name removed for anonymity* Low Secure Unit.

What will happen to me if I take part?

After you have read this information sheet, you might want to ask questions. You can direct these to the research team, or to someone in your care team like your primary nurse, or Psychologist. You can also talk to them about whether you would like to take part and whether this study might be the best fit for you, before making a decision.

If you would like to take part, and you are eligible, you will be asked a few questions about yourself, like your age, gender, ethnicity, which section of the mental health act you are under and how long you have been in hospital.

The interview will take place at a time and day that suit you. You will be asked about your experiences of therapeutic endings during your time in secure hospitals. You will be interviewed by Sophie Collingwood, in a quiet room off of the ward, which will take up to an hour. A Dictaphone will be used to record the interview. Sophie will let you know when the recording is starting and stopping. You can take a break or stop the interview at any time.

Your care will not be affected by taking part, unless you share something which raises concern about yours or others' safety, what you say will not be shared with your clinical team. If you disclose something, which raises concern that someone is at risk of harm, then steps will be taken to ensure your/their safety. This might include talking to what is called the 'safeguarding' lead for Southern Health NHS Foundation Trust, to get advice about how to keep you and others safe.

After the interview, you will have access to a debrief about the study, which can be read to you and you can have a paper copy to take with you. There will also be a chance to talk about what the interview was like and how you were feeling. If you feel at all upset or distressed following the interview, please let Sophie (the interviewer) know, and you will be offered more support.

The recording of the interview will be kept securely until it is typed up, then it will be deleted. The typed version of the interview, called a transcript, will not have information on which identifies you personally, and we will use a different name than yours.

The interview transcript will be analysed to look for themes and then written up as a research article for Southampton University, as well as for an academic journal so people can read the results. This write up may include direct quotes of what you have said. However, you will not be directly identified and names or places will be removed. You can let the researcher know if you would like to see a copy of the full research report, by asking a member of your care team to contact the researcher. Alternatively, summary personal contact details will be retained for this purpose, if you would like to be contacted directly. There will also be a summary available at *service name removed for anonymity* following the study, made by the researcher and an expert by experience.

If you choose to take part, then you will receive a £20 voucher of your choice (e.g. Amazon, Morrisons etc). or cash to spend as you wish, as a thank you for your time. The researcher will let the nurse in charge know that participants will be getting £20 for taking part in the study.

Are there any benefits in my taking part?

It is hoped that by taking part, it will help us understand how people in secure settings experience endings and what we as professionals might be able to do to make these endings easier for our patients and provide the best support we can. You might find it helpful to have the time and space to talk about what endings have been like for you.

Are there any risks involved?

As you will be talking about endings, and these can be difficult to experience, you may find it brings up some emotional distress or may feel uncomfortable, this is completely understandable. You have control over what you say, so please let the researcher know if there is anything you do not want to talk about and you will not be asked about this. Please do not share anything you do not feel happy to. Once

the recording is stopped, you will have a chance to speak to the researcher about your experience of the interview and make a plan for how you might manage if you are feeling distressed.

The interview will follow any COVID restrictions set out by Southern Health NHS Foundation Trust, such as wearing a face mask and social distancing.

What data will be collected?

This study will be collecting some data about you such as your age, gender, ethnicity, section of the mental health act and how long you have been in hospital, as well as the audio recording of the interview, which will be recorded by Dictaphone.

This data will be stored securely; paper copies of forms will be scanned in digitally and paper copies destroyed. Audio files will be kept in a password protected file on a secure server on the researcher's computer and only the research team will have access to this. You will be given a number on all forms, so you will not be identified and there will not be any identifiable information in the write up of this study.

If you would like a copy of the full research report after the study, this can be provided via your care team. Alternatively, summary personal contact details will be retained, if you would like to be contacted directly.

Will my participation be confidential?

Your participation and the information we collect about you during the course of the research will be kept strictly confidential. This is unless you raise concerns about the safety of yourself or others, then this information will be shared with your clinical team.

Only members of the research team and responsible members of the University of Southampton may be given access to data about you. This is for monitoring purposes and/or to carry out an audit of the study to ensure that the research is following the right rules. Individuals from regulatory authorities (people who check that we are carrying out the study correctly) may require access to your data. All of these people have a duty to keep your information, as a research participant, strictly confidential.

Do I have to take part?

No, it is entirely up to you to decide whether or not to take part. If you decide you want to take part, you will need to sign a consent form to show you have agreed to take part.

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What happens if I change my mind?

You have the right to change your mind and withdraw at any time without giving a reason. If you chose to withdraw from the study, your care at *service name removed for anonymity* will not be affected. If you withdraw from the study, we will keep the information about you that we have already obtained for the purposes of achieving the objectives of the study only.

What happens if I lose capacity during the study?

If you lose capacity or become unwell during the study and can no longer consent to taking part, then your data will be withdrawn from the study,. Unless it is not identifiable to the research team, then it may be retained.

What will happen to the results of the research?

Your personal details will remain strictly confidential. The write up of the research (in reports and publications) will include quotes of things you have said word for word; however, this will not include your name or offending history, or other information that will directly identify you. You can ask for a copy of the research report, after the study has finished.

Where can I get more information?

If you would like to talk to someone about the study, you can speak to a member of the psychology team, such as an Assistant Psychologist, or you can speak to Dr Caroline Clarke, who is a Clinical Psychologist at *service name removed for anonymity*, or your primary nurse.

If you would like to speak to the researcher, you can email s.r.collingwood@soton.ac.uk, or you can ask a member of the psychology team to arrange a telephone call.

What happens if there is a problem?

If you have a concern about any aspect of this study, you should speak to the researcher, Sophie Collingwood, who will do their best to answer your questions. You can do this via email at s.r.collingwood@soton.ac.uk

University of Southampton

If you remain unhappy or have a complaint about any aspect of this study, please contact the University of Southampton Research Integrity and Governance Manager (023 8059 5058, rgoinfo@soton.ac.uk).

Who has reviewed the study?

The North of Scotland (2) Research Ethics Committee has reviewed the study.

Data Protection Privacy Notice

The University of Southampton conducts research to the highest standards of research integrity. As a publicly-funded organisation, the University has to ensure that it is in the public interest when we use personally-identifiable information about people who have agreed to take part in research. This means that when you agree to take part in a research study, we will use information about you in the ways needed, and for the purposes specified, to conduct and complete the research project. Under data protection law, 'Personal data' means any information that relates to and is capable of identifying a living individual. The University's data protection policy governing the use of personal data by the University can be found on its website (https://www.southampton.ac.uk/legalservices/what-we-do/data-protection-and-foi.page).

This Participant Information Sheet tells you what data will be collected for this project and whether this includes any personal data. Please ask the research team if you have any questions or are unclear what data is being collected about you.

Our privacy notice for research participants provides more information on how the University of Southampton collects and uses your personal data when you take part in one of our research projects and can be found at http://www.southampton.ac.uk/assets/sharepoint/intranet/ls/Public/Research%20and%20Integrity%20Privacy%20Notice/Privacy%20Notice%20for%20Research%20Participants.pdf

Any personal data we collect in this study will be used only for the purposes of carrying out our research and will be handled according to the University's policies in line with data protection law. If any personal data is used from which you can be identified directly, it will not be disclosed to anyone else without your consent unless the University of Southampton is required by law to disclose it.

Data protection law requires us to have a valid legal reason ('lawful basis') to process and use your Personal data. The lawful basis for processing personal information in this research study is for the performance of a task carried out in the public interest. Personal data collected for research will not be used for any other purpose.

For the purposes of data protection law, the University of Southampton is the 'Data Controller' for this study, which means that we are responsible for looking after your information and using it properly. The University of Southampton will keep identifiable information about you for 10 years after the study has finished after which time any link between you and your information will be removed.

The NHS requires that it be documented in your clinical notes that you have consented to take part in research with the researcher and have taken part in an interview. Unless you share risk information such as a risk to yourself or others, which we have a duty of care to report, the information you share within the interview will remain confidential and not be shared with your clinical team.

To safeguard your rights, we will use the minimum personal data necessary to achieve our research study objectives. Your data protection rights – such as to access, change, or transfer such information - may be limited, however, in order for the research output to be reliable and accurate. The University will not do anything with your personal data that you would not reasonably expect.

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If you have any questions about how your personal data is used, or wish to exercise any of your rights, please consult the University's data protection webpage (https://www.southampton.ac.uk/legalservices/what-we-do/data-protection-and-foi.page) where you can make a request using our online form. If you need further assistance, please contact the University's Data Protection Officer (data.protection@soton.ac.uk).

Thank you for considering taking part in this research and for taking time to read this information sheet.

University of Southampton

CONSENT FORM

Study title: How do people under section in a low secure unit experience therapeutic endings? With therapeutic endings encompassing the end of therapy, staff endings and service endings.

Researcher name: Sophie Collingwood, Dr Caroline Clarke, Dr Melanie Hodgkinson, Dr Pete Lawrence.

ERGO number: 78579 **IRAS reference**: 322445

Participant Identification Number*:*

Please initial the box(es) if you agree with the statement(s):

1. I have read and understood the information sheet [Version: 6 Date: 19/05/23] and have had the opportunity to ask questions about the study.	
2. I agree for my interview to be audio recorded. You will be told when the recording starts and stops.	
3. I understand that the recording of my interview will be typed up, any identifiable information removed and then analysed by Sophie Collingwood (the researcher)	
4. I understand that I will be asked to give my age, gender, ethnicity, which section of the mental health act I am under and how long I have been in hospital for (which is called special category data), to help meet the objectives of the study.	
5. I agree to take part in this research project and agree for my data to be used for the purpose of this study.	

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6. I understand my participation is voluntary and I may withdraw at any time and for any reason. Should I withdraw from the study then the information collected about me up to this point may still be used for the study.	
7. I understand that direct quotes from what I have said may be used in the write up of the research; however, I will not be directly identified and names or places will be removed.	
8. I understand that relevant sections of my notes and data collected during the study, may be looked at by individuals from the University of Southampton, from regulatory authorities or from Southern Health NHS Foundation Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records	
9. I would like to have a copy of the final research, or have someone from my care team go through this with me.	

This consent form will be securely uploaded to a password protected file and the paper copy destroyed. Participants may also have a copy, if requested.

Name of participant (print name)……………………………………………………………………………

Signature of participant…………………………………………………………………………………….

Date………………………………………………………………………………….. ………………….

Name of researcher (print name)…………………………………………………………………………

Signature of researcher …………………………………………………………………………………….

Date………………………………………………………………………………………………………..

University of Southampton

Demographic Questions

STUDY TITLE: The Experience of Therapeutic Endings for Low Secure Service Users

VERSION: 2.0 **DATE:** 24/03/2023 **RESEARCHER:** Sophie Rose Collingwood

ERGO NUMBER: 78579 **IRAS NUMBER:** 322445

Participant Number:

1. What is your age?

2. What gender do you identify as?

3a. What is your Ethnicity?

3b. Which ethnicity do you identify with from the list below?

Asian or Asian British - Any other Asian background

Asian or Asian British - Bangladeshi

Asian or Asian British - Indian

Asian or Asian British - Pakistani

Black or Black British - African

Black or Black British - Any other Black background

Black or Black British - Caribbean

Mixed - Any other mixed background

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Mixed - White and Asian

Mixed - White and Black African

Mixed - White and Black Caribbean

Other Ethnic Groups - Any other ethnic group

Other Ethnic Groups - Chinese

White - Any other White background

White - British

White - Irish

4. What section of the mental health act are you under?

5. How long have you been at *low secure unit*?

6. How long have you been in secure services?

University of Southampton

Debriefing Form

Ethics/ERGO number: 78579

IRAS Project ID: 322445

Researcher(s): Sophie Collingwood, Dr Caroline Clarke, Dr Melanie Hodgkinson, Dr Pete Lawrence

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Version and date: Version 3, 28/04/23

Dear Participant,

Thank you so much for giving up your time to take part in the research study titled 'The experience of therapeutic endings for low secure service users.'

The aim of this research was to gain understanding about the experiences of therapeutic endings of people residing in secure hospitals. Especially your experiences of ending therapy (such as psychology, or OT), staff in your care team leaving the service, or moving between or out of hospital. We understand that people will have differing experiences of endings and what is helpful, and not so helpful. Your interview will help our understanding of how endings can be managed in a safe, secure and compassionate way, that minimises distress.

This study did not use deception, that means you had all of the details about the study, before taking part. When the research is written up, it may include direct quotes from things you have said; however, it ***will not*** include any personal identifiable information, like your name, hospital or offending history.

If you feel worried or distressed after your interview, then please speak to someone in the Psychology team, or a member of staff on the ward and they will be able to support you.

The researcher will read this out to you following taking part in the study and you can also take a paper copy back to the ward. If you would like to read the final research report, this can be sent to you, or shared with you by a member of your team. You can contact the researcher on the details below, or ask someone in your care team to support you with this.

If you have any more questions, you can contact Sophie Collingwood at s.r.collingwood@soton.ac.uk

Thank you so much for taking part!

Signature____

Name____ Date________________________

If you remain unhappy or would like to make a formal complaint, please contact the Head of Research Integrity and Governance, University of Southampton, by emailing: rgoinfo@soton.ac.uk, or calling: + 44 2380 595058. Please quote the Ethics/ERGO number which can be found at the top of this form. Please note that if you participated in an anonymous survey, by making a complaint, you might be no longer anonymous.

Appendix E – Example Case Level Summary (Penelope)

Appendix E Table

Example Case Level Summary Table (Penelope)

PET 1 - The passage of time - from childhood to the future		
Experiential Statement	**Pg/ line No.**	**Quotation**
Endings are viewed through the lens of past experience (attachment history) and current difficulties	104-109, pg 7	You just count down the days until they're going and like, because I've got EUPD, I have attachment issues. [Okay.] So, when I get close to someone, if they leave it really upsets me.
Coming to terms with the inevitability and unpredictability of loss	163-164, pg 11	Because you never know what's around the corner or what's going to happen.
Savouring last moments together	354-355, pg 21	Because it’s the last time you're going to get to see them.
Therapeutic endings have permanence to the ending	381-382, pg 23	That someone’s going to leave and not come back.
PET 2 - Being shown care BY others in the ending		
Dialectic - I deserve notice and notice is hard	91-95, pg 7	It was easier because you didn't have to ruminate about it. … But I was so angry he didn't give us any real notice
Significance of taking part in societal norms together as the ideal ending	337, pg 20	go out for a cup of coffee
Quality time outside the unit is meaningful and valuable	350-351,pg 21	Just getting out of this place and spend some quality time together.
Time to show you care	257-258, pg 16	Yeah. Umm *long pause* maybe spend a bit more time with you.
Experiential Statement	**Pg/ line No.**	**Quotation**

Closeness indicates the need for time spent before an ending	267-268, pg 16	Especially if they know you're close to them.

PET 3 - Vulnerability in sharing my narrative

Making sense of closeness, as feeling safe enough to share feelings	284-286, pg 17	Because the people that you're not close to, you don't tell them like how, all your feelings.
Vulnerability in disclosure - I need to trust you can contain my feelings and experiences	290-295, pg 18	Because, because you trust them. Okay. And if you trust one person and then you've got no one, because some people would tell people things that are quite personal.
Bravery in sharing my story turns to shame and regret when ending follow disclosure	304-310, pg 19	Well, when I was in *another secure unit* and my primary nurse, I told her about all the abuse when I was younger [ok] and three weeks later she left.
Different staff hold different roles and skills	320, pg 19	I only talk to psychologists about it now.

PET 4 - Closeness and Loss

Coping with Loss in the only way I know how

Understanding the role of talking through feelings in incidents and accessing care	206-211, pg 13	Yeah. Because I find if I only talk to that person and I've got no one to talk to… I build everything up in my head [yeah, OK]. And then when it gets too much, I have an incident and then I've got to talk to someone.
Awareness of the consequences of not being able to share internal experiences (on felt sense safety and stability)	179-185, Pg 11-12	It just taught me to talk to more people, because if you only talk to like one or two people, if they're on annual leave or anything and you're upset, you've got no one to talk to and you bottle things up, then you have an incident and then it steps your care back.

Experiential Statement	Pg/ line No.	Quotation

Loss of care triggers implicit need to elicit care by any means	147-151, pg 10	Horrible. You just, it makes you, it made me like stressed and angry and I ended up kicking the office door. [Okay] And getting myself into trouble.
Difficult feelings around loss and abandonment lead to avoidance of the end	222-228, pg 14	long pause* I don't know... Probably… don't leave on a bad note. [Yeah] Because I've done that to a couple of people where on the last session, I haven't spoken to them and I've ignored them and then when they're gone, I think what are they thinking?
	Keeping those I trust close to feel secure	
Realising the opportunity for continued connection and care	237-241, pg 15	And if they're moving wards or say, just like with Dr X when he walked past me, I ignored him. But now I speak to him and say, "How how are you doing?"
Proximity seeking as a cue for closeness in the relationship	274-278, pg 17	By body contact, not body contact, body like expressions [mm] and you know if you work a shift and that person nearly always comes to you, you know you're close to that person.
Endings mean the loss of safe and cared for time (closeness in proximity)	50-55, pg 4	Horrible because like I trust very few people [Okay]. So then people I do trust, I like to spend a lot of time with them. And now I can't see her because she's on [another ward].
Bonds broken by external factors beyond our control	43-45, pg 4	I really trusted C [mm]. And now she's not allowed on the ward because another patient did something to her.
Terrifying realisation of having lost 'my person'	140-144, pg 9	Because with me, I find that I put all my eggs in one basket and I don't spread them around. So, when that person leaves, I'm like, "Oh, I've got no one, shit, I've got no one to talk to".
Protecting self from the impact of future loss by increasing my circle	155-159, pg 10	It's taught me not to, not to put all my eggs in one basket. [Yeah, Okay] Like now I talk to quite a few people, instead of just one person.