

Volume I
Research Component

WORKING PSYCHOLOGICALLY IN INPATIENT SERVICES

By

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DEDICATIONS

Spiritual guidance has played a significant role for me; therefore this thesis is dedicated to two very special people in my life.

Peggy I hope this makes you proud, you always believed in me and encouraged me to follow my dreams.

Bapuji, as always, I hope you will continue to look down on me and continue to guide me as I endeavour to start this new professional pathway as a Clinical Psychologist.

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OVERVIEW

This thesis is submitted in partial fulfilment to the requirements for the degree of Doctorate of Clinical Psychology (D.Clin.Psy) at the University of Birmingham. It is presented in two volumes.

Volume I of the thesis represents the research component; it is presented in the form of three papers which are related to working psychologically within an inpatient setting. The first paper is a systematic review of the literature exploring whether existing evidence supports the use of psychodynamic therapy for inpatient service users with a personality disorder. This will be prepared for submission to the Journal of Psychodynamic Practice. The second paper consists of an empirical paper exploring how psychologists' make sense of and understand their engagement with service users in a medium secure unit, this will be prepared for submission to the International Journal of Forensic Mental Health. The third paper is a brief public domain briefing paper which summarises the key findings from both the literature review and empirical paper. This is intended for dissemination to a wider audience, in particular for those who participated in the research.

Volume II of the thesis represents the clinical component, and contains five clinical practice reports which reflect the clinical training of the D. Clin. Psy. These include:

1. A cognitive behavioural and systemic formulation of a 15 year old boy presenting with obsessive compulsive disorder.
2. A service evaluation detailing a survey that was conducted to review service user satisfaction.
3. A case study of 24 year-old male presenting with challenging behaviour.
4. A single case experimental design of a 75 year old gentleman presenting with depressive symptoms.
5. A case study presentation of a 24 year-old male with a learning disability who presented with symptoms of post traumatic stress disorder.

CONTENTS PAGE: VOLUME I

Dedications	I
Acknowledgments	II
Overview	III
Literature Review: Does the existing evidence support the use of psychodynamic therapy for inpatient service users with a personality disorder?	
Abstract	1
Introduction	2
Search Criteria & Overview of Search Findings	5
Findings	11
Comparison of Outcomes across Different Treatment Settings	11
The Impact on Psychiatric Symptomatology	16
The Impact on Interpersonal Functioning	19
The Impact on Functional Impairment	23
The Impact on Deliberate Self-harm & Attempted Suicide	26
The Impact on Diagnosis of Personality Disorder	28
The Impact on Service Utilisation	28
Predictors of Outcome and Premature Termination of Treatment	30
Methodological Limitations	32
Discussion & Conclusion	33
References	36

Empirical Paper: How do Psychologists' make sense of and understand their engagement with service users in a medium secure unit?

Abstract	44
Introduction	45
Method	51
Results	58
Discussion	77
Strengths & Limitations	79
Summary	80
Recommendations	81
References	83

Public Domain Paper: Working psychologically with service users within inpatient services

Overview	88
Part I: Literature Review	88
Background	88
Aims	88
Method	89
Results	89
Main Findings	89
Conclusions	89
References	90
Part II: Empirical Paper	
Introduction	91
Method	91
Results	92
Conclusion & Recommendations	93
References	95

Volume I: Figures & Tables

Literature Review:

Table 1: Search Terms	7
Figure 1: Detailed Search Process	6

Empirical Paper

Table 1 Participant's Demographic Information	52
Table 2: Summary of super-ordinate and sub-ordinate themes	58

Volume I: Appendices

Literature Review

Appendix A: Search Process for Electronic Databases	96
Appendix B: Summary Table of Studies Identified for Review	100
Appendix C: Quality Review Table	114

Empirical Paper

Appendix A: Interview Schedule	118
Appendix B: Participant Information Sheet	119
Appendix C: Participant Consent Form	120
Appendix D: Debrief Sheet	122
Appendix E: Ethical Approval	123
Appendix F: Example of Data Analysis	124
Appendix G: Supporting Quotes	130

Additional

Appendix H: Instructions for Authors	137
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VOLUME II: CLINICAL COMPONENT

Clinical Practice Report - Psychological Models

Abstract	1
Introduction	2
Assessment	2
Background Information	5
Cognitive Formulation	10
Systemic Formulation	16
Critical Appraisal	25
References	28

Clinical Practice Report – Service Evaluation

Abstract	32
Introduction	33
Method	41
Results	45
Discussion	49
Strengths & Limitations	54
Recommendations	56
References	58

Clinical Practice Report – Case Study

Abstract	63
Introduction	65
Assessment	67
Formulation	77
Interventions	86
Reflections	87
References	89

Clinical Practice Report: Single Case Experimental Design

Abstract	92
Case Summary	94
Assessment	95
Relevant Clinical History	97
Frequency Charts & Mood Rating Scale	99
Formulation	100
Intervention	105
Single Case Experimental Design	108
Analysis & Results	110
Discussion	113
Reflections	115
References	117

Clinical Practice Report: Case Presentation

Abstract	121
References	122

Volume II: Tables & Figures

Clinical Practice Report - Psychological Models

Table 1: Results from the CY-BOCS Compulsive Checklist Assessment	3
Table 2: Strengths & Weaknesses of Adopting a Cognitive & Systemic Formulation	27
Figure 1: Genogram	6
Figure 2: Cognitive Longitudinal Formulation for Owen	14
Figure 3: Feedback Process: Hot Cross Bun	15
Figure 4: Maintenance Cycle for OCD	15
Figure 5: Possible Circular feedback loop for maintaining anxiety	19
Figure 6: Triangulation of Conflict	21
Figure 7: Systemic Formulation: CMM Model	24

Clinical Practice Report - Service Evaluation

Table 1: Demographic Information	42
Figure 1: Bar chart displaying the responses to Question 1	45

Clinical Practice Report – Case Study

Figure 1: Genogram	71
Figure 2: Hot Cross Bun	81
Figure 3: Cognitive Behavioural Formulation	85

Clinical Practice Report: Single Case Experimental Design

Table 1: Behavioural Activation techniques implemented in intervention	106
Figure 1: Diagrammatical Behavioural Formulation	104
Figure 2: Line Graph of Raw Data for Subjective Daily Mood Rating	111
Figure 3: Line Graph of the Raw Data for the Number of Activities Engaged in Per Day	111

Volume II: Appendices

Clinical Practice Report - Service Evaluation

Appendix A: Service User Satisfaction Survey 12-18 Year Old Children	123
Appendix B: Information Sheet for parents/careers of service users under the age of 16 years old	126
Appendix C: Information Sheet for Service Users 16 years old and over	128
Appendix D: Consent Form	130
Appendix E: Raw Qualitative Data	131

Clinical Practice Report – A Case Study

Appendix A: Sainsbury's Clinical Risk Management Tool	134
Appendix B: Early Warning Signs	143
Appendix C: Relapse Prevention Plan	144

Clinical Practice Report - Single Case Experimental Design

Appendix A: Timetable Template to schedule, monitor and plan activities	145
Appendix B: Daily Mood Rating Score and Number of Activities Completed Each Day	146
Appendix C: Raw Data	147

SYSTEMATIC LITERATURE REVIEW

DOES THE EXISTING EVIDENCE SUPPORT THE USE OF PSYCHODYMANIC THERAPY FOR INPATIENT SERVICE USERS WITH A PERSONALITY DISORDER?

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Key words: personality disorder, inpatient, psychodynamic therapy, psychotherapy, psychiatric symptomology, stress, interpersonal functioning, functional impairment, self harm, suicide, service utilisation, treatment termination.

ABSTRACT

Background: There are many expressed views about whether individuals with a personality disorder are ‘treatment resistant’, and if they are deemed as treatable, whether they require psychodynamic therapy. The evidence for the effectiveness of psychodynamic therapy in inpatient populations is limited. Therefore, it is clear that there is a need to evaluate the current literature to examine the effectiveness of inpatient psychodynamic treatment for individuals with a personality disorder.

Method: The electronic databases of PSYCINFO, SCOPUS, and WEB OF KNOWLDEGE were used to conduct a systemic search of the literature. A review of the reference lists was also carried out to expand the search.

Results: Following the implementation of an exclusion criterion, a total of seventeen relevant articles were found and quality reviewed.

Conclusions: The review highlighted favourable outcomes in psychiatric symptomology, interpersonal functioning, functional impairment, self harm, and levels of service utilisation for service users that have engaged in an inpatient psychodynamically orientated interventions. This supports the use of psychodynamic therapy in inpatient settings. However, the methodological limitations of the reviewed studies prevent the review from drawing firm conclusions. Recommendations for future research are related to the importance on establishing robust outcome measures to assess the impact of psychodynamic treatment for service users with a personality disorder.

1.0. INTRODUCTION

1.1: Context of the Literature Review

Individuals with a personality disorder have been described as presenting with pervasive and longstanding traits that affect their perception, views of themselves and others, impulse control, and emotional regulation. These difficulties can impact on individuals' social functioning, interpersonal relationships and psychological distress (Leichsenring & Leibing, 2003; Livesley et al., 1994). There are many expressed views about whether individuals with a personality disorder are 'treatment resistant', and if they are deemed as treatable, whether they require a specialist treatment programme (Fagin, 2004). Due to the perception that this clinical population is 'treatment resistant' it may become a challenge to produce evidence to support or disprove claims regarding treatment for individuals with a personality disorder. Bender et al (2001) reported that individuals with borderline and schizotypal personality disorders are associated with extensive use of mental health and social care services, which highlights the concern of financial cost to the health and social care services. The research group also concluded that further work is required to determine whether service users with a personality disorder are receiving adequate and appropriate mental health treatment. By doing so, this would also assist in meeting the health economic principles as the research would identify whether there was a need for services, and the efficiency of providing specialist treatment to individuals with a personality disorder residing in an inpatient setting (Scott, Soloman & McGowan, 2001).

Clinicians and researchers have identified that psychodynamic therapy is an effective treatment option for individuals with a personality disorder (Perry, Banon & Ianni, 1999; Leichsenring, Rabung & Leibing, 2004). The literature exploring the effectiveness of psychodynamic therapy is limited and researchers have stated that if "*psychoanalytic treatment is to*

survive in the era of evidence-based medicine and managed care systems, empirical evidence is needed to demonstrate its unique nature and effectiveness” (Blatt & Shahar, 2004, pp. 393).

It is clear from the literature that there is a need to evaluate the current literature to examine the effectiveness of inpatient psychodynamic treatment for individuals with a personality disorder, in order to contribute to the evidence-based literature within this unique field.

1.2: Scope of the Review

This review considers literature from peer reviewed journals within a twenty year period, however the literature identified for review was based within a thirteen year period (1999-2012), and it originated from Europe. Evidently, the experiences of psychodynamic therapy within inpatient settings may differ across different models of care and cultures, consideration of this will be raised during the review.

The current review aims to examine the use of psychodynamic therapy for inpatient service users with a personality disorder. The principal question of the review is: “What effects does psychodynamic therapy have on inpatient service users with a personality disorder?” The review will therefore seek to identify how inpatient psychodynamic therapy may impact on service users’ psychiatric symptoms, interpersonal functioning, and social functioning, self harming behaviours and service utilisation. This review will also examine the comparison of outcomes across different treatment settings, predictors of outcome and characteristics that might influence premature termination of treatment.

1.3: Definition of Concepts

Psychodynamic Therapy

Psychodynamic oriented therapy, also known and referred to as psychoanalytic therapy has been a psychological model of choice for treating the traits and behaviours that an individual with a personality disorder might present with. Although the literature within this field is not as well established, the current literature concludes that psychodynamic therapy is an effective treatment for individuals with a personality disorder (Perry, Banon & Ianni, 1999; Leichsenring, Rabung & Leibing, 2004).

The psychodynamic model originally developed from Freudian theory (Frosh, 1987) and the model has continued to develop over the decades, although it is thought that some of the core principles within the model such as the role of the 'id' and 'ego' have been lost (Westen, 1998). Blagys & Hilsenroth (2000) identified the following seven reliable features that distinguished psychodynamic therapy from other therapies, such as cognitive behavioural therapy, and these features are supported by the claims made by Westen (1998). Blagys & Hilsenroth (2000) identified that psychodynamic therapy has a focus on:

1. Affect and expression of emotion as psychotherapists encourage their service user to explore and discuss a range of emotions
2. Exploration of attempts to avoid distressing thoughts and feelings
3. Identify reoccurring themes and patterns
4. Discussion of past experiences
5. Focus on interpersonal relations
6. Focus on therapy relationships
7. Exploration of wishes and fantasies

The literature review has discussed and taken into consideration that clinicians have not utilised a standardised treatment programme and that various methods of delivery have been used to facilitate psychodynamic orientated therapy for service users. As a result, this will impact on the conclusions that can be made in regards to the effectiveness of inpatient psychodynamic therapy for individuals with a personality disorder.

2.0. SEARCH CRITERIA & OVERVIEW OF SEARCH FINDINGS

2.1: Review Method

The review includes all published journal articles that refer to the use of psychodynamic therapy in inpatient services with clients with a personality disorder. Published research papers were identified by conducting individual electronic database searches using PsycInfo, SCOPUS and Web of Knowledge. A review of reference lists of published articles was also included to expand the search.

2.2: Search Terms & Strategy

Search terms to describe effectiveness, inpatient settings, personality disorders and psychodynamic therapy were generated by the reviewer (see Table 1 for Search Terms). The search terms identified were then used to search the electronic databases individually. All searches were limited to inpatients, service users with a diagnosis of a personality disorder, psychodynamic therapy, and adults. Appendix A, and Figure 1 displays the detailed search process and the number of articles identified at each stage. The electronic database search identified twelve articles and a further five articles were identified as suitable from the review of reference lists in published articles, giving a total of seventeen articles.

Figure 1: Detailed Search Process

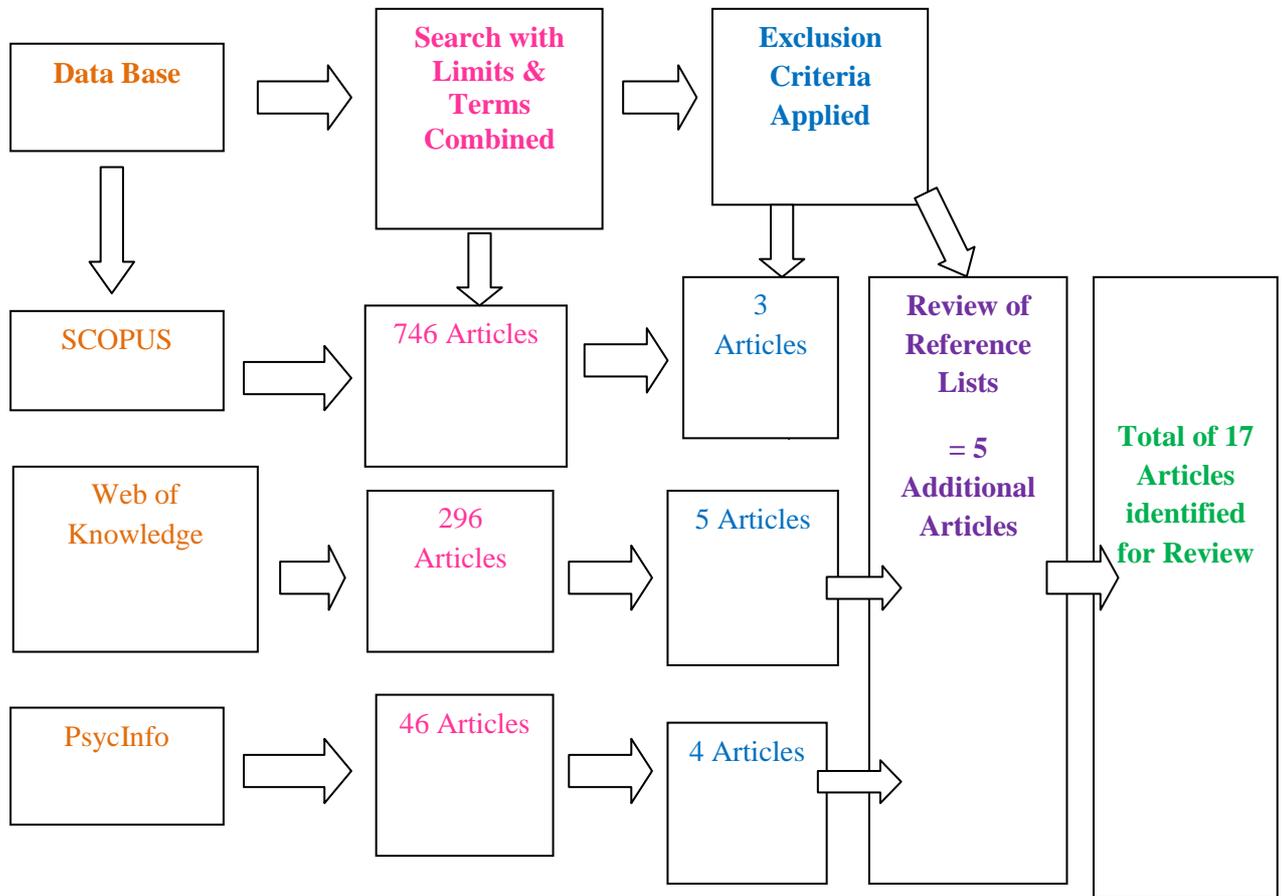


Table 1: Search Terms

Search Terms
Evidence base, outcome, empirically, empirically support, effective, efficacy, evidence, effect
Inpatient unit, Secure service, secure facility, secure hospital, secure institution, forensic, hospital, institution, forensic psychiatry, detention, camp, detention facility, detention establishment, detention service, HMP.
Personality disorder, personality cluster, cluster A, cluster B, cluster C, borderline personality disorder, antisocial personality disorder, not specified personality disorder, personality adjunction to (antisocial or paranoid or schizoid or schizotypal or antisocial or borderline or histrionic or narcissistic or avoidant or dependent or obsessive compulsive or depressive or passive-aggressive or sadistic or self-defeating).
Psychodynamic, psychodynamic therapy, psychotherapy, psychoanalytic therapy, psychoanalytic, transference focused psychotherapy, psychoanalysis.

2.3: Inclusion & Exclusion Criteria

The following inclusion criteria were applied to articles searched:

- Participant sample must have a diagnosis of a personality disorder and based within an inpatient setting
- Psychological intervention (group work or 1:1 sessions) primarily based on a psychodynamic orientation
- Psychodynamic intervention based in an in-patient setting
- Adult participants (18 years or above)

Articles that did not meet the inclusion criteria were excluded from the review.

2.4: Range of Studies Identified

Appendix B summarises the articles which were identified for review along with the detailing of the methodology, results and methodological limitations. The systematic literature search identified one study which was in German and this article was translated into English (Spitzer et al, 2012). The review contains some articles which overlap as researchers have published a variety of outcomes using the sample from the original study and follow-up studies have been published independently. These studies are asterisked in the table featured in Appendix B and this methodological implication has been taken into consideration throughout the review.

From the seventeen identified studies, sixteen studies employed quantitative methods (Bartak et al., 2010, 2011a, 2011b; Bateman & Fonagy, 1999, 2001, 2008; Chiesa & Fonagy, 2000, 2007; Chiesa, Fonagy, Holmes & Drahorad, 2004; Gabbard et al., 2000; Luyten, Lowyck & Vermote, 2010; Spitzer et al., 2012; Vermote et al., 2009, 2010, 2011 & Werbart, Forsstrom & Jeanneau, 2012) and one used a mixed method design (Chiesa, Drahorad & Longo, 2000).

The studies identified for review were heterogeneous in regards to the principles of psychodynamic therapy implemented within the treatment programmes, the use of multi-modal model therapy, delivery of treatment, sample population, and definition of inpatient setting.

The studies identified for the review were only included if the main treatment was based on psychodynamic principles, however, a number of treatment programmes also incorporated pharmacological treatment, expressive and creative therapies, socio-therapy, psycho-education and milieu therapy (Bartak et al., 2010, 2011a, 2011b; Chiesa & Fonagy, 2007; Gabbard et at, 2000; Luyten et al., 2010; Vermote et al., 2010, 2011; Werbart et al., 2012). The mode of delivery of treatment also varied across the articles, as individual and

group sessions have been facilitated by various health professions (i.e. psychiatrists, nursing, psychologists and social workers).

The participant sample characteristics are also diverse in regards to the participants' clinical diagnosis. Within the identified studies, there is co-morbidity of types of personality disorders, or co-morbidity defined by the presence of personality disorder and another disorder such as a mood or anxiety disorder. Also, there is a variation in the definition of inpatient treatment across the identified studies. Therefore, this review will aim to take into consideration the differences in treatment setting and consider whether this variation has an impact on treatment outcome.

The review will take into consideration the above limitations when examining the impact of psychodynamic therapy for inpatient service users with a personality disorders.

2.5: Quality Assessment

Assessing the quality of the identified studies was aided by the 'Effective Public Health Practice Project Quality Assessment Tool for Quantitative Studies' (Thomas, 1998). This tool was identified by Deeks et al. (2003) as being a suitable tool to assess the methodological quality of studies for systematic reviews. The tool can be used with randomised and non-randomised studies and it has been evaluated to ensure it has validity and reliability (Thomas, Ciliska, Dobbins, & Micucci, 2004; National Collaborating Centre for Methods and Tools (NCCM, 2008). The tool consists of eight components (selection bias*, study design*, confounders*, blinding*, data collection methods*, withdrawals and drop-outs*, intervention integrity and analyses) with sub-questions that relate specifically to each component. The asterisk components are rated strong, moderate, or weak. Following this, each article is globally rated strong, moderate or weak. See Appendix C for the evaluation for the seventeen articles identified for review.

The articles published by Bartak et al. (2010, 2011a, 2011b) and Bateman and Fonagy (1999, 2001, 2008) were globally rated at moderate and the remaining eleven articles were rated as weak. All of the seventeen articles were rated as weak in the ‘confounders’ domain due to a number of possible confounding variables, such as, the use of psychotropic medication, previous treatment history, and social support. The seventeen articles that were globally rated as weak were also rated weak within the ‘blinding’ domain as it did not appear to have been possible as a result of not having a control group. All of the seventeen articles were rated as strong within the ‘data collection method’ domain as the studies utilised valid and reliable measures. The three studies published by Bateman and Fonagy (1999, 2001, 2008) were rated as strong within the ‘study design’ domain as they implemented a randomised controlled trial.

3.0. DOES THE EXISTING EVIDENCE SUPPORT THE USE OF PSYCHODYNAMIC THERAPY FOR INPATIENT SERVICE USERS WITH A PERSONALITY DISORDER?

3.1: Comparison of Outcomes across Different Treatment Settings

Service users with borderline personality disorder are treated within a number of different settings such as inpatient, day hospital, or outpatient psychiatric services. These services are either generic mental health services (non-specialist services for individuals with a personality disorder) or services that have adopted more specific psychological orientation such as psychodynamic therapy (Waldinger, 1987) and Dialectical Behavioural Therapy (DBT, Linehan et al., 1991). The literature suggests that these theoretical orientations support the recovery of individuals with personality disorders as they can assist in establishing an environment that is structured and predictable, and therefore the service users feel emotionally contained (Norton & Hinshelwood, 1996).

Although this review is focused on examining inpatient settings it is apparent that there is a variation in the definition of 'inpatient' throughout the literature, and some studies have compared models of treatment within different treatment settings. For the purpose of this review, the treatment settings will be classified according to the following categories drawn from the Bartak et al. (2010, 2011a, 2011b) studies:

- Long-term inpatient (admission is more than six months)
- Short-term inpatient (admission is less than six months)
- Long-term day hospital (more than six months)
- Short-term day hospital (less than six months) and outpatient treatment.

Bartak et al. (2010, 2011a, 2011b) examined the effectiveness of different treatment modalities of psychotherapeutic treatment for service users with a DSM-V (American Psychiatric Association, APA, 2013) diagnosis of cluster A (Bartak et al., 2011b), cluster B (Bartak et al., 2011a) and cluster C (Bartak et al., 2010) personality disorder. The findings from Bartak et al's (2010) study demonstrated that all the treatment groups showed an improvement in psychiatric symptoms, psycho-social functioning and quality of life. However, the short-term inpatient group overall showed significantly more improvements in psychiatric symptoms in comparison to the other four groups (long-term outpatient, short-term day hospital, long-term day hospital, and long-term inpatient), with a within group effect size from baseline 0.62 (medium effect) to 1.78 (large effect) at 12 months after baseline. It was also found that improvements in interpersonal functioning were significantly higher in the short-term inpatient group in comparison to the short-term day hospital, and the quality of life variable significantly improved in service users in the short-term inpatient group in comparison to the other groups.

Interestingly, Bartak et al's (2011a) study, which compared the effectiveness of three different treatment modalities (outpatient, day hospital and inpatient) for service users with Cluster B personality disorder diagnosis found that 18 months after base line all three treatment modalities had slightly improved in regards to psychiatric symptoms, psychosocial functioning and quality of life. However, the effect sizes were small for psychosocial function and quality of life. The group comparison data identified that the difference in improvement of psychiatric symptoms between outpatient and day hospital treatment was rather small ($\beta=0.11$, $p=0.44$), and the difference between day hospital and inpatient treatment was also small ($\beta = 0.18$, $p=0.14$). However, the difference in improvement between outpatient and inpatient treatment was marginally significant ($\beta = .030$, $p=0.057$). The authors

concluded that these results suggested inpatient treatment being effective with regard to reducing psychiatric symptoms. In reviewing the mean duration of treatment, the inpatient mean treatment duration was 9.1 months in comparison to 14.5 months (outpatient) and 10.4 (day hospital), therefore it may be possible that these findings are related to treatment duration and/or treatment setting.

The findings from Bartak et al. (2011b) found that the day hospital and inpatient treatment group showed significant improvements in reduction of psychiatric symptoms, social/interpersonal functioning, and quality of life from baseline to post treatment. However, the outpatient group did not significantly improve in these domains. It is important to note that these findings may have been influenced by the fact that the outpatient group commenced treatment less symptomatic and improved little (effect size = 0.004), whereas the service users in the other two groups commenced treatment less healthy and substantially improved (effect sizes: day hospital = 1.03; inpatient = 0.74). Therefore, it may be possible that the changes that did occur within the outpatient group may have been too small for the statistical data analysis methods to capture.

Considering the findings discussed above from Bartak et al's (2010, 2011a, 2011b) studies it appears that inpatient treatment appears to be effective for treating individuals with a personality disorder. However, the data also suggests that both treatments demonstrate some efficacy in reducing psychiatric symptoms, increasing psychosocial functioning, and quality of life. It is important to highlight the main methodological limitation across these three studies is that the same participant data may feature in more than one study, and as the authors note in Bartak et al. (2011b) study, the majority of the sample presented with a high comorbidity with the other two personality disorder clusters. Therefore this questions whether the treatment gains can be attributed to an improvement in cluster A pathology.

Bateman & Fonagy (1999, 2001, 2008) conducted a Randomised Controlled Trial (RCT) to examine the effectiveness of partial hospitalisation in the treatment of service users with a primary diagnosis of borderline personality disorder. Follow-up data was also available at 18 months and 5 years post-treatment (Bateman & Fonagy, 2001, 2008). The control group received outpatient psychiatric treatment which did not contain any formal psychotherapy and the treatment group received partial hospitalisation which consisted of long-term psychoanalytically orientated treatment. The overall findings from Bateman & Fonagy's (1999) study found a significant reduction in self harming behaviours in the treatment group, however, this was not significantly different from a reduction in self harm also found in the control group. There was also a significant reduction within the suicide and anxiety domain within the treatment group whereby there was no significant difference in the control group. The follow-up at 18 months (Bateman & Fonagy, 2001) and 5 years (Bateman & Fonagy, 2008) revealed that the clinical gains made during treatment were maintained and additional improvements were made at 18 months. Although the study uses a 'gold standard' methodological design, it is important to highlight the limitations that authors have identified, such as the small sample size and the loss of self-report data, which may have had an impact on the results. Unfortunately, a treatment integrity measure was not used and therefore the authors could not identify the active ingredients of the treatment. However, overall these findings indicate that a specialist inpatient (partial hospitalisation) treatment is found to be more effective in the short- and-long term for treating individuals with a personality disorder.

Chiesa & Fonagy (2000) compared the effectiveness of two treatment models for service users with a diagnosis of personality disorder. The first treatment group was based on a one-stage model, which was primarily inpatient treatment, whereas the second treatment group was receiving treatment based on a two-stage model. The latter receiving inpatient care

and then stepping down into outpatient treatment. Overall, the findings indicated that improvements were made across both groups, although there were higher rates of improvement for service users within the two-stage model (39% of service users improved in stage two in comparison to 18% in the stage one model). In addition, significant differences were achieved at 6 months and 12 months within the stage two model, whereas significant differences were only achieved at 12 months in the stage one model of care. These findings suggest that the two-stage model which comprised of two treatment settings was more efficient at achieving higher significant differences in regards to psychotic symptoms, social adjustment and global functioning. These findings are also supported by Chiesa et al. (2004) and Chiesa & Fonagy (2007) as they found that the two-stage model of care achieved the most improvements in global functioning, self harm and symptom severity in comparison to inpatient or outpatient treatment. The findings from Chiesa et al. (2002) also highlighted that there was a significantly lower drop-out rate in the two-stage model in comparison to the one-stage model which is based on inpatient treatment only.

In regard to drawing conclusions from these findings, Chiesa & Fonagy (2000) have highlighted that the average inpatient (8.8 months) stay in the one-stage model was not much longer than the average inpatient stay (6.2 months) in the two-stage model and therefore the study cannot efficiently conclude the value of inpatient treatment. However, the authors suggest that a shorter inpatient stay may assist with helping the service user and caregivers to stay motivated and focused on the treatment programme offered and as a result this may create a more positive environment to facilitate positive outcomes. In addition to this, the service users are able to work towards 'stepping down' from inpatient treatment to outpatient treatment which is less restrictive, and this can reduce anxieties associated with discharge as the service users will continue to receive the support they may require (Gunderson, 1996;

National Institute for Health & Care Excellence, NICE, 2009; Saarento, Nieminen, Hakko, Isohanni, & Väisänen, 1997).

It is also important to highlight that the above discussion has not drawn any firm conclusions due to the methodological limitations of the identified studies, as the quality criteria assessment tool globally rated the Bartak et al. and Bateman & Fonagy studies as 'moderate' in regards to quality and the remaining studies referred to were rated as 'weak'.

3.2: The Impact on Psychiatric Symptomatology

Current literature within the field of psychodynamic therapy has clearly demonstrated the effectiveness of the therapy contributing to the reduction of psychiatric symptoms (Leichsenring & Rabung, 2008; Perry, Banon & Ianni, 1999; Svartberg, 2004). All of the seventeen papers identified for the review have investigated psychiatric symptomatology and reported this as an outcome variable. In addition, six papers have reported specific outcomes related to anxiety and depression (Bateman & Fonagy, 1999, 2001; Luyten et al., 2010; Vermote et al., 2009, 2010, 2011) and eight articles have reported outcomes related to self-harm and/or suicide (Bateman & Fonagy, 1999, 2001, 2008; Chiesa et al., 2004; Chiesa & Fonagy, 2007; Luyten et al., 2010; Vermote et al., 2009, 2011).

All identified literature presented in the review has reported this reduction as measured by the General Severity Index (GSI) score, which is a subscale derived from the Symptom Check List-90 (SCL-90) and the Brief Symptom Inventory (BSI). This provides an outcome that is specifically based on the participants' subjective experiences of symptomatic distress. As a result, this limits the ability to identify and discuss the specific scales within the SCL-90 and BSI such as somatisation, depression and anxiety (Derogatis & Melisaratos, 1983).

Bartak et al., (2010, 2011a, 2011b) utilised the standardised Dutch version of the BSI and reported that all participants in the treatment groups had improved with regard to psychiatric symptoms post-treatment. The primary significant finding from Bartak et al.'s studies was that the inpatient groups showed significantly more improvements in psychiatric symptoms in comparison to the other treatment groups, such as outpatients and day hospital treatments.

The remaining studies, with exception to Gabbard et al. (2000) and Bateman & Fonagy (2008), utilised the SCL-90 (Derogatis & Unger, 2010). Fourteen of the articles reported that symptom distress had reduced in participants with a personality disorder following inpatient treatment based on psychodynamic principles (Bartak et al., 2010, 2011a, 2011b; Bateman & Fonagy, 1999, 2001; Chiesa et al., 2000; Chiesa & Fonagy, 2000, 2007; Chiesa et al., 2004; Gabbard et al., 2000; Vermote et al., 2009; 2010, 2011; Werbart et al., 2012).

Interestingly, the reviewed literature found that there was a relationship between time and symptom reduction (Bateman & Fonagy, 1999; Chiesa et al., 2004; Vermote et al., 2009, 2011). Bateman & Fonagy (1999) found that a reduction in symptom distress did not occur within the first six months of treatment and Vermote et al. (2009) found minimal improvement within the first three months of treatment, although there was considerable improvement in the GSI score between four and twelve months and both studies demonstrated that these treatment gains were sustained at follow-up. These findings raise important questions for clinicians and researchers, as the mean number of treatment sessions and duration of treatment may be other variables to consider when designing and implementing psycho-dynamically orientated treatment pathways for individuals with a personality disorder (Bartak et al., 2011a).

One of the studies (Spitzer et al., 2012) reported the ‘failures’ of inpatient psychodynamic therapy for service users with a personality disorder. The definition of ‘treatment failure’ is an absence of improvement in psychopathological symptoms or a deterioration of the symptoms at the end of treatment (Spitzer et al., 2012). The findings indicated 228 (18.7%) participants believed that their treatment was unsuccessful in the sense that their symptoms had not improved or they had deteriorated. However, in comparison, the therapist believed that 138 (11.1%) of the participants were not successful. The results from the GSI scale revealed that 30.7% did not show any signs of improvement in regards to symptomology. Spitzer et al. (2012) have highlighted how treatment failure can be measured and the importance of measuring direct (service users) and indirect (therapists) views regarding the assessment of change in psychodynamic research. The researchers have recommended that future research should focus on establishing recommendations for the evaluation of psychodynamic treatment. The use of ‘psychiatric symptomology’ as an outcome measure has questionable relevance to the personality disorder population because it is not described as a core feature of the disorders within the DSM V classification tool (APA, 2013). However, measuring specific outcomes related to the presenting features of personality disorders, such as impairment in interpersonal functioning, impulsivity, and impairment in daily living skills, may prove to be a more effective model to evaluate the effects of psychodynamic therapy for individuals with a personality disorder.

Overall, these findings relating to symptomatic distress can be criticised because a number of researchers reported that the participants were receiving concurrent pharmacological treatment (Bateman & Fonagy, 1999, 2001, 2008; Chiesa et al., 2000; Chiesa & Fonagy, 2000, 2007; Chiesa et al., 2004; Gabbard et al., 2000; Werbart et al., 2012). This uncontrolled confounding variable may have influenced symptomatic improvement and

therefore it cannot be accurately concluded which factor (i.e. the treatment programme or psychotropic medication) influenced change (Bateman & Fonagy, 2001). In order to statistically measure the role of medication, a principle component analysis design would be required. The use of pharmacological treatment may also be viewed as an outcome measure, as Werbart et al. (2012) reported that at discharge a majority of their service users had stopped utilising prescribed regular medication. Bateman & Fonagy (1999) also included the use of psychotropic medication as an outcome measure. They found that in the control group, 78% of the participants were still taking medication, whereas only 38% of those in the partially hospitalised group were utilising medication at the end of the study. In addition to this, at the five-year post-treatment follow-up, Bateman & Fonagy (2008) reported that the treatment group had an average of over three years of taking anti-psychotic medication, whereas the treatment group had less than two months. This suggests the need for future research to control and report on variables such as the use of prescribed medication during treatment. In addition, Spitzer et al. (2012) concluded that symptomology alone is not a sufficient variable to conclude whether or not a treatment is successful and a multi-dimensional approach would be more meaningful, which would allow other factors such as inter-personal problems, psychosocial functioning and personality pathology to be taken into consideration. In line with this, the author has also taken into account that the methodological limitations of the identified studies also indicates that future research is required which utilises more robust methodological designs as firm conclusions cannot be accurately drawn due to the 'weak' quality of the reviewed studies.

3.3: The Impact on Interpersonal Functioning

There is a notion that interpersonal difficulties are one of the core features within personality disorders (Fonagy & Luyten, 2009; Pincus & Wiggins, 1990) and this characteristic is also a

key feature within the DSM-V diagnostic manual (APA, 2013). The notion of interpersonal difficulties has been strongly influenced by attachment theory (Levy, 2005). Psychodynamic treatment for individuals with a personality disorder aims to enhance feelings of inner safety, increase the capacity for mutual interpersonal relatedness, and enhance the ability for reflective functioning (Clarkin et al., 2001; Vermote et al., 2009, 2010). Luyten et al. (2010) highlighted that despite there being a strong focus on personality pathology and more specifically interpersonal difficulties within the psychodynamic theory, only a small number of studies directly investigate the role of interpersonal problems in psychodynamic treatments for service users with a personality disorder. The review supports this notion as only three research groups have utilised standardised measures (i.e. Inventory of Interpersonal Problems, Horowitz et al. 1988) to directly measure outcomes in interpersonal difficulties and/or personality organisation (Bateman & Fonagy, 1999, 2001; Vermote et al, 2009, 2010, 2011; Luyten et al., 2010). However, other research groups (Bartak et al, 2010, 2011a, 2011b) considered the importance of interpersonal relations and they measured this using a subscale derived from the Outcome Questionnaire-45 (Lambert et al., 1996).

Bartak et al. (2010, 2011a, 2011b) and Bateman and Fonagy (1999, 2001, 2008) found significant improvements in interpersonal functioning post treatment. The Bartak et al. group found that service users who attended the day hospital and inpatient treatment made improvements in their interpersonal functioning and the improvements were significantly higher in the short-term in-patient group than the short-term day hospital group (Bartak et al., 2010, 2011a, 2011b). Interestingly, although there were significant improvements in interpersonal functioning, the effect sizes for this outcome measure were smaller compared to the effect sizes for psychiatric symptoms (Bartak et al., 2011a).

Luyten et al. (2010) specifically examined whether there was a relationship between interpersonal problems and outcome in psychodynamic hospitalisation-based treatment for personality disorders. The analysis found that there were significant improvements in interpersonal functioning from baseline to post-treatment and there was a considerable continuation of improvement from post-treatment to three month follow-up, a small improvement continued from three month follow-up to twelve month follow-up. The interpersonal problems that mainly changed during and after treatment were in the non-assertive, exploitable and overly nurturing domains. However, difficulties within the cold and socially avoidant domains tended to show little improvement during treatment and there was a slight increase within the domains of dominant and vindictive. The authors conclude that these findings are congruent with the theoretical assumptions and the findings support the claims that psychodynamic treatment for individuals' with a personality disorder are associated with changes in personality, as these changes are expressed through an improvement in interpersonal functioning (Luyten et al., 2010).

Luyten et al. (2010) and Vermote et al. (2010) found that there was a reciprocal relationship between symptomatic distress and interpersonal difficulties. Luyten et al. (2010) found that at baseline all types of interpersonal problems with the exception of the intrusive domain were significantly correlated with symptomatic distress. These findings suggested that at baseline the reciprocal relationship between symptomatic distress and interpersonal difficulties mutually reinforce each other in vicious, maladaptive interpersonal cycles, and between six to twelve months into treatment this relationship slowly disappears. However, towards the end of treatment this relationship started to re-appear as Luyten et al. (2010) found that interpersonal problems with regards to the dominant and intrusive domains were positively related to symptomatic outcome at twelve months. These findings may be

explained by the service users are preparing themselves for treatment termination which can activate separation anxieties due to their relationship with the therapist coming to an end Luyten et al. (2010).

The findings from Vermote et al's. (2010) study contradicts the findings reported by Luyten et al. (2010). Vermote et al. (2010) found that there was a decrease in the Global Personality Score (GPS; a subscale derived from the Structured Clinical Interview for DSM-III-R, Williams, 1992, Inventory of Personality Organization, Lenzenweger, Clarkin, Kernberg, & Foelsch, 2001 and Inventory of Interpersonal Problems, Horowitz, Rosenberg, Baer, Ureño, & Villaseñor, 1988) during treatment and at follow-up; however the rate of change was not significant. The researchers also found that there was a significant increase in the subscales of felt safety and interpersonal relatedness during treatment but not at follow-up. Furthermore, the results showed no linear increase in the capacity for reflective functioning during treatment and at follow-up. This may be because the complex dynamic relationship between reflective functioning and change could be influenced by environmental and therapist variables. It is hypothesised that service users may demonstrate high levels of reflective functioning and felt safety before commencing treatment but the containing hospital and the treatment environment may evoke feelings of uncertainty and felt safety, and therefore levels of reflective functioning would decrease as service users become dependent on the service structure and support given by clinicians. This association between feelings of felt safety and the attachment model identifies that individuals with a personality disorder perceive that they lack a 'secure base'. It is therefore important to identify how clinicians can increase this sense of having a 'secure base' and/or feelings of basic trust and safety, as these factors appear to be important mechanisms of change in treatment for individuals with a personality disorder (Levy et al., 2005; Vermote et al., 2010).

Although the studies discussed above have highlighted the positive changes that have occurred in regards to interpersonal functioning, and they have made future recommendations, it is important to hold in mind that the quality of the reviewed studies were globally assessed and they have ranged from ‘moderate’ and ‘weak’. Therefore, it is important to interpretate the findings with caution.

3.4: The Impact on Functional Impairment

Individuals with a personality disorder are described as having pervasive and long standing traits which impact on social role functioning and quality of life (APA, 2013; Perry, Banon & Ianni, 1999). The understanding of the impact of symptom severity on social and occupational function has led researchers to include impairment of functioning as an outcome variable when evaluating the effectiveness of a treatment model for individuals with a personality disorder (Gunderson, 2011; Moos, Nichol & Moos, 2002). The systematic review identified twelve out of the seventeen articles which included an outcome measure related to assessing change in social and/or occupational functioning or quality of life after the service users with a personality disorder engaged in a form of inpatient psychodynamic therapy (Bartak et al., 2010, 2011a, 2011b; Bateman & Fonagy, 1999, 2001, 2008; Chiesa et al., 2000; Chiesa & Fonagy, 2000, 2007; Chiesa et al., 2004; Gabbard et al., 2000 & Werbart et al., 2012).

The Bartak et al. group found significant improvements for service users within day hospital and inpatient treatment on outcome measures for social functioning and quality of life. Bartak et al. (2010) reported that quality of life significantly improved in the short-term inpatient group in comparison to the short-term day hospital and long-term inpatient group. Interestingly the EuroQol Questionnaire -Visual Analogue Scale score (Brooks, 1996), which represents the service users own value of quality of life, highlighted that the outpatient group highly valued their quality of life at the start of treatment and the level of value hardly

improved after treatment (effect size = 0.04). In contrast, the service users in the day hospital and inpatient groups started treatment with less value to their quality of life and subsequently their value of quality of life improved post treatment, with effect sizes of 1.03 and 0.74 respectively (Bartak et al., 2011b). These findings suggest that the treatment is effective for those service users who perceive themselves to have a low value of quality of life before commencing treatment. These differences in quality of life value may be influenced by the service users personality disorder cluster type, the severity of their illness and their social support network, therefore it is important to consider these confounding variables when discussing quality of life and social functioning.

Bateman & Fonagy (1999, 2001) utilised the Social Adjustment Scale (SAS, Cooper et al., 1982) to measure the service users' level of satisfaction with their social situation at pre-treatment, post-treatment and at eighteen months follow up. Bateman and Fonagy (1999, 2001) found that their partially hospitalised treatment group reported a greater level of satisfaction with their social situation than did the control group at the end of treatment, with the differences remaining significant at follow-up. Supporting these findings, Chiesa & Fonagy (2000) and Chiesa, Fonagy, Holmes & Drahorad (2004) reported that service users in the treatment group, which included a short inpatient admission followed by an outpatient step down programme, achieved the most improvements in SAS scores post-treatment in comparison to the other treatment groups, such as inpatient treatment and community based programmes. These findings highlight that it is important for clinicians to consider the treatment model and the impact this will have on the individual's level of satisfaction with their social situation. Gradually transitioning the service user into the community with support after an inpatient admission may help the individual to steadily re-build their social network,

as well as take up interests and employment. These protective factors are known to minimise relapse in the future (Zanarini, 2006).

It is important to highlight that researchers have also utilised global functioning measures such as the Global Assessment of Functioning (GAF, Jones, Thornicroft, Coffey, & Dunn, 1995) and the Global Assessment Scale (GAS, Endicott, 1976) which both produce an overall outcome score that is based on a number of domains such as asymptomatic, occupational, interpersonal and social adjustment. The GAF score was introduced within the DSM-III (American Psychiatric Association, 1987) and it is used to assist clinicians to determine the service users' level of psychosocial functioning. Six articles have reported a GAS or GAF score as an outcome measure and found significant improvements post treatment (Bateman & Fonagy, 2008; Chiesa & Fonagy, 2000, 2007; Chiesa et al., 2004; Gabbard et al., 2000 & Werbart et al., 2012). Werbart et al. (2012) found that the mean pre-treatment scores of global functioning corresponded to levels typical of psychiatric inpatients, whilst at discharge, the mean level of global functioning was commensurate with an outpatient clinical population. There was a significant improvement in global functioning at the end of treatment, although no follow-up data was available and therefore it is difficult to identify if the treatment gains were maintained after treatment.

At the five year follow up, Bateman and Fonagy (2008) utilised the GAF and the findings revealed that 54% of the treatment group, compared to 89% of the control group, had GAF scores lower than 60. A score below 60 indicates that the individual is experiencing moderate to severe difficulties within social functioning and/or psychotic symptoms. Therefore a high proportion of service users in the control group were experiencing greater difficulties within the social and/or symptomology domains in comparison to the treatment group at five years' post-treatment. In addition to this, the treatment group were

occupationally employed nearly three times as long as the treatment as usual group. The authors have recognised that it is unclear whether there is causal effect between the GAF score and vocational activity, however they have suggested that the mentalisation based treatment may help the participants to manage social situations by enabling a process of distancing from the interpersonal pressures of the work situation, and foreseeing other peoples thoughts and feelings (Bateman and Fonagy, 2008, pp.636).

Chiesa et al. (2000) found that having a higher occupational and educational status, a diagnosis of borderline personality disorder, and receiving treatment from the two-stage programme were predictors of continuation in treatment. It was argued that it is possible that having a better educational and occupational status equips individuals with greater resilience to withstand their difficulties in the short-term and focus on the long-term gains. It is important to note that this study was rated as 'weak' within the quality assessment tool and a majority of the studies with exception to Bartak et al. (2010, 2011a, 2011b) and Bateman & Fonagy (1999, 2001, 2008) were also rated as 'weak' therefore the overall findings and conclusions drawn must be interpreted within consideration of the methodological limitations.

3.5: The Impact on Deliberate Self-harm & Suicide

Individuals with a personality disorder may engage in Deliberate Self-Harming (DSH) behaviours, and the associated risk of concern for service users, families and clinicians is suicide (Haw, 2001). The context of DSH is described as a continuum from actual self-harm (i.e. cutting/burning self) to milder forms of self-sabotaging behaviours that may be viewed as self-defeating behaviours (Sansone, Wiederman & Sansone, 1998). The review identified that only two research groups incorporated DSH and/or suicide as an outcome variable (Bateman & Fonagy, 1999, 2001, 2008; Chiesa et al., 2004).

Chiesa et al. (2004) found that DSH behaviours had decreased noticeably by 12 and 24 months in the step-down residential programme whereas in the long-term inpatient programmes there was an increase in DSH at 12 months. The odds ratios revealed that the participants in the step-down residential programme were three times less likely to engage in DSH behaviours by 24 months, whereas the inpatient programme predicted a 1.5 increase in DSH. In addition, the service users in the step-down residential programme were six times less likely to attempt suicide by 12 months and three times less likely to attempt suicide at 24 months. The findings from Bateman and Fonagy (1999, 2001, 2008) identified that there was a clear reduction in attempted suicide and DSH behaviours, and these treatment gains were maintained at 18 months and five years post-treatment. The number of reported incidents of DSH decreased over the course of treatment in the partially hospitalised group but it remained constant in the control group. In addition, there was a statistically significant reduction in suicidal attempts in the partially hospitalised group as there was a clear reduction from 94.7% on admission to 5.3% at 18 months, and the analysis concluded that there was no significant trend for the control group (general psychiatric service).

These findings have highlighted the importance of monitoring DSH and attempted suicide as an outcome variable when evidencing the effectiveness of inpatient psychodynamic treatment for individuals with a personality disorder. By doing so, it may allow clinicians to conclude whether or not the psychodynamic treatment has assisted the service users' to develop their psychological ability to cope with stresses and strains within their lives using adaptive coping strategies. However, these findings and conclusions must be held in relation to the quality and quantity of the reviewed studies, see Appendix C.

3.6: The Impact on Diagnosis of Personality Disorder

Considering that the studies identified within the review are focused on evaluating the effectiveness of psychodynamic based treatment models for individuals with a personality diagnosis, it is interesting that only one study within the review evaluated whether the service users continued to meet the diagnostic criteria for PD at post-treatment (Bateman & Fonagy, 2008). Bateman and Fonagy's five year follow-up found that 13% of the mentalisation-based service users continued to meet the diagnostic criteria for borderline personality disorder in comparison to 87% of the service users that received treatment from the general psychiatric service. Interestingly, a majority of the studies utilised a standardised measure such as the structured interview for DSM-IV personality (Pfohl, Blum, & Zimmerman, 1997) to ensure their service users met the personality disorders diagnostic criteria (APA, 2013) before they commenced treatment. Although firm and accurate conclusions cannot be drawn due to the quality of the reviewed study, it is suggested that future studies may wish to consider using the diagnostic criteria as an outcome variable to establish the effectiveness of inpatient psychodynamic orientated treatment programmes for individuals with a personality disorder.

3.7: The Impact on Service Utilisation

Several studies that have examined treatment histories have shown that individuals with a personality disorder have more frequent psychiatric admissions, utilise outpatient psychotherapy, and have more emergency admissions in comparison to other clinical populations (Bender, 2001; Clarke, Hafner & Holme, 1995). Many of the researchers within the review recommended that further research was required in order to establish whether or not there was a financial gain in providing specialist psychodynamic orientated services for service users with a personality disorder.

Two research groups (Bateman & Fonagy, 1999, 2001, 2008; Chiesa et al., 2004) incorporated the level of service utilisation by service users as an outcome variable. At this point, it is important to take into consideration the quality of the reviewed studies as Bateman and Fonagy's studies were globally assessed as 'moderate' and Chiesa et al., (2004) study was rated as 'weak' in regards to the quality assessment framework, therefore these methodological limitations must be taken into consideration when interpreting and drawing conclusions. Bateman and Fonagy (1999) found that the average length of hospitalisation in the general psychiatric treatment group in the last 6 months of treatment increased dramatically, whereas the partially hospitalised group remained relatively stable at approximately 4 days per 6 months. In support of Bateman and Fonagy's findings, Chiesa et al. (2004) found that their step-down treatment group achieved a significant reduction in outpatient consultations, whereas the long-term inpatient group and the community comparison group maintained similar or higher levels of utilisation of outpatient services. In addition, it was concluded that in the year after expected discharge, the service users in the residential step-down treatment programme were four times less likely to be re-admitted to psychiatric services.

Bateman and Fonagy (2003) compared healthcare costs associated with psychoanalytically oriented partial hospitalised treatment for individuals with a personality disorder and general psychiatric services. The findings concluded that there were no cost differences, therefore specialist treatment for service users is no more expensive than general psychiatric care, and considerable savings could be made over time by providing specialist services for individuals with a personality disorder. These results highlight the importance of reporting outcome variables that are able to demonstrate whether specialist treatment can be

cost effective in the long term and whether these financial savings and clinical gains can be maintained within the health and social care industry.

3.8: Predictors of Outcome and Premature Termination of Treatment

It is widely recognised that the treatment of individuals with a personality disorder is a difficult and challenging task and it is extremely difficult to obtain ‘successful’ outcomes and treatment compliance.

Chiesa & Fonagy (2007) examined 41 demographic, diagnostic and clinical variables to test their association with outcome at 24 months follow-up. The researchers found that age, DSH, personality disorder type, the average number of personality disorder diagnoses, symptom severity, global functioning and length in treatment were significantly associated with improvement status at 24 months follow-up. Although, the literature does not appear to be well established within this area, it is important to highlight that the findings hold a substantial amount of clinical relevance as they would assist clinicians’ to develop effective psychodynamic treatment and identify realistic therapeutic goals that take into consideration the service users’ clinical and diagnostic variables. It is suggested that a more selective assessment for inclusion in treatment could also be facilitated by developing knowledge in this area.

The premature termination of treatment, also described as the drop-out rate has been reported across the studies and approximately 11% to 47% of service users were reported to have prematurely terminated treatment. The financial and clinical impact of dropping out of treatment has been researched and researchers have attempted to identify underlying factors that may influence service users prematurely terminating treatment (Chiesa et al., 2000; Rossi, 2002). Chiesa et al. (2000) reported that service users within the two-stage model,

which consisted of six months inpatient stay followed by 18 months of outreach support, showed significantly lower drop-out rates (8%) than service users in the one-stage model (36%) which consisted of one year of inpatient treatment. The research group also highlighted that type of personality diagnosis and occupational status are variables that are likely to predict premature termination from treatment. The qualitative data gained from interviewing participants to explore their experiences of their treatment highlighted the following themes: (a) Institutional culture and structure (b) Organisation of treatment, and (c) relationship with other service users (Chiesa et al., 2000). Taking into account the service users' views of their hospital experience may assist clinicians and researchers to identify other variables that may influence early termination of treatment, and as a result collaboratively work with the service users to identify how positive changes can be implemented to minimise service users terminating treatment.

The overall quality of the studies discussed were assessed as 'weak' therefore it is important to highlight that firm and accurate conclusions cannot be made, and the results must be interpreted with holding in mind the methodological limitations.

4.0 METHODOLOGICAL IMPLICATIONS

4.1: Methodological Limitations

Overall, the applied quality criteria identified that a majority of the articles reviewed were rated as 'weak' and only six articles were globally rated as moderate in regards to the methodological quality of the studies therefore firm conclusions cannot be drawn due to the quality of the studies. A number of the methodological limitations were discussed above within the 'Range of Studies Identified' section and it is important to highlight that the studies identified for review were heterogeneous with respect to the principles of psychodynamic therapy implemented within the treatment programmes, the use of multi-modal model therapy, delivery of treatment, sample population and the definition of 'inpatient' varied amongst research groups. A number of treatment programmes also incorporated concurrent interventions such as pharmacological treatment, expressive and creative therapies, socio-therapy, psycho-education and milieu therapy. Also, the facilitation of treatment varied from individual to group therapy sessions (Bartak et al., 2010; Chiesa & Fonagy, 2007; Gabbard et al., 2000; Luyten et al., 2010; Vermote et al., 2010; Vermote et al., 2011; Werbart et al., 2012). In addition to this, researchers did not utilise a treatment integrity measure and therefore conclusions cannot be drawn as to the active ingredients of treatment that produced favourable outcomes.

The participant sample characteristics are also diverse with regard to the participants' clinical diagnosis and sample size. Within the identified studies, there is co-morbidity of types of personality disorders or co-morbidity of personality disorders and axis I disorders (APA, 2013). The small sample size variable makes it difficult to generalise the findings to the general population, however it is important to note that these studies have demonstrated the

clinical utility of treatment as well contributed to the evidence based literature within this field.

5.0 DISCUSSION AND CONCLUSION

Based on the evidence reviewed, it is apparent that there is evidence to support the use of psychodynamic therapy for inpatient service users with personality disorders. However, a firm conclusion cannot be made as there were many confounding variables (i.e. the type of personality disorder, the delivery and content of the treatment programme, clinical setting and measures utilised to evaluate the intervention) and a variety of variables that were not evaluated in all the studies identified for the review. Therefore the review has categorised the variables that have been evaluated to assess the effectiveness and efficacy of psychodynamic based treatment for individuals with a personality disorder in an inpatient service.

The existing research highlights favourable outcomes in psychiatric symptomology, interpersonal functioning, functioning impairment, self harm and levels of service utilisation for service users that have engaged in an inpatient psychodynamic orientation based interventions. A number of research groups also argued that ‘inpatient’ treatment was the most effective treatment setting in comparison to day hospitals and general outpatient psychiatric treatment (Bartak et al., 2010, 2011a, 2011b; Bateman & Fonagy, 1999, 2001, 2008). In addition, the review also highlighted the apparent superiority of a two-stage model (short term inpatient treatment followed by outpatient step-down support) as this model was also efficient at achieving significant differences in regards to psychotic symptom severity, social adjustment, global functioning and deliberate self-harm (Chiesa et al., 2004; Chiesa & Fonagy, 2000, 2007).

The review also recognised that the treatment of individuals with a personality disorder is a difficult and challenging task and therefore it is extremely difficult to obtain

‘successful’ outcomes and treatment compliance. Therefore, the review reported that the following variables were significantly associated with gaining favourable outcomes in treatment: age, DSH, personality disorder type, the average number of personality disorders diagnosis, symptom severity, global functioning and length in treatment (Chiesa & Fonagy, 2007). The researchers also highlighted that type of personality diagnosis and occupational status are variables that are likely to predict premature termination from treatment (Chiesa et al., 2000). Although, the literature does not appear to be well established within this area it is important to highlight that the findings hold a substantial amount of clinical relevance for clinicians’ and service users.

The financial element of providing a specialist psychodynamic based treatment service to individuals with a personality disorder has also been discussed within the review. A majority of the research groups recommended that further research was required in order to establish a cost-benefit analysis to demonstrate whether or not there was a financial gain to providing specialist psychodynamic interventions over other forms of treatment. The limited findings available indicated that at post-treatment, service users’ tended to utilise outpatient services less frequently and the likelihood of re-admission was also less likely (Bateman & Fonagy, 1999, 2001, 2008; Chiesa et al., 2004). Research conducted by Bateman and Fonagy (2003) concluded that there were no cost differences between specialist psychodynamic based treatment than general psychiatric care, and considerable savings could be made over time by providing specialist services for individuals with a personality disorder.

Upon reviewing the literature identified, the author and researchers (Spitzer et al., 2012) highlighted the importance for future research to focus on establishing a robust outcome measures of psychodynamic treatment for service users with a personality disorder. For example, the use of ‘psychiatric symptomology’ as an outcome measure has little

relevance to the diagnostic criteria, in contrast to measuring specific outcomes related to the presenting features of an the disorder, such as impairment in interpersonal functioning, impulsivity, and impairment of daily living skills. It is also suggested that future studies may wish to consider using the diagnostic criteria for personality disorder as an outcome variable to establish the effectiveness of inpatient psychodynamic orientated treatment programmes. By doing so, the validity and reliability of such interventions might be more clearly established.

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EMPIRICAL PAPER

**HOW DO PSYCHOLOGISTS' MAKE SENSE OF AND UNDERSTAND THEIR
ENGAGEMENT WITH SERVICE USERS IN A MEDIUM SECURE UNIT?**

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Key words: Engagement, therapeutic relationship, containment, empowerment, Interpretative
Phenomenological Analysis

ABSTRACT

Background: Literature has suggested that therapeutic engagement is considered as an important construct to assess as premature termination of therapy can influence clinical outcome and increase the chances of services becoming cost ineffective (McMurrana, Huband & Overton, 2010). This study aimed to explore how Psychologists' make sense of and understand their engagement with service users in a Medium Secure Unit (MSU).

Method: Semi-structured interviews were conducted with six participants (psychologists working in a MSU) and the transcripts were subjected to Interpretative Phenomenological Analysis (IPA).

Results: Three super-ordinate themes emerged from the data with sub-ordinate themes: 'being human together', 'the matryoshka doll of containment' and 'the psychologist as an empowerer in a disempowering system'. The research identified that the participants in the study described experiences of relating to service users at a humanistic level, their experiences of feeling contained, and being a facilitator of containment. The narratives also captured the experiential claims of service users being in a disempowered system but also the psychologists being a facilitator of empowerment.

Conclusions: The recommendations that arose were placed within literature and the methodological limitations of the study. They were centered on how services and psychologists can aid service users' engagement in psychological therapies, within MSU.

INTRODUCTION

Current Policies and Guidelines

Literature and clinical practice suggests that therapeutic engagement is considered as an important construct to assess as premature termination of therapy can influence clinical outcome and increase the chances of services becoming cost ineffective (McMurrana, Huband & Overton, 2010; Edlund, 2002). Over the past thirty years researchers and clinicians have witnessed a significant international growth in the provisions of forensic mental health services, which has resulted in policies and guidelines shifting from institution based care and aiming towards a rehabilitative and recovery model of care (Childs & Brinden, 2002; Ramon, Healy, & Renouf, 2007; Robertson, Barnao, & Ward, 2011; Shepherd, Boardman & Slade, 2008).

The term ‘recovery’ was previously predominately based on the medical model which emphasised on the removal of psychiatric symptoms and curing the mental illness. In contrast, the revised recovery model provides a holistic view of the person that is focused on the service user developing a meaningful life, irrespective of illness (Ramon, Healy & Renouf, 2007). The model also focuses on the service user collaboratively defining their recovery model of care with health professionals. By doing so, this empowers service users as they are able to actively take control over their lives (Shepherd, Boardman & Slade, 2008). The relationship between the health professionals and the service user is also modified as there is a shift from professionals being seen as an expert to them becoming a coaching partner who joins them on their journey of discovery. This development of the recovery based approach also emphasises the personal qualities of the health professional as the approach is geared up to develop their abilities to instil hope, creativity, care, compassion, and resilience in order to

successfully collaboratively work with the service users' inner resources to achieve their goals (Shepherd, Boardman & Slade, 2008).

The 'Best Practice Guidance' for adult medium secure services highlights that a multi-modal framework should be offered within Medium Secure Units (MSUs) in order to provide an high-quality care and treatment package that meets the needs of each service user and supports their recovery (Jobbins et al, 2007, pp. 26). There has also been a focus on identifying that there needs to be an emphasis within services to ensure that they are doing all they can to encourage clients to seek and accept relevant services and receiving a care package which optimises engagement (Thornicroft, 2000). As a result, researchers and clinicians have focused upon exploring health professionals' experiences of engaging service users, particularly within services that provide services for 'difficult clients' (McMillian, 1998).

Definitions & Psychological Models of Engagement

The term 'engagement' is a relatively new concept that has arisen within the field of mental health services, however, similar terms such as 'therapeutic alliance' (Freud, 1912), 'working alliance' (Greenson, 1965), 'helping alliance' (Luborsky, 1976) and 'treatment engagement' (Staudt, Lodato, & Hickman, 2011) have also been employed. Such terms are largely interchangeable (Gillespie, Smith, Meaden, Jones, & Wane, 2004).

As early as 1913, Freud explored the relationship between the client's attachment to the therapist and the feelings the therapist had towards the client. This is known as transference and counter-transference (Racker, 1982). He felt that the positive, reality-based component of the relationship provided the basis for a unique therapeutic partnership (Martin, Garske, & Davis, 2000, p. 139). Rogers (1957, p. 96) elaborated on the engagement process

and he identified six basic conditions which he felt were vital characteristic for a relationship. These conditions included the therapist being: congruent, genuine, integrated in the relationship, showing unconditional positive regard for the client, and experiencing an empathic understanding of the client's internal frame of reference alongside an endeavor to communicate the experience to the client. These concepts and definitions have been mainly developed within the psychodynamic model, however psychological models that have been developed post-psychodynamic therapy have also placed a high importance on engagement factors and the therapeutic relationship (Garfield, 1992; Krupnick et al, 1994; Keys to engagement, 1998; Wampold, 1997).

The attachment model (Bowlby, 1988) has also been an influencing psychological model which has assisted researchers and clinicians to understand the therapeutic alliance. It is thought that an attachment system that is developed in childhood will influence social, intimate and therapeutic relationships in adulthood (Hazan & Shaver, 1994). Bowlby (1988, cited in Mallinckrodt, Gantt & Coble, 1995) argued that a therapist is similar to a primary caregiver as they are emotionally available, have a comforting presence, provide affect regulation, and provide a secure base from which service users can safely explore their inner and outer worlds.

The Therapeutic Relationship and Engagement

Literature has suggested that the therapeutic alliance is considered to be an important factor of successful treatment as it has been found to be a consistent predictor of therapy outcome (Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000). Recent findings highlight that the quality of the therapeutic engagement between the therapist and client is predominately based on the actions and characteristics of the therapist, and therefore it has been concluded that the therapist's role is most important for achieving favourable outcomes in therapy (Del

Re, Flückiger, Horvath, Symonds, & Wampold, 2012; Lambert & Barley, 2002; Mosher & Stiles, 2009).

Researchers suggest that a strong therapeutic bond within therapy makes a good impression on the patient and this results in the client experiencing positive feelings towards the therapist, which also evokes positive emotions when the client internalises therapy (Hartmann, Orlinsky, & Zeeck, 2011). Hartmann et al (2011) hypothesised that these clients would be likely to approach their therapy sessions with positive expectations, perceive their interactions with the therapist favourably, and collaborate openly, through the experience of a strong therapeutic alliance. Similarly, if the therapist makes little or no impression on the client during therapy this results in the client holding a weak internalised representation of therapy and then they would be likely to approach therapy with negative expectations and resist in collaborating in therapeutic interventions. This highlights the importance of the therapist collaborating with the client to discuss their engagement within therapeutic sessions.

Although the literature discussed above highlights many important factors to consider, it does not effectively examine the within-therapist variances and how clinicians operationalize the factors that aid the engagement process (Stiles, 2009). For example some therapists might be more responsive to particular types of clients than others and therapists may behave differently towards particular clinical populations, such as clients in a forensic mental health service, but the actual process the therapist goes through is not entirely clear or well researched.

The Therapeutic Relationship and Engagement in Forensic Services

Forming a therapeutic alliance within a forensic setting is quite distinctive and presents with unique difficulties (Meissner, 2007). Long, Dolley, & Hollin (2012) & Vincent (2002) highlighted a number of factors that are related to the environment, service user, therapist, and the therapeutic working alliance that are likely to impact on engagement in treatment. Within the service user, the nature of the mental illness, potential associated risks, and impulsivity may impact engagement. In a setting where treatment is mandatory, non engagement or disengagement from treatment is perceived and associated with failure to reduce risk and a higher risk of recidivism. A meta-analysis suggested that coerced treatment is less likely to be effective as ‘treatment failure’ may increase and the client displays ‘treatment resistant’ behaviours (McMurrin & Theodosi, 2007; Nunes, Cortoni, & Serin, 2010; Parhar, Wormith, Derksen, & Beauregard, 2008). A study conducted by Long et al. (2012) recommended that motivational interventions should be developed and therapists should be able to adapt a “customised” approach, which allows them to be client centred when facilitating interventions, in order to aid the engagement process and therapeutic alliance.

The literature discussed above suggests that it may be more of a challenge to engage service users within a forensic setting due to a number of variables; however there a number of techniques can aid the engagement process. The literature has not suggested a specific method and/or model that can aid to create engagement between clients’ and therapists (Minichiello et al, 1990 cited in Collins, Lincoln & Frank, 2002). In addition, the current literature has neglected the experiences and challenges psychologists face. Therefore this study is particularly keen to focus upon psychologists’ experiences of how they make sense of, and understand, engagement with service users in a medium secure unit.

Research Question

The primary research question is therefore ‘how do Psychologists’ make sense of and understand engagement with service users in a MSU.

In order to attempt to answer the research question, a qualitative design study was implemented due to the minimal amount of literature in this field. Therefore the study took an exploratory stance in an attempt to understand phenomena and answer the question. As a result the study used Interpretative Phenomenological Analysis (IPA, Smith, Flowers & Larkin, 2009) as it permitted a greater understanding of the participants’ subjective experiences of how they made sense and understood engagement with service users in a MSU. The research also wanted to stay close to the participants narratives in order to gain a greater understanding into their subjective experiences; the detailed stage by stage analysis used in IPA allows this to happen.

METHOD

Context

To place the researcher into context of the study, she is a 26 year old Asian female who is a Trainee Clinical Psychologist studying at the University of Birmingham. Her previous experiences consist of over five years of working clinically with a variety of clinical populations in different service structures. The researcher's interests are within forensic mental health, and this is what drew her to the research project.

The Participants were recruited from three MSUs operating in the same NHS foundation trust. Two of the MSUs were male units and the other unit was a female only unit. Each MSU had a treatment pathway and a multi-disciplinary team. The researcher had previous experience of working within a psychology team in a forensic service, therefore she had to be mindful about bringing in her own preconceptions and biases during the interviews and analysis.

Design

Six participants were interviewed using a semi-structured interview schedule (see Appendix A). The interview transcripts were qualitatively analysed using the principles of Interpretative Phenomenological Analysis (IPA, Smith, Flowers, & Larkin, 2009). This study was conducted as a part of a two-way multi-perspective study, with the other member of the research team carrying out a similar study to focus on service users' experiences and sense making of engaging with their psychologist.

Participants

The self-selecting participant sample used in the research consisted of six Psychologists that worked within a Medium Secure Unit (MSU) in the National Health Service, therefore they were selected purposively. Table 1 displays the participant demographic information.

Table 1 Participant's Demographic Information

*Pseudo name	Gender	Age Range (years)	Ethnicity	Job Title	Time Spent Working in a MSU
Monica	Female	36-41	White British	Principle Forensic Psychologist	8 years
Rachel	Female	30-35	White British	Clinical Psychologist	18 months
Phoebe	Female	30-35	White British	Forensic Psychologist	8 years
Janice	Female	24-29	White British	Clinical Psychologist	4 years
Erica	Female	30-35	White British	Highly Specialist Clinical Psychologist	6 years & 6 months
Emma	Female	30-35	White British	Clinical Psychologist	7 years

The sample sizes for IPA studies vary but they are relatively small because the approach has an idiographic commitment to depth of analysis, and to the reporting of commonalities and differences between individuals' accounts. A small, purposive, homogenous sample was used in accordance with IPA principles (Smith, Flowers, & Larkin, 2009) as the research was keen to reach out to potential participants that had experienced engaging with service users

regardless of their qualifications. This allows for a focused, detailed account of the experience of psychologists' in this context. According to Smith and Osborn (2008), the sample size of six is held as an appropriate number for the methodology adopted.

The primary inclusion criteria were based on the following points:

- Must have a current position as a qualified psychologist (clinical or forensic) or assistant psychologist or honorary psychologist or trainee psychologist in a MSU
- Have at least one year experience of working with service users in a MSU
- Aged 18 or above to ensure informed consent could be obtained.
- If participants met the above criteria, they were considered appropriate for the study; no further exclusion criteria were stipulated.

Materials

An interview schedule was developed by the researcher in collaboration with the supervisory members of the research team. The schedule focused on collecting Psychologists' narratives on their experiences of engaging service users who were working in a medium secure unit. The interview schedule was designed in a manner that was consistent with the epistemological underpinnings of an IPA approach. The individual items of the schedule comprised open-ended questions in order to enquire about the participants' understandings, experiences, and sense-making of their experience of engaging service users. By adopting this approach to questioning, the research is viewed as phenomenological and as being consistent with the principles advocated by Smith, Flowers & Larkin (2009).

The potential participants were provided with an information sheet (see Appendix B) in order to outline the research study. The information sheet outlined the purpose of the study,

the benefits of the research, the procedure of their participation (i.e. length of time, location, audio taped) and contact details of the chief investigator if they require further information.

The research team obtained informed consent to participation via an opt-in consent form, see Appendix C.

Participants were given a de-brief sheet (see Appendix D) which included the contact details for the research team.

PROCEDURE

Ethical Approval

The University of Birmingham granted ethical approval for the research study and the research and development team within the foundation trust gave their approval to access the MSUs and interview their staff for the purposes of the research study, see Appendix E.

Identification and Recruitment of Participants

A member of the research team acted as an agent to facilitate the recruitment of participants. Across the three MSU wards, there were approximately 35 participants that would have been eligible to participate in the research project, 23 qualified psychologist, 11 assistant psychologists and 1 trainee psychologist. Of these, 30 were female and 5 were male. All of the potential participants were informed of the research at psychology team meetings and the information sheet was cascaded to provide further details. Potential participants were given a minimum of twenty-four hours to consider taking part. Following this, the six willing participant's contact details were made available. The researcher then made contact with the participant to offer additional information if requested, provide the information sheet and

consent form (for information purposes only at this stage), and to arrange the subsequent interview. Signed consent and the demographic information was obtained at the point of interview. Due to the nature of the recruitment of self-selecting participants, it is possible that bias may have occurred as the participants may have had particular reasons why they wished to participate in the study.

Interviews

On average, a sixty-minute interview was conducted with each participant at their preferred location. The practical arrangements of interviews were collaboratively coordinated by the participant and researcher.

The interview style adopted by the researcher was consistent with Smith, Flowers & Larkin's (2009) principles of IPA interviewing. An interview schedule was used to guide the interview. All interviews were recorded on an encrypted digital recording device. The researcher briefed the participant prior to the interview commencing about the nature of the interview being predominately based on their experiences and therefore the researcher would attempt to enter the participant's experiential world. At the end of each interview the participant had the opportunity to ask the researcher questions and they were asked if they would like to omit any information and view their final transcript. Participants were also given a second opportunity to omit any information after they had viewed their transcript and they were given a debrief sheet

Sequence of Analysis

Firstly, the generated interview data were transcribed according to the principles of IPA suggested by Smith, Jarman and Osborn (1999). The essentials of IPA transcription include constructing a verbatim record which included utterances and pauses. The non-verbal social interaction was also considered relevant and this was noted in the reflective diary. Outlined below is the four-stage procedure that was followed:

Stage 1: Reading and re-reading

During this stage of the analysis the researcher's primary concern is immersing oneself in the data transcripts. The focus was on "slowing down" and beginning to enter the world of the participant, responding to what is being read, and entering into a phase of active engagement with the data (Smith, Flowers & Larkin 2009).

Stage 2: Initial noting

This stage represents the initial level of analysis. Following Smith, Flowers & Larkin (2009), exploratory coding began at this stage with a focus on examining semantic content and use of language. This involved looking at the language the participant used and thinking about the context of their experiential world. With this, the researcher identifies abstract concepts to help with sense making of the patterns identified in their account.

Stage 3: Developing emergent themes

The third stage involved re-organisation of the data and emergent themes are identified. The researcher took a more central role in imposing an order (the 'interpretative'), but attempting to remain close to the participant's experience (the 'phenomenological').

Stage 4: Searching for connections between emergent themes

The fourth stage involved synthesising the emergent themes into a structured, organised analysis to illustrate the themes. At the end of the process a summary table was generated displaying how themes are intertwined within super-ordinate themes. Appendix F displays an example extract of the different analysis stages.

Credibility

Reflective supervision was attended on a regular basis throughout the process in order to facilitate reflection on personal assumptions, goals, individual beliefs, and subjectivities. In order to further enhance validity and minimise research bias, the interpretations and emergent themes were discussed in a supervision group of doctoral students engaged in a range of IPA studies, facilitated by an experienced supervisor. After stages one and two (outlined above) were individually completed, the researchers and supervisors met to discuss, review, and reflect on process and emergent concepts. This process was repeated following stages three and four. Such a process of triangulation and validity checking is considered to enhance the credibility of the interpretation and final analysis.

RESULTS

Analysis

The in-depth analysis of the qualitative data resulted in three super-ordinate themes with sub-ordinate themes that are closely grounded to the data to reflect the principle experiences and concerns of the participants. These are summarised in Table 2 and discussed in detail below. Further supporting quotes for the superordinate themes can be found in Appendix G, this demonstrates credibility and representation of all of the participants’ voices that support the theme.

Table 2: Summary of Super-ordinate and Sub-ordinate Themes

Super-ordinate Themes	Sub-ordinate Themes
Theme 1: Being human together	1.1: Reciprocity- Being attuned: <i>“some sense of me being on a level, being able to kind of attune to him.... He felt we had a more reciprocal balance and equal relationship I guess (Phoebe, L117)</i>
Theme 2: The matryoshka doll of containment	2.1: The outer layer of the matryoshka doll 2.2: The inner layer of the matryoshka doll 2.3: The innermost doll: <i>“I think that is thereally important aspect of good engagement, just to be consistent and containing and not give up” Emma, L252.</i>
Theme 3: The Psychologist as an empowerer in a disempowering system	3.1: Being in a disempowered system: <i>So it’s a really disempowered place to be” (Rachel, L61)</i> 3.2: Psychologist as an empowerer

Super-ordinate Theme 1: Being Human Together

All of the psychologists interviewed discussed their therapeutic relationship with the service user and their phenomenological experiential interaction was understood as the psychologists' "*being human*" (Janice, L34). The psychologists discussed and related to their interaction with service users at a humanistic level whereby they attuned to the service users as human beings rather than a service user within a MSU. The term 'humanistic' was used by the participants throughout their narratives, and it has been interpreted as a term to describe genuineness within the therapeutic relationship. They also discussed how they used their time to get to know more about the person and the things that are important to them.

1.1: Reciprocity- Being Attuned

Throughout the participant's narratives there was a recurrent theme, which was based around the interaction between the psychologist and the service user, more so, how they attune and relate to each other. An example of this is demonstrated in the quote that is placed within the sub-ordinate theme by Phoebe (L117), she expressed herself as being at the same level of the service user as opposed to being superior as she was able to attune to him by interacting with the service user in a non condescending manner, this then transpired into a relationship with an equal dynamic.

"I had one particular client say to me, not sure if this is a good thing or bad thing actually but he seemed to think it was a good thing. He had not engaged with anyone throughout his treatment, he came from a different hospital then came here. And I asked him why he hadn't engaged with people and what was different about him starting to engage with psychology and his responses was that "I'll talk to you because you're not up yourself, or not posh" something like that. Some sense of me being on a level, being able to kind of a-tune to him

and being more on a level [than] he felt other people had been. He felt people had talked down to him and been quite condescending, he felt we had a more reciprocal balance and equal relationship I guess” (Phoebe, L113)

Throughout the narratives, the participants often referred to the service users as “*chap*”, “*guy*” and “*person*” which also demonstrate that they were relating to each service user as an actual person instead of a patient in a MSU. Some of the participants placed themselves in the service users’ position to try and understand and relate to the experiences of what it must be like for a service user interacting with a psychologist in a medium secure unit.

“sometimes they see you as psychologists in an ivory tower, you know all these brains, theories and models but actually what they want is for you to relate to them as a human being” (Monica, L320)

In Monica’s (L320) quote and across most of the data, the participants expressed concern that service users might perceive that the psychologists were more successful than them in terms of their level of intellect due to their differences in life experience. This can impact on engagement as service users may not necessarily connect and relate to those differences within the relationship, whereas service users may feel as though they can engage with an individual that presents as a human being. Monica’s (L320) language in the quote highlights this by using the metaphor of an ivory tower which suggest that psychologists are seen to be placed high up which is disconnected from the service users’ real environment and experiences. In this example, Monica’s tone of voice and use of language can be viewed as having empathy for the service user’s position and this may have impacted on her engagement style as she would be aware of the differences. This awareness may assist on being able to work towards minimising the noticeable differences and supporting the service users’ stance, that all they want is their psychologist to relate to them as a human being.

All of the participants reflected upon a variety of ways in which they had engaged with the service user at a humanistic level. In particular, the psychologists described spending time with service users by engaging in activities that were of interest to them (i.e. playing pool, discussing films and watching TV programmes such as MTV) and giving validating human responses to the service users' experiences in order to relate to them as human beings. The quotes below by Janice (L293) and Erica (L170) are an example of this.

“be able to show that you are interested in people, what they are talking about, a film they have watched or something. You know, just being interested, I think that I am, generally I am, not trying to be a false self” Janice, L293.

“I think you can be honest about your response as a human being to a particular experience, so I do use lots of that. I think that can be helpful in the therapeutic process as well you know, something sounds terrible, shocking or sad I think it can be validating for somebody to have some human response back” Erica, L170.

The participants also compared the different ways of working within a MSU and a community mental health team. For example, in a community mental health service, service users would be expected to attend their scheduled psychology sessions and if they disengage then limited and/or no contact is maintained with the psychologist. Whereas within a MSU, psychologists continue to attempt to engage the service users and identify alternative ways to maintain contact, this is demonstrated in Janice's quote below.

“Some people are just not at that level and it's depending on someone's level and where they are at really. If they are not ready for that then it's trying to think of other ways to engage with somebody. Try starting from a point that they enjoy, like playing pool, I think that's an important basis to have, that seems outside [to] the role of a Psychologist in other settings but I think here that is important” Janice, L104.

Not only were the participants attuned to the service users, some of the narratives also placed an importance of being attuned to the therapeutic process to ensure they were ready and

prepared to work with the service user when they exhibited a degree of readiness and motivation to engage in psychological therapy.

“It’s about making sure you are available with options so when the timing does come and somebody is ready that you are available” Erica, L361.

Erica’s (L361) quote is an example of the Psychologists’ experience of being attuned into the service users’ readiness and ensuring they can reciprocate this by being available and prepared to engage the service user in psychological therapy. In addition, this highlights that if the psychologist is not available and ready then they may miss an opportunity to engage the service user in psychological therapy.

All six participants expressed that there were factors within the service users, the system and themselves that became barriers to being attuned to the service users. For example, in all of the narratives, the participants discussed how particular types of offending behaviour (i.e. rape or cruelty to animals), specific personality traits and the service users’ attitude and level of remorse towards their offending impact on attuning to the service users.

“I guess the only individuals that I find it particularly difficult are perhaps the more psychopathic traits where I am not quite sure erm [pause]. That what we are doing is genuine or helpful or if they are fully engaged in the process, but that is quite a challenge. I’ve never had experience of someone’s offence been a barrier to engagement, for me personally I think I would struggle if someone was really cruel to animals. I know it sounds a bit ridiculous, but I have not come across that at all, I would have to probably take that to supervision” Rachel, 106.

“Thinking about a patient I saw this morning, when the patient doesn’t necessarily see the seriousness of their offence, or they don’t appear take on board the impact or behaviour on other people. So for example, the patient this morning who was grinning when he was talking about his offence, it was quite a serious offence. He did not seem to have any remorse or regret about what had happened. That was hard, I was getting wound up” Phoebe, L81.

Within Erica's narrative, she spoke about how her experience as a psychologist helped her overcome her "wariness" (Erica, L292) towards service users with a sexual offending history but also she has adopted the view of seeing the person in a broader context to manage her personal apprehensions. The quote below by Erica (L311) illustrates this.

"the bottom line of it from my experience of going through with it, is having an understanding of the person beyond their offence because obviously there is a lot more to people" Erica, L311.

Erica discusses how her experiences have also helped her to adopt an understanding of the service user as a person and that she takes the position that there is a person beyond their offence and there is more to the service user than their offence and mental illness. Likewise, some of the psychologists described that they have been judged by service users as being different to them. But demonstrating that they have similar interests and can relate at a human level helped to minimise the barriers of developing a therapeutic rapport, and allowed the service user to view the psychologist as a human being that is able to relate to them at a personal level. An example of this is demonstrated in the quote below (Rachel, L487).

"With one client I think I was able to develop our engagement after he quoted a rap lyric to me. After he said it, I said, "Isn't that from a Tupac song?" He looked at me and said, "How do you know who Tupac is", I said, "I liked the music" and he said, "I have misjudged you and I was wrong". I think he thought I was so different to him that we had nothing in common. Obviously, we do have very different lives and experiences, but I think that helped to have at least something in common. The relationship developed well from then on and we have been able to complete some good work together" Rachel, L487.

Psychologists acknowledged that although their lives and experiences are somewhat different from the service users, the importance of commonalities, irrespective of their

relationship within therapy, such as music, between both parties aided the process of attunement and facilitated engagement.

All of the participants' narratives include the difficulties of balancing professional and personal barriers whilst trying to attune to the service users at humanistic level in order to facilitate engagement and therapeutic work, which in turn can bring challenges to engagement.

“There are moments when somebody asks you something and it is not maliciously, it's not because they are trying to harm you, it is just normal human interest in another human and then you say ‘no I am not going to talk about that’ and sometimes it can feel really hard to say no that is out of bounds I am afraid, that's not what I talk about” Erica, L211.

In Erica's quote (L211), which is representative of the participants concerns, she describes how having these boundaries in place can actually become difficult for service users and psychologists to work with as it goes against the unwritten script of how human beings interact together.

The participants perceived a further barrier which was related to service users' personality traits and/or stability of mental illness. All of the participants described that how clients who had a diagnosis of a personality disorder/s, i.e. antisocial personality disorder and borderline personality disorders, particular personality traits.

“Things that might make it more difficult is somebody who might be heavily suspicious and paranoid to a point where they don't want to talk to anybody, they can't trust anybody and that can be a symptom of their diagnosis or it could be a personality trait, some people are just very wary and I think that can make it tricky to engage sometimes because somebody's' out and out stance is just ‘why should I tell you anything’ that is a part of their core belief then that is going to make it harder to engage somebody. There are certain personality constellations which will lend themselves to a more cautious stance or people who might be

anxious about other peoples' motives themselves, those things can make it more difficult" Erica, L226.

"I have experienced some difficulty with working with a client more recently; she was a borderline client who engaged in splitting so the clinical team became quite split. Borderline clients have a tendency to put the clinical team or whoever they are working with into two categories, so denigration or really holding some members of the team on a pedestal and I guess I was at the end of the denigration so I was experiencing lots of verbal abuse. I was also experiencing other members of the clinical team questioning my approach with this particular client, because of conversations they had with the client so it is very apparent because of the clients pathology this process was happening" Emma, L202.

This snapshot within Erica's narrative (L226) highlights that suspicion and paranoia can influence the service users' level of engagement as their thought processes may present as being anxious and/or defensive. These are two factors that made it harder for her to engage with service users. Emma's quote (L202) highlights that specific traits related to borderline personality disorder can impact on the team's engagement with each other and also become a barrier within the therapeutic relationship.

In contrast to identifying factors that service users and psychologists have in common in order to facilitate engagement, one of the participants, Erica, discussed how her gender and ethnicity made it more difficult for her to be able to relate to a service user and how the system within the MSU contributed to this barrier as there was an unequal gender balance amongst the professionals.

"But I think being a woman and being a white women can occasionally be tricky sometimes.... I think that can make it a bit little tricky sometimes for some people to engage with you. Because sometimes they can look at you and say you don't have a clue about what I am talking about" Erica, L225.

The quote presented demonstrates a perception that the service user found it difficult to relate to the psychologist due to the differences in ethnicity and gender and as a result they assumed that the psychologist would not be able to understand them. The repeated use of the word “tricky” indicates that Erica did not perceive these factors as a blockage within the process of developing a therapeutic rapport; however, it was viewed as it making it more difficult to relate to and engage the service user.

In summary, the theme of ‘being human together’ was evident throughout all of the data and the important elements within the theme was primarily based on the psychologist and service user relating to each other as human beings in order to facilitate engagement. The participants also identified the barriers of being able to attune to the service users.

Super-ordinate Theme 2: The Matryoshka Doll of Containment

A matryoshka doll, also known as a Russian nesting doll, is a set of wooden dolls that are decreasing in size and placed within each other. The second superordinate theme has been named ‘The Matryoshka Doll of Containment’ because the outer layers of the matryoshka doll of containment represent the larger systems of containment such as the environment, the inner layers represent the clinical team and supervisory relationship and the smallest, innermost doll resembles the psychologists’ and service users’ humanistic, therapeutic bond being containing.

2.1: The Outer Layer of the Matryoshka Doll

A majority of the participants identified that the environment was a container for the service users and themselves as it helped them to feel safe and secure within a MSU environment. It appeared that the security systems such as the alarms, the operational policies and the physical environment were appraised as being containing factors for the psychologists, and this was

important within this type of environment as many risk factors such as violence, aggression and self-injurious behaviours could be present.

“I didn’t feel so unsafe where I felt I had to leave, but I had one session where I checked where my alarm was” Rachel, L429.

This experience of the alarms being a container for psychologists is reflected in Rachel’s account (L429). Rachel’s appraisal of the safety mechanism being a risk reducer enabled her to feel safe enough to stay in the room knowing that she had a mechanism that could contain and reduce her anxieties as she was aware that she was able to get help and assistance if she encountered a difficulty.

However the service user may adopt the opposite stance as reflected upon by Rachel, who commented on the position of the service user and her experiential concern that the operational policies were evoking defensive feelings for a service user who was experiencing paranoia. Therefore the service user did not perceive this as an act of containment; rather it was quite the opposite as his curiosity of the presence of the safety check impacted on the engagement. An example of this is within Rachel’s narrative (L411).

“When I saw him on the ICU he wasn’t used to seeing me with someone standing outside the door and he was quite distressed about that, why is that person there? What do you think I am going to do? You know those kinds of questions, so that’s the only time I think that the constant curiosity has impacted on engagement” Rachel, L411.

In summary, the environment was appraised to be a containing factor for the psychologists, however the participants also recognised that service users may not experience the security aids and policies serving a purpose of containment.

2.2: The Inner Layers of the Matryoshka Doll

The inner layers of the matryoshka doll represent the systems of containment provided by the clinical team and supervisory relationship.

Based on Erica's (L23) narrative, it is also speculated that the clinical team assist to contain everything and everyone within the environment and that this creates a calming environment.

"I think in some ways I might have expected the environment to be at times more challenging than I think it is and hopefully that is a credit to the staff team that work here, and everybody is doing things reasonably well, keeping things quite calm and contained" Erica, L23.

The feelings of containment also operate between the clinical team and the psychologist as all of the participants placed value on the support they received from the multi-disciplinary team and the psychology team within the medium secure service.

"there is always somebody either a part of the clinical team or colleague that are around to help you if you encounter something with a particular patient. And of course there is the nursing staff on the ward as well who also help with your psychological work in particularly" Emma, L25.

This picture created in Emma's (L25) narrative illustrates that the multi-disciplinary teams are supportive to the psychologist and psychological ways of workings as they are always present and available to offer support. At a phenomenological level, Monica's quote (L222) below identifies how seeking reassurance from her colleagues gives her the sense of feeling contained within her role as a psychologist when she experiences difficulties.

"so you can pick a book which is great, it will give you a lot of things to think about but sometimes there's nothing quite like hearing one of your peers saying 'ooo have you gone in and tried this?' and sometimes you can say oh yes I actually have, so it's about hearing that you can do no more and you just need to keep going" Monica, L222.

Moving closer into the layers of the matryoshka doll of containment, all of the participants touched on offering a safe space (i.e. reflective practice & supervision sessions) for staff to reflect and gain support from colleagues and the psychologist. These sessions are offered to all staff members' and they can serve a variety of purposes, such as having an opportunity to reflect upon their clinical practice and seek peer support regarding any difficulties they are experiencing or envisage.

“That is why we try to set up lots of supervision groups and things like that to support people, and we need it as well, so having a bit of space for that” Janice, L278.

Within Janice's (L278) script she also identified that everyone within the clinical team required support, including herself.

All the participants' experiential accounts viewed supervision as being highly supportive and valuable in assisting the participants with their therapeutic relationships. Participants appeared to receive comfort from knowing that they were able to access their supervisor frequently, and the commonality of their psychology background aided the containing supervisory relationship. This is demonstrated in Janice's (L349) narrative below.

“But I actually think the support comes from supervision and the way you can think it through because psychologists see it differently don't they” Janice, L349.

2:3: The Innermost Doll

The innermost matryoshka doll of containment represents the psychologists' and service users' humanistic therapeutic bond. This was interpreted as being a secure and safe therapeutic relationship for the service user as the psychologist was able to provide a consistent and safe interaction and support the service user during therapy (for example: *“And if they completely crumble they won't just be left in a big heap on the floor but we are there to*

help them pick back up” Monica, L252). The psychologists were also able to evidence that they would continue to maintain a presence even if the service user presented as being resistant to engaging with the psychologist.

“I think that is the really important aspect of good engagement, just to be consistent and containing and not give up. I think it is really important that the client understands that even despite the behaviour and presentation you are going to be there consistently” Emma, L252.

In addition, the reiteration of not giving up regardless of the challenging behaviour the service user presents in Emma’s quote (L252) is also a theme among all the narratives; the psychologist being resilient. The psychologists’ narratives highlight how they had to be resilient, more so within a MSU environment in comparison to a community service, as they encountered a lot of resistance and behaviour that challenged (i.e. verbal aggression), yet had to continue to be physically present and attuned to the service user in order to build and maintain the therapeutic relationship.

In summary, the theme of ‘being human together’ was evident throughout all of the data and the important elements within the theme was primarily based on the psychologist and service user relating to each other as human beings and valuing the resource of containment from multiple layers within the MSU.

Super-ordinate Theme 3: The Psychologist as an Empowerer in a Disempowering System

The first subtheme, ‘being in a disempowered system’ represents all of the transcripts related to the impact of both service users and the participants feeling that they are within a disempowering system. The quote by Rachel (L61) demonstrates this: *“So it’s a really disempowered place to be”* (Rachel, L61). The psychologists made sense of a

disempowerment as not having a sense of control over certain factors such as the Mental Health Act (1983) and policies which are very much present within a MSU. The second subordinate theme 'Psychologist as a empowerer' encapsulated the psychologists' role as an empowerer, creating space for service users and themselves to feel empowered about their ability to make choices and influence change.

3.1: Being in a Disempowered System

The recurrent theme of the impact of the "*anonymous figures in peoples' eyes*" (Erica, L416), the wider agencies such as the Ministry of Justice and the Mental Health Act (1983) were within all of the participants' narratives. The participants recognised that these agencies can make service users feel disempowered as they dictate their future. An example of this is within the quote below (Monica, L164).

"But it can be really tough, some team members just don't get it, and I think it's because most people are just happy to abide by the criteria of the Mental Health Act that people have to have treatment, they are detained specifically for purposes of treatment and risk" Monica, L164.

Monica also highlights how the clinical team feel that they have to abide by the Mental Health Act as there are specific purposes for their detention within a MSU.

In addition, the structured environment within the MSU can also be perceived as disempowering, as service users are stripped of their freedom to make basic decisions such as when they eat. The example from Erica (L56) exemplifies this.

"So there's a gentleman I am working with at the moment and his kind of goal is to live a independent life and to be able to make his own choices. And he is a very assertive gentleman and he really struggles with the idea that he can't make basic decisions about his life, even like when he eats lunch, there are many limited choices and it is really difficult for him. He is

a very capable, intelligent, articulate man and there are some things about being in the service that he feels stuck with and feels disempowered by, and it's challenging for a lot of people” Erica, L56.

Although working within a clinical team can be viewed as being supportive as discussed in theme 2.2, all of the participants also experienced feeling disempowered by the clinical team at times, especially by the members that hold a medical stance who are perceived as having the “*loudest and more authoritative voices*” (Erica, L40). However, it is also important to acknowledge that the Responsible Clinicians also have statutory responsibilities which may influence their position within the clinical team.

“we have clinical team meetings with the whole team every Tuesday morning where a lot of the decisions, not all the decisions are made. It's a chance to talk about different opinions but ultimately the decision lies with the psychiatrist” Rachel, L201.

In reference to Rachel's quote (L201), although the clinical team are present within the meetings and there is the opportunity to for the psychologist to voice her opinions, she is also aware that ultimately the psychiatrist is the empowered one, as the Responsible Clinician. This experience is shared amongst all of the participants and it had evoked feelings of frustration.

The sense of the participants' frustration was shared within the analytic process as all of the participants voiced their experiences of service users being coerced by the clinical team to attend psychological therapy. More often than not, the participants described how service users would openly state that they had been made to attend therapy and/or the service users' body language would illustrate that they were passively engaging. This is demonstrated in Rachel's (L295) quote below.

“Usually people will tell you in the group that they have been made to come here and they don’t want to be there. In my experience, I suppose you might have some people who passively experience the group but don’t really engage in it” Rachel, L295.

All of the participants expressed that this act of coercion made it challenging for them to develop a therapeutic rapport, however, there have been some occasions whereby this passive engagement has transformed into a *“more meaningful therapeutic endeavour”* (Phoebe, L145).

“and at the moment he is exercising the control he has got, the last session he walked out which is unusual for him and for me that makes sense in the formulation. It is one of the few things he has got control over is whether or not he engages at all” Erica, L69.

The impact of service users feeling disempowered also influences their engagement with the psychologist. In Erica’s quote (L69) the service user terminates the session by leaving the session before it had finished, demonstrating and exercising that he still has some choice and control.

3:2: Psychologist as an Empowerer

This sub-ordinate theme encapsulates the Psychologists’ role as an empowerer, empowering the service user and themselves within a system characterised by disempowerment.

All of the participants discussed how they had taken on an advocacy role for the service users as they advocated to the clinical team that service users should not be coerced into psychological therapy, quote by Emma (L144) is an example of this:

“sometimes that can be communicated that they have no choice not to engage but I guess I am an advocate” Emma, L144.

The participants also related to their difficulties of working with the Mental Health Act which detains service users for treatment and working to their professional guidelines which thinks about the role of consent to engage in treatment.

“But it can be really tough, some team members just don’t get it, and I think it’s because most people are just happy to abide by the criteria of the Mental Health Act that people have to have treatment, they are detained specifically for purposes of treatment and risk but then the psychologist has to hold the BPS and HCPC guidelines in terms of people have to consent and have to be willing to engage in treatment. It is a very difficult line I find to have to balance the team are getting used to it [laughs]. I think it’s about being clear and consistent, that this isn’t me just being difficult or unhelpful by saying I don’t want to see a patient, it’s about saying they are good reasons why this patient is not undergoing psychological therapy at the moment.” Monica, L164.

Although Monica (L164) has found it difficult to balance the different approaches between the Mental Health Act and British Psychological Society (BPS) ethical guidelines, she has also placed herself within an empowered position by explaining to the clinical team her decision and being assertive with the team to stand by her professional decision. A further assertive stance which places the psychologist in an empowering position is shown in the quote below by Monica (L188).

“I’ve had to say to the clinical team stop saying this, just lay off, stop saying its psychology work, you need to help him understand the areas that he needs to address and they don’t necessarily have to be addressed by me” Monica, L188.

The linguistics within the quote (Monica, L188) allows the audience to feel the participant’s frustration with her clinical team. The repetitive use of ‘stop’ enhances this and places her in the position of wanting to assert some control as she is taking control over the way the clinical team communicates about psychology within the service users’ treatment pathway.

The act of giving choice to the service users to engage in psychological therapy was a way the participants were able to empower the service users, and was evident in all of the participants' narratives and demonstrated in Emma's (L93) script below.

"I felt that it was a good way just to make that initial contact with her and highlight to her that actually I am on her side, I am not here to make her do this scary horrible trauma work if she is not ready to do that" Emma, L93.

The quote by Emma (L93) also highlights that the psychologist can take the same position as the service user, which was also highlighted and discussed within the first super-ordinate theme as the psychologist demonstrated that they are on an equal playing field with the service user, and as a result this can minimise the power dynamic within the therapeutic relationship.

A therapeutic relationship that contains a collaborative working alliance and future orientated aspects is also a factor which can empower the service user. The service user is also able to contribute to and maneuver their psychological treatment pathway with the assistance of their psychologist. All six participants placed value on developing a collaborative relationship which was future orientated and goal directed based on the service users needs.

"But I also think it is really important to start to think about goals and what people would like to do different, and offering them the opportunity to think about the things could be different in the future. And maybe that's quite a good way to engage people, so it's just not about talking about their past and their difficulties, its thinking about how things can be different in the future" Rachel, L268.

The facilitation of a discussion that is primarily based around the service user and their future felt like an empowering process to be in, Rachel's (L268) quote illustrates that she was

giving the service users the chance to think about themselves in this way and demonstrating that she would be present to aid the process.

Working collaboratively with specific areas such as risk can also progress to be an empowering process for service users. A majority of the participants reflected on their positive experiences of using the Structured Assessment of Protective Factors for violence risk (SAPROF, De Vogel, De Vries Robbé, De Ruiter & Bouman, 2011), a new risk assessment tool with service users, due to its focus on examining the service users' protective factors. Developing the service users' knowledge into their protective and risk factors also gives them the choice and hope to take control of their own risk factors and develop therapeutic goals. Rachel's (L237) and Janice's (L132) quote exemplifies this.

“If you are not doing this [risk assessment] collaboratively with the service user, if they aren't aware of their risks, then they have not got NO agency or control over their risks” Rachel, L237.

“I've used risk assessments to come up with therapeutic goals” Janice, L132.

In summary, although the psychologist and the service user are within a potentially disempowering system, the participants' experiential claims highlight that they are determined to try and empower, and advocate for, the service users and themselves by using the resources they have; their training; psychological tools; professional guidelines; and finally their innate personality.

DISCUSSION

In summary, the participants in this study described experiences of relating to service users at a humanistic level and they also discussed their experiences of feeling contained and being a facilitator of containment within a MSU. The narratives also captured the participants' experiential claims of service users and themselves feeling disempowered by the wider agencies, the environment and the clinical team, but also the psychologists being facilitators of empowerment through collaboration with service users and the clinical team, being an advocate, and through sheer determination and resilience.

The Therapeutic Relationship in the Eyes of the Attachment Model

The experiences and concerns regarding attunement and containment were coherent with the theoretical underpinnings of the attachment model (Bowlby, 1988). The participants' described their role within the therapeutic alliance as being emotionally available and providing a consistent secure base from which they can collaboratively explore the service users' inner and outer worlds (Bowlby, 1988). The participants' experiential claims of this were predominately based around being able to attune with the service users as human beings and have an understanding of the person beyond their diagnosis and offending history. This process was aided by the psychologists' innate personality, such as being able to be open, warm, and resilient. The participants also provided a consistent secure base for their service users, as they continued to keep a presence regardless of any ruptures within their therapeutic relationship may have promoted a sense of felt security within the relationship (Meyer & Pilkonis, 2005).

The narratives describing the experiences of the participants facilitating containment are similar to the unconscious maternal containment functions described by Bion (1984).

This is defined as the therapist being able to help the service user, during psychological therapy, to develop their capacity to tolerate distress. This process is facilitated through the psychologist's mental process as they are able to hold and digest the internal projections from the service user and as a result the service user makes sense of this experience of feeling understood and soothed. Consciously, the participants described how the process of being boundaried, consistent, and available in their approach also aided the felt sense of containment (Adshead, 1998).

The participant's experiences of feeling contained were predominately based on their interactions with their supervisors, clinical team, and the environment. The participants expressed that the continuous support of their supervisors and/or colleagues being available to provide advice and reassurance contained their anxieties around the service users and their engagement in psychological therapies.

The Facilitation of Recovery

At an interpretive level, the participants' sense making of their style of engagement was intertwined in the central tenets of the recovery model (Roberts, Davenport, Holloway & Tattan, 2006). The psychologists' placed a value on working collaboratively with the service users to develop and work towards their meaningful and relevant goals, which also empowered the service users to take active control and responsibility over their recovery and lives (Shepherd, Boardman & Slade, 2008). In addition, the participants' experiences of working in an disempowering system, characterised by coercion, led to psychologists being 'advocates' for service users and in doing so promoted choice and rights for service users.

The experiences of the participants collaboratively working with risk, for example, by adopting the SAPROF demonstrates the psychologists willingness to work with service users

to explore and develop their inner resources and understanding into their protective and risk factors. This can instil hope within the service user that they can take control of their own risk factors to aid the development of a meaningful life (Ramon, Healy & Renouf, 2007). The utilisation of the SAPROF risk assessment also allows the shift from the psychologist being seen as an expert to them becoming a partner that joins the service user on their journey of discovery and recovery.

Strengths & Limitations of the Study

The study benefits from being a part of a wider research project as this enabled the researcher to access peer support and peer researchers to assist with credibility checking. Validity checking of the findings was carried out in order to minimise potential biases during the analysis, as the researcher was aware that their own experiences and interests in working within a forensic service might have influenced the data.

The findings of the study were based on experiential claims of six female psychologists working within a MSU within one NHS Foundation Trust and therefore the results cannot be generalised to the wider population of psychologists working within a MSU. It is also important to note that male psychologists working with male service users may also have different experiences of working with service users therefore their sense making of engagement in a MSU maybe somewhat different to the participants experiences.

The psychologists' self-selected to participate in the research project, therefore volunteer bias could have been present (Heiman, 2002). The participants also had a thorough understanding of psychological literature and theories therefore it is likely that they were drawing upon and relating to their experiences in relation to the literature and theoretical models instead of attempting to express their actual experiences and sense making of their engagement with service users.

SUMMARY

In summary, the research identified that psychologists made sense of their engagement with service users as being characterised by a humanistic relationship whereby they try to feel attuned to the service user, in order to relate to them as human beings, thereby facilitating a secure and safe attachment. The participants also identified possible factors that may act as barriers to feeling attuned and maintaining the therapeutic humanistic relationship. The narratives also explored their experiences of feeling contained and their role as a container for service users. The psychologists strive to consistently be present, regardless of the difficulties the service user brings, and provide a safe space for service users to explore their inner and outer world with guidance and support.

The final subordinate theme identified that techniques such as collaborative working and giving choice can empower the service users to feel in more active control over their recovery. The psychologist taking an advocate stance and guiding the clinical team also enables them also feel a sense of empowerment within a potentially disempowering system.

CLINICAL AND RESEARCH RECOMMENDATIONS

The recommendations that have arisen from this study are placed within current literature, policies, guidelines, and the methodological limitations of the study and they are centered on how services and psychologists can aid service users' engagement in psychological therapies, within medium secure services.

Opportunities to inform psychologists of the importance of working humanistically, how this can be achieved (i.e. how to be open and transparent), and the importance of reflection upon their own barriers to attunement with service users could be explicitly implemented into the clinical and forensic doctorate training programmes. Consequently, it would also allow future psychologists to understand and value the importance of working collaboratively, and in a future and recovery-orientated way with service users.

The selection process psychologists go through, for example, to gain a place on clinical/forensic psychology training or to gain a position to work within a MSU, could also be an opportunity for selectors to identify whether the potential candidates have the requisite ability, determination, and resilience for the kind of clinical work described in this study. In addition, these personality characteristics would also aid the psychologists' confidence and ability to be a voice for the service users and themselves when they are faced with disempowering situations. It is also recommended that these factors are considered during clinical supervision in order to support and contain the psychologist with this way of working.

The recovery model and the participants' experiences both focus upon working collaboratively with the service users and empowering them to take active control in their recovery. Therefore, it is important that the clinician thinks about the psychological approach and style of therapy they are going to use with service users. For example, Cognitive Behavioural Therapy (CBT, Garrett & Lerman, 2007), Dialectical Behaviour Therapy (DBT,

McCann, Ball, & Ivanoff, 2000) or Acceptance and Commitment Therapy (ACT, Luoma, 2007) may be preferred as these models place an emphasis on working collaboratively, and in a future-orientated manner. They also emphasise recovery-consistent ideas and values, such as self and other acceptance, choice, self-determinism, and service user empowerment. Such models support identifying where the service user is currently at, and how progression can be made with the psychologist and the wider service acting as a support network during their journey.

In addition, the empowerment of service users to actively take control of their recovery can be aided by the clinical team and the wider system, who can support and guide them to contemplate engaging in psychological therapies by offering the relevant information and supporting the psychologist. The participants' narrative described how coercing service users to engage in psychological therapy can actually become a barrier as they may make a conscious decision not to attend sessions in order to exercise the control they are left with. Reviews of the manner of delivery of care planning meetings and ward reviews may enable reflection on whether any changes can be made that would encourage the service user to be able to take control over their recovery programme and feel empowered.

A limitation with this type of study is that whilst the researcher is able to describe changes that might intuitively be seen as making a difference to engagement, they cannot currently be supported at a quantitative level. Therefore, further research is required in order to measure the effectiveness of any recovery-orientated change within particular areas of interest, such as motivation, readiness, and successful discharge/recidivism rates once changes in the identified areas (i.e. empowerment and collaboration) are implemented.

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PUBLIC DOMAIN PAPER

**WORKING PSYCHOLOGICALLY WITH SERVICE USERS WITHIN INPATIENT
SERVICES**

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OVERVIEW

The research detailed below was submitted as partial fulfilment for the degree of Doctorate in Clinical Psychology. The first part represents a literature review, in which the author questioned whether the evidence supports the use of psychodynamic therapy in inpatient services for individuals diagnosed with a personality disorder. The second part of the research project was a study that explored psychologists' experiences of working with service users in a medium secure unit. The purpose of this paper is to provide the reader with a brief summary and key findings from the research projects.

PART I: LITERATURE REVIEW: Does the existing evidence support the use of psychodynamic therapy in inpatient services for individuals diagnosed with a personality disorder?

Background: There are many expressed views about whether individuals with a personality disorder are 'treatment resistant', and if they are deemed as treatable, whether they require psychodynamic therapy. The literature exploring the effectiveness of psychodynamic therapy is limited. Therefore, it is clear that there is a need to evaluate the current literature to examine the effectiveness of inpatient psychodynamic treatment for individuals diagnosed with a personality disorder.

Aims: This review aimed to undertake a systematic search of the literature using a variety of search terms that were relevant. The literature was reviewed using a more objective and critical stance in order to examine whether psychodynamic therapy is an effective therapy to treat individuals with a personality disorder in an inpatient service. A number of factors were explored in order to assess effectiveness.

Method: The electronic databases of PSYCINFO, SCOPUS, and WEB OF KNOWLDEGE were used to conduct a systemic search of the literature. A review of the reference lists was also carried out.

Results: Following the implementation of an exclusion criterion, a total of seventeen relevant articles were found and quality reviewed using the standardised tool, 'Effective Public Health Practice Project Quality Assessment Tool for Quantitative Studies' (Thomas, 1998).

Main Findings: The review highlighted favourable outcomes in psychiatric symptomology, interpersonal functioning, social and occupational functional impairment, self-harm, and levels of service utilisation for service users that have engaged in an inpatient psychodynamically orientated interventions. The review also found that the studies had reported that inpatient treatment appeared to be effective for treating individuals with a personality disorder. Particular models of care that had shorter inpatient stays may have assisted with helping the service user and caregivers to stay motivated and focused on the treatment programme offered. As a result, this may create a more positive environment to facilitate positive outcomes.

Conclusions: Based on the literature reviewed, it is apparent that there is evidence to support the use of psychodynamic therapy for inpatient service users diagnosed with personality disorders. However, a firm conclusion cannot be made as there was considerable methodological variance in the studies (e.g. the type of personality disorder, the delivery and content of the treatment programme, clinical setting, and measures utilised to evaluate the intervention). Therefore the review has categorised the variables that have been evaluated to assess the effectiveness and efficacy of psychodynamic based treatment for individuals with a personality disorder in an inpatient service.

The methodological variations, such as the variations between the delivery and content of psychodynamic treatment, and the participant's clinical diagnosis, are highlighted as limitations, as they are barriers to being able to make firm conclusions. A number of recommendations have been made for future research. These include establishing a cost-benefit analysis to demonstrate whether or not there was a financial advantage in providing specialist psychodynamic interventions over other forms of treatment, and to focus on establishing robust outcome measures of psychodynamic treatment for service users with a personality disorder.

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PART II: RESEARCH STUDY

INTRODUCTION

Background: Literature has suggested that therapeutic engagement is considered an important construct to assess, as premature termination of therapy can influence clinical outcome and increase the chances of services becoming cost ineffective (McMurrana, Huband & Overton, 2010). This study aimed to explore how do psychologists make sense of, and understand, engagement with service users in a Medium Secure Unit (MSU).

METHOD

Study Design: A semi-structured interview was conducted with each participant and the transcripts were subjected to Interpretative Phenomenological Analysis (IPA; Smith, Flowers, & Larkin, 2009). IPA was selected because it allows a greater understanding of the participants' subjective experiences and enables us to their sense making of engagement.

Ethical Approval: The University of Birmingham granted ethical approval and the research and development team within the relevant NHS Foundation Trust approved access.

Participants: The self-selecting participant sample used in the research consisted of six psychologists that varied in level of experiences. All the participants worked within a MSU in the National Healthcare Service.

Procedure: The potential participants were informed of the research at psychology team meetings and the information sheet was cascaded to provide further details. Potential participants were given a minimum of twenty-four hours to consider taking part. The researcher then made contact with the participant to offer additional information, provide the information sheet, and consent to arrange the subsequent interview. Signed consent and

demographic information were obtained at the point of interview. Due to the nature of the recruitment, it is possible that bias may have occurred as the participants may have had particular reasons why they wished to participate in the study.

Credibility: Reflective supervision was attended on a regular basis throughout the process in order to facilitate reflection on personal assumptions, goals, individual beliefs, and subjectivities. In order to further minimise bias, the stages of analysis were discussed in a research team of doctoral students and with an experienced supervisor.

RESULTS

Three super-ordinate phenomenological themes emerged from the data with sub-ordinate themes: ‘Being Human Together’, ‘the matryoshka doll of containment’ and ‘the psychologist as an empowerer in a disempowering system’.

‘Being Human Together’ represented the psychologists’ sense making of their engagement with service users as having a humanistic relationship whereby they relate to, and interact with, service users as human beings and in a wider context than simply using the service. The participants also identified factors, such as having to maintain professional boundaries and the secure environment may act as barriers to forming and maintaining the therapeutic humanistic relationship.

The second super-ordinate theme has been named ‘The Matryoshka Doll of Containment’ because the outer layers of the matryoshka doll represent the larger systems of containment such as the environment, the inner layers represent the clinical team and supervisory relationship, and the smallest, innermost doll resembles the psychologists’ and service users’ humanistic, therapeutic bond being containing.

The participants also explored their experiences of feeling contained and their role as a container for service users, as the psychologists had an ability to consistently be present, regardless of the difficulties of the service user, and to provide a safe space for service users to explore their inner and outer world with guidance and support.

The final super-ordinate theme identified that techniques such as collaborative working and giving choice can empower the service users to feel in control and take active control over their recovery. The psychologist also taking an advocate stance and guiding the clinical team enables them also feel a sense of empowerment within a system that is inherently disempowering.

CONCLUSIONS & RECOMMENDATIONS

In summary, the research identified how psychologists make sense of and understand their engagement with service users in an MSU. The recommendations that arose were considered within the literature of attachment theory (Bowlby, 1988), the recovery model (Shepherd, Boardman & Slade, 2008), and the methodological limitations of the study. They were also centred around how services and psychologists can aid service users' engagement in psychological therapies, within a MSU.

The clinical and forensic doctorate training programme can be utilised as an opportunity to inform psychologists of the importance of working humanistically, how this can be achieved (i.e. how to be open and transparent), and guiding them to be able to reflect upon their own barriers to relating to service users at a humanistic level. This would also allow future psychologists to understand and value the importance of working collaboratively and in a future orientated manner. In addition, the ability to empower service users to actively take control of their recovery can be aided by the clinical team and the wider system supporting and guiding the service users to contemplate engaging in psychological therapies

by offering the relevant information, and by supporting the psychologist. The interviews described how coercing service users to engage in psychological therapy can actually become a barrier as they may decide not to attend sessions in order to exercise the control they are left with. Therefore, the delivery of care planning meetings and ward reviews may also be reviewed in order to reflect upon whether any changes can be made which would encourage the service user to be able to take control over their recovery programme and feel empowered.

A limitation with this type of study is that whilst the researcher is able to express the view that these changes would make a difference to engagement, this cannot as yet be supported with quantitative data. Therefore, further research is required in order to quantitatively measure the particular areas of interest, such as motivation, readiness, and successful discharge rates, once changes in the recommended areas are implemented.

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APPENDICES: SYSTEMATIC LITERATURE REVIEW

Literature Review: “Does the existing evidence support the use of psychodynamic therapy for inpatient service users with a personality disorder?”

Appendix A: Search Process for Electronic Databases

Search Engine	Search term (in Article Title, Abstract, Keywords)	Results Yielded with limits (English language, all journals 2003-2013), all searcher terms combined with 'OR'	Searches Terms combined with 'AND'	Final Number of Articles (inclusion & exclusion criteria applied)
SCOPUS	Psychodynamic Psychodynamic therap* Psychotherap* Psychoanalytic therap Psychoanalytic* Transference focused psychotherap* Psychoanalysis	78,182 results	746 Articles	3 Articles
	Evidence base* Outcome* Empirically Empirically support* Effective* Efficacy Evidenc* Effect*	9,232,903 results		
	Detention W/2 (cent* OR camp* OR institut* OR facilit*) Correction* W/2 (cent* OR camp* OR institut* OR facilit* OR establishment OR service*) Secur* W/2 (unit OR service* OR facilit* OR Hospital* OR institut*) Inpatient* Forensic* Unit* Hospital* Insitut* HMP	2,792,567 results		

Personalit* disorder*	
Personalit* cluster*	
Cluster b	
Cluster c	
Cluster a	420,024 results
Borderline personalit* disorder*	
Antisocial personalit*disorder*	
Not specified personalit* disorder*	
antisocial* personalit*	
Paranoid personalit*	
Schizoid personalit*	
Schizotypal personalit*	
Histrionic personalit*	
Narcissistic personalit*	
Avoidant personalit*	
Dependent personalit*	
Obsessive compulsive personalit*	
Depressive personalit*	
Passive aggressive personalit*	
Sadistic personalit*	
Self defeating personalit*	

Search Engine	Search term in 'Topic' Field (Title, Abstract, Author, Keyword, Keywords Plus)	Results Yielded with limits	Searches Terms combined with 'AND'	Final Number of Articles (inclusion & exclusion criteria applied)
Web of Knowledge	Topic=(Inpatient*) OR Topic=(Secure*) OR Topic=(Forensic) OR Topic=(Forensic psychiatry) OR Topic=(Unit*) OR Topic=(Hospital*) OR Topic=(Insitut*) OR Topic=(Detention Near/2 (cent* or camp* or insitut* or facility*)) OR Topic=(Correction* NEAR/2 (cent* or camp* or institute* or facility* or establishment or service*)) OR Topic=(Secur* NEAR/2 (unit or service* or facility* or hospital* or insitut*)) OR Topic=(HMP) OR Topic=(Prision*)	877,571 results		
	Topic=("Personality disorder*") OR Topic=(Personalit* cluster*) OR Topic=(Cluster B) OR Topic=(cluster A) OR Topic=(Cluster C) OR Topic=("Borderline personality disorder*") OR Topic=("Antisocial personalit* disorder*") OR Topic=("Not specified personality disorder*") OR Topic=((Personalit* NEAR/2 antisocial or Paranoid or Schizoid or Schizotypal or Antisocial or Borderline or Histrionic or Narcissistic or Avoidant or Dependent or Obsessive compulsive or Depressive or Passive aggressive or Sadistic or Self defeating)) NOT Topic=(Depress*) NOT Topic=("Eating disorder*")	934,001 results	296 Articles	5 Articles
	Topic=(psychodynamic) OR Topic=(Psychodynamic therap*) OR Topic=(Psychotherap*) OR Topic=(Psychoanalytic therap*) OR Topic=(Psychoanalytic*) OR Topic=(Transference focused psychotherap*) OR Topic=(Psychoanalysis)	20,266 results		
	Topic=(Evidence base*) OR Topic=(Outcome*) OR Topic=(Empirically) OR Topic=(Empirically support*) OR Topic=(Efficacy) OR Topic=(effect*) OR Topic=(Evidenc*) Refined by: Document Types=(ARTICLE)	4,077,657 results		

Search Engine	Search term in 'Topic' Field (Title, Abstract, Author, Keyword, Keywords Plus)	Results Yielded with limits (English language, all journals 2003-2013), all searcher terms combined with 'OR'	Searches Terms combined with 'AND'	Final Number of Articles (inclusion & exclusion criteria applied)
PsycInfo (1987 to August Week 3 2013)	Psychodynamic, Psychodynamic therap*, Psychotherap*, Psychoanalytic therap*, Psychoanalytic*, Transference focused psychotherap*, Psychoanalysis	128,207 results	46 Articles	4 Articles
	Evidence base*, Outcome*, Empirically, Empirically support*, Effective*, Efficacy, Evidenc*, Effect*	354,068 results		
	Inpatient*, Secure*, forensic, forensic psychiatry, unit*, hospital*, Insitut*, Detention adj2 (cent* or camp* or insitut* or facility*), Correction* adj2 (cent* or camp* or institute* or facility* or establishment or service*). HMP, Secur* adj2 (unit or service* or facility* or hospital* or insitut*).	84,765 results		
	Personality disorder*, personalit* cluster*, cluster B, cluster C, cluster A, Borderline personality disorder*, Antisocial personality disorder*, Not specified personality disorder*, Personalit* adj2 (antisocial or Paranoid or Schizoid or Schizotypal or Antisocial or Borderline or Histrionic or Narcissistic or Avoidant or Dependent or Obsessive compulsive or Depressive or Passive-aggressive or Sadistic or Self-defeating)	19,889 results		

Appendix B: Summary Table of Studies Identified for Review

Author, Country & Aim	Methodology	Outcomes Assessed	Outcome/s	Methodological Strengths & Limitations
*Bartak et al (2010) Netherlands Compared the effectiveness of 5 treatment modalities for patients with cluster C diagnosis	<i>N</i> =96:Long term outpatient (>6months) <i>n</i> = 85 short term day hospital (up to 6 months) <i>n</i> =103 long term day hospital <i>n</i> =63 short-term inpatient <i>n</i> =101 long term inpatient None randomised Treatment based on individual or group sessions Effectiveness assessed 12 months after baseline	1. Brief symptom Inventory BSI 2. OQ45-social role: 3. Quality of life: EQ-5D 4. OQ-45 interpersonal relations	*12 months after baseline: all patients showed improvement in psychiatric symptoms *Improvements in psychosocial functioning & quality of life * Short Term inpatient group showed significantly more improvement in psychiatric symptoms & social role functioning *Improvement in interpersonal functioning was significantly higher in the short term inpatient group than short term day hospital *Quality of life improved significantly more in the short term inpatient group *Overall most improvements observed in short term inpatient	* Has clinical utility. * Rigorous statistical control of potential confounders * large number of participants * Follow up data points was not consistent due to logistic reasons * No control group * Missing follow up data in long term treatment groups * Bias in Short term groups as patients might have been still in therapy at 12 months after baseline <hr/> Future Recommendations * Replicate in order to gain longer term follow up data – after therapy is completed * Cost benefit analysis required

Author, Country & Aim	Methodology	Outcomes Assessed	Outcome/s	Methodological Strengths & Limitations
*Bartak et al (2011a) Netherlands Compared the effectiveness of 3 treatment modalities for cluster B PDs	n=207 n=46: Outpatient n= 81 Day hospital n=80 Inpatient None randomised Treatment based on individual or group sessions Effectiveness assessed 18 months after baseline March 2003-June 2008	*Brief symptom Inventory BSI (* Outcome questionnaire OQ45-social role: * Euroqol- EQ-5D- Health related quality of life	* 18 months after baseline patients in all 3 settings improved in terms of psychiatric symptoms * Improvements in psychosocial functioning & quality of life * Small differences in improvement of psychiatric symptoms between outpatient and day hospital treatment * Small differences in improvement of psychiatric symptoms between day hospital & inpatient treatment	* Clinical utility * Rigorous statistical control of potential confounders * large number of participants * Follow up data points was not consistent due to logistic reasons * No control group * Majority of patients had diagnosis of Borderline PD Future Recommendations * Future research should focus on the ‘ideal dosage’ of treatment for patients with PD * Inpatient therapy should still be considered as a valuable option for patients with cluster B PD.
Author, Country & Aim	Methodology	Outcomes Assessed	Outcome/s	Methodological Strengths & Limitations
*Bartak et al (2011b) Netherlands Compared the effectiveness of 3 treatment modalities for cluster A personality	n=57 70.2% female n=20: Outpatient n= 19 Day hospital n=18 Inpatient March 2003-June 2008	<i>Outcome Measures</i> *Brief symptom Inventory BSI * Outcome questionnaire OQ45-social role: * Euroqol- EQ-5D- Health related quality of life	* Day hospital & inpatient showed larger improvements than patients in outpatients * Day hospital & inpatient showed significant improvements after 18 months in terms of psychiatric symptoms. * Significant improvements from day hospital & inpatient for social & interpersonal functioning &	* Clinical utility. Conducted in regular clinical practice * Substantial baseline differences * Higher treatment gains cannot be attributed to a certain treatment due to confounding variables * Majority had a diagnosis of paranoid PD, results mainly applicable to this diagnostic group

disorders			quality of life.	Future Recommendations * Intensive treatment such as day hospital & inpatient may be the treatment choice for cluster A PD.
Author, Country & Aim	Methodology	Outcomes Assessed & Measures Used	Outcome/s	Methodological Strengths & Limitations
*Bateman & Fonagy (1999) UK	RCT Treatment group: Partial hospitalisation Control group: general psychiatric services Total: n=38 Control group: n19 Treatment group :n19 Individual & group psychoanalytic psychotherapy for maximum of 18 months	1. Frequency of acts of self harm: 2. Suicide attempts 3. Number of inpatient admissions 4. Duration of inpatient admission 5. Use of Psychotropic Medication 6. Depression: BDI 7. Anxiety: BAI & STAXI 8. SCL-90R 9. Interpersonal functioning: Social adjustment scale & Inventory of interpersonal problems 10. Social adjustment : Social adjustment scale & Inventory of interpersonal problems	* Self-harm: Treatment group: Decreased over the course of treatment Control group: reduced but was not significant * Suicide: Treatment Group: Clear reduction from 94.7% on admission to 5.3% at 18 months Control group: No significant difference *Anxiety: Treatment Group: Decreased substantially Control group: remained unchanged * Depression: Treatment Group: Significantly decreased after 9 months * Symptom distress: Treatment group by time significant at 12 & 18 months Interaction between group & time on the positive symptom was not significant. * Significantly lower for treatment group than the control group at 18 months.	* Did not take into account the cost effectiveness between each group * Did not use the minimization method of random assignment * small sample size * Relied heavily on self-reporting measures * Measures symptoms at 3 monthly intervals * Low dropout rate (12%) * Standardised outcome measures used * Method allows for replication Future Recommendations * Multi-component programme is necessary * Essential features are theoretically coherent treatment approach, relationship focus, consistent application over a period of time * Partial hospitalisation seems a promising, possibly cheaper alternative to specialist inpatient &

Author, Country & Aim	Methodology	Outcomes Assessed	Outcome/s	Methodological Strengths & Limitations
*Bateman & Fonagy (2001) UK 18 month follow up from Bateman & Fonagy (1999) study	n= 44 A follow up programme was offered to the treatment group (group analytic therapy) twice a week – group attendance 75% Control group continued to receive general psychiatric treatment	1. Frequency of acts of self harm: semi structured interview 2. Suicide attempts: semi structured interview 3. Service utilisation 4. Use of Psychotropic Medication 5. Depression: BDI 6. Anxiety: BAI & STAXI 7. SCL-90R 8. Interpersonal functioning: Social adjustment scale & Inventory of interpersonal problems 9. Social adjustment : Social adjustment scale & Inventory of interpersonal problems	- Reduction in the frequency & duration of hospital admissions occurred in the last 6 months of treatment Clinical gains made during treatment were maintained and additional improvements were made. Decline in symptom distress, absence of major clinical problems, low admission rates, minimal acts of self harm through follow up period suggests that the treatment group developed the psychological ability to cope with normal stresses and strains of everyday life.	general psychiatric treatment for BPDs. * Small sample size * Loss of self-report data at some points * No treatment integrity measure, not able to identify the active ingredients of the treatment *Treatment differences may be related to staff experiences with BPD patients, enthusiasm of treatment team. * staff time may be a factor, however the control group received considerably more staff time during follow up than the treatment group. * Group attendance 75% which indicates stability of the cohort
				Future Recommendations *Establish if attendance at partial hospitalisation is necessary for the effective delivery of psychotherapeutic interventions. * Possible that psychotherapeutic intervention would be equally

effective if it had been delivered in a modified form in an outpatient setting.

Author, Country & Aim	Methodology	Outcomes Assessed	Outcome/s	Methodological Strengths & Limitations
*Bateman & Fonagy (2008) UK Follow up 8 years after random assignment, 5 years after they had finished treatment in original study- Bateman & Fonagy (1999)	n=41 participants in control & treatment group in Bateman & Fonagy (1999) study	Number of suicide attempts over 5 years post discharge <ul style="list-style-type: none"> • Service utilisation • Medication use • Use of psychological therapies • Symptom status: Zandarini rating scale • Global functioning: GAF • Medical & psychiatric records used to obtain data 	Article includes a detailed table of effect sizes Treatment group continued to do well 5 years after treatment. Beneficial effects are maintained for a long period of time. Differences found in suicide attempts, global functioning and symptom status at 5 years post discharge.	* Interviewed by a research psychologist who remained blind to the original study – limits researcher bias * 2 interviews were telephone interviews * Patient recall for self harm was unreliable & could not be independently confirmed from medical records, so was not reported. * Measure of suicide had an extremely skewed distribution, nonparametric mann-whitney test applied * Article includes 2 case examples * Some measures used in the original study were not used at this follow up
Author, Country & Aim	Methodology	Outcomes Assessed	Outcome/s	Methodological Strengths & Limitations
Chiesa, Drahorad & Longo (2000) UK Prospective outcome study to investigate early	n=134 Two stage model: 6 months in hospital followed by 18 months psychosocial outreach work	<i>Quantitative data collection</i> -DSM-III clinical interview - Symptom checklist-90 - Social adjustment scale - Global Assessment scale <i>Qualitative data collection</i>	<i>Quantitative data</i> * Significant difference between early drop-outs & those remaining in level of occupation, BPD status and treatment programme to which they were allocated to *-Those employed in a skilled	* Definition of drop out is given * Quantitative & qualitative data collection * The generalizability of the findings to a wider setting is limited. * Interviews only conducted with the drop-out sample, to obtain a more

drop-out variables in two treatment models for personality disorders	One stage model: 1 year hospital stay with no outpatient follow up January 1993-July 1997	18/43 participants were interviewed using semi structured interviews	manual, partly skilled or unskilled occupation were more likely to leave hospital in 14 weeks of admission than those in higher occupations * Participants allocated to the 2 stage model showed significantly lower early dropout rates <i>Qualitative data</i> 3 main categories: A: Institutional culture & structure B:Organisation of treatment C:Relationship with other patients	comprehensive picture a comparison could be made between the continuers and the drop-outs. Future Recommendations * Treatment model used maybe a possible explanation for early dropouts from treatment – A two phase model might be better to laden conflicts to do with termination and separation from treatment * Shorter in-patient stay and assured long term continuation of treatment in the community may be more tolerable
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Author, Country & Aim	Methodology	Outcomes Assessed	Outcome/s	Methodological Strengths & Limitations
Chiesa & Fonagy (2000) UK Compare the effectiveness of 2 treatment models for PD, results based on treatment effects only.	Non randomised n=90 one stage model n=46 two stage model n=44 Inpatient treatment: group & individual psychoanalytic psychotherapy, rehab model & medication 2 stage model: inpatient followed by outpatient step down: group psychoanalytic psychotherapy & additional	Multidimensional evaluation of functioning 48 socio-demographic & clinical variables were collected Structured clinical interview DSM-III Symptom check list (SCL-90) – GSI score Social Adjustment Scale	Mean scores on the GAS were significantly higher for the 2 stage model at 6 & 12 months SAS mean scores for the 2 stage model were significantly lower at 12 months One stage model: significant differences from baseline were only achieved by 12 months 2 stage model: significant differences achieved by 6 months	* Inter-rater reliability * Ethical concerns: patients denied treatment due to the geographical area they live in London *Under 5% did not complete outcome questionnaires either at 6 months or 12 months, missing data inputted using a maximum likelihood regression approach * Absence in follow up data prevents conclusions about the stability of the improvements * Period of inpatient stay on average in the one stage model was not much

psychosocial interventions	(SAS)	and 12 months	greater than the 2 stage model – study cannot test the specific value of inpatient treatment
January 1993-July 1997	Global Assessment Scale (GAS)		* Difficult to generalise results to other settings * Absence of a untreated control group * No agreement as to which measures are the best indicators of outcome in PDs

Author, Country & Aim	Methodology	Outcomes Assessed	Outcome/s	Methodological Strengths & Limitations
Chiesa, Fonagy, Holmes & Drahorad (2004) Compared the effectiveness of three treatment models for Personality Disorder	None randomised n=143 - 3 groups Inpatient treatment: group & individual psychoanalytic psychotherapy, rehab model & medication 2 stage model: inpatient followed by outpatient: group psychoanalytic psychotherapy & additional psychosocial interventions General psychiatric group: medication, supportive outpatient contact, hospital admissions when needed. No psychoanalytic therapy	<i>Psychiatric symptoms & social adaption</i> - Symptom checklist-90R (SCL-90) = GSI - Social adjustment scale (SAS) - Global Assessment scale (GAS) <i>Clinical Measure</i> * Structured interview modelled on the suicide & self-harm inventory * Number & length of psychiatric inpatient admissions * Psychiatric outpatient attendance over the past year	* Symptom severity & number of symptoms reported decreased significantly more sharply in the step down programme, * Significant improvement in the 3 groups over time * 53% in the step down group scored below the cut off point for symptom severity by 24 months compared with 14% (n=7) and 12% (n=6) in the inpatient & community groups – highly significant difference * Improvement in social adaption was evident in the inpatient & step down group * Step down patients achieved most marked improvements in global assessment * Self-harm had decreased	* None randomised, therefore issues of comparison between the groups is difficult. * Biases may be introduced when comparing groups that are referred from different geographical areas for the same kind of treatment * Patients referred for specialist treatment, could be argued that they were selected on the basis of their potential for responsiveness to such approach * Strict funding arrangements meant that only severe & chronically disturbed patients were funded for treatment at the specialist hospital * Unequal length of treatment between the 3 groups – intention to follow the natural course of treatment

Demographic & clinical characteristics outlined pg1465
- Cassel Hospital 1993-1997

markedly by 12 & 24 months in the step down whereas it increased at 12 months in the inpatient group
* Odds ratios – step down were three times less likely to self harm by 24 months while inpatients programme predicted a 1.5 increase in self harm
* In the year after expected discharge, step down patients were 4 times less likely to be re-admitted to psychiatric services
* Step down achieved a significant reduction in outpatient consultations from baseline.

Future Recommendations

* Providing a long term outpatients specialist psychosocial aftercare programme seems to protect patients from the anxieties connected with discharge
* Initial phase of hospital is based on a structured setting with multiple & intensive therapeutic input may be an important component for treatment for PDs
* Demonstrated that cost of specialist inpatient admission relative to that of treatment as usual reduces health & social care costs in the year after treatment termination.

Author, Country & Aim	Methodology	Outcomes Assessed	Outcome/s	Methodological Strengths & Limitations
Chiesa & Fonagy (2007) UK Prediction of outcome in the treatment of Cluster B Personality Disorders	n=73 <i>2 programmes:</i> a: long term inpatient – 12 months (Therapeutic community- non psychodynamic treatment) b: Step down programme 6 months inpatient followed by 2 years of psychotherapy & outreach nursing	* Structured interview modelled on the suicide & self-harm inventory * Number & length of psychiatric inpatient admissions * Psychiatric outpatient attendance over the past year Primary Outcomes: a. Severity of symptom presentation (GSI)	* 56.2% showed overall improvement (improved in at least one measure) * Rates of improvement in GSI & SAS were significantly for patients who had been treated in the step down model * Cluster B patients with no previous self-mutilation, no comorbid avoidant PD, with higher Gas intake scores, longer treatment exposure & younger age were more	* 41 demographic, diagnostic & clinical variables were tested for their association with outcome at 24 months follow up * Multimodal of psychological therapy in step down programme * Follow up for long term inpatient only at 24 months, as step down programme participants were still engaging in therapy * Small sample size for a regression analysis

		b. Social adjustment (SAS) c. Global assessment of functioning (GAS) - Symptom checklist-90R (SCL-90) - Social adjustment scale (SAS) -Global Assessment scale (GAS)	likely to improve * Long term inpatient model:24% improved in self-mutilation	Future Recommendations * Large sample of cluster B patients are required to ensure reliability of results and the ability to generalise results to the wider population
Author, Country & Aim	Methodology	Outcomes Assessed	Outcome/s	Methodological Strengths & Limitations
Gabbard et al (2000) USA Determine whether severe PDs improve or deteriorate with intensive inpatient treatment	Non randomised, naturalistic approach n=216 two treatment hospitals with similar treatment programs milieu orientated with a strong emphasis on group treatment and individual psychotherapy December 1986-1993	Semi structured interviews (face to face or telephone) were conducted on admission, within 2 weeks of discharge and one year after discharge Interviews based on Bellak's interview for the ego function scales. Specific questions added from the: - Brief Psychiatric rating scale (BPRS): psychiatric symptoms - Global Assessment Scale (GAS): level of functioning - Risk Scales: Risk	* GAS highly significant. Changes in GAS ratings from admission to discharge, discharge to follow up was highly significant * Significant change from admission to discharge for all 8 scales & additional change from discharge to follow up on all 8 scales * 2 risk scales were significant * Change from discharge to follow up was only significant for anxiety, & a trend toward significance for hostility	* Large sample size * Prospective approach allowed authors to make meaningful comparisons between the different stages & ratings * Follow up assessment was conducted at a fixed period * Mean number of prior hospitalization (range 0-35) indicates that the sample may have been 'treatment resistant' * Lack information regarding type of treatment patients received between discharge & follow up * None randomised study, cannot be certain that the improvements are a result of treatment.

Author, Country & Aim	Methodology	Outcomes Assessed	Outcome/s	Methodological Strengths & Limitations
*Luyten, Lowyck & Vermote (2010) Belgium Whether hospitalization based psycho-dynamic treatment is associated with changes in interpersonal problems – Investigates the role & nature of interpersonal problems	n=44 (<i>used same sample as Vermote et als (2010)</i>) *31 patients residential treatment *13 patients in day treatment Treatment: open-ended residential & day hospital – average stay 11.7 months Group psycho-dynamic, non verbal therapies, individual sessions May 2001 – July 2002	<i>Symptom Severity (GSS)</i> -Self harm Inventory -Symptom checklist-90 -Spielberger state trait anxiety inventory - Spielberger state trait anger inventory -Beck depression inventory <i>Interpersonal functioning/problems</i> -Inventory of interpersonal problems – circumplex (IIP)	Significant improvements in total interpersonal functioning (IPP total score) from baseline to end of treatment, continuing improvement from to 3 month follow up & small improvement from 3 month follow up to 12 month follow up. All types of interpersonal problems with the exception of problems in the intrusive domain were significantly correlated with the symptoms assessed by the GSS	*Follow up time scale is not at consistent intervals (3 months then 12 months) * 73% continued with some form of psychotherapy (psychoanalytically orientated) after discharge. – improvements in interpersonal problems might have been related to additional treatment * Small sample size * 2 Different treatment conditions * Treatment also includes attachment therapy, non-verbal * No control group Future Recommendations * Study to be replicated in larger samples
Author, Country & Aim	Methodology	Outcomes Assessed	Outcome/s	Methodological Strengths & Limitations
Spitzer et al (2012) Germany Examined the failures of inpatient psychodynamic therapy for service users with a personality disorder	n=1239 Group & individuals psychodynamic therapy	Symptomology – SCL-90-R & standard questions – measure service users views BSS – impairment severity – measure therapists views Examined therapists & service users views	* 18.7% of participants believed the treatment was a failure as there were no improvement in their symptoms. * SCL-90-R: 30.7% did not show any signs of improvement * Patients that did not benefit from treatment showed more suicidal tendencies in the run up to inpatient admission	* Standardised questions used the study but they were not reported to be reliable or valid * Large sample size * Used a similar methodological design as previous research * Examined a wide range of confounding variables

Future Recommendations

* future research should establish compulsory recommendations for the evaluation of psychodynamic therapy

Author, Country & Aim	Methodology	Outcomes Assessed	Outcome/s	Methodological Strengths & Limitations
<p>*Vermote et al (2009) Belgium Investigate the effectiveness of psychoanalytically inform hospitalization Identify outcome trajectories and their relation with pre-treatment characteristics</p>	<p>n=70 Length of stay 1.5months to 13 months (mean, 9.2months) Treatment: individual, group, nonverbal therapies, social work May 2001 – July 2002</p>	<p><i>Symptom Severity</i> (GSI score) -Self harm Inventory -Symptom checklist-90 -Spielberger state trait anxiety inventory - Spielberger state trait anger inventory -Beck depression inventory <i>Personality Functioning</i> -Structured clinical interview DSM-III -Inventory of interpersonal problems -Inventory of personality organization -Experience checklist – Trauma</p>	<p>* GSI- little improvement in the first 3 months, considerable improvement between 4-12months, followed by further and sustained improvement in the 12 month follow up. * For the whole sample, results showed little improvement in the first 3 months of treatment, but considerable & consistent improvement later in treatment as well as sustained improvement during follow up. Trajectories: 1. high initial symptom levels & considerable & consistent improvement late in treatment 2* medium initial symptom levels and a quick sustained response 3* medium initial symptom levels without substantial improvements 4. low initial symptom levels without substantial further improvement during and after</p>	<p>* Length of treatment varied for each participant * Majority of patients have cluster B PD – difficult to generalise results * 30% drop out rate *Co-morbidity of patients may have been underestimated because the SCID was not used * Did not include a control group</p>

treatment
 *= 2 largest groups of patients

Author, Country & Aim	Methodology	Outcomes Assessed	Outcome/s	Methodological Strengths & Limitations
*Vermote et al (2010) Belgium Examined the relationship between the psychotherapeutic process & outcome in patients who completed hospitalization based psychodynamic treatment for PDs	n=44 *31 patients residential treatment *13 patients in day treatment Treatment: open-ended residential & day hospital – average stay 11.7 months May 2001 – July 2002	<i>Symptom Severity (GSI)</i> -Self harm Inventory -Symptom checklist-90 -Spielberger state trait anxiety inventory - Spielberger state trait anger inventory -Beck depression inventory <i>Personality Functioning (GPS)</i> -Structured clinical interview DSM-III -Inventory of interpersonal problems (IPP) -Inventory of personality organization (IPO) -Object relations inventory	* Significant decrease in GSI score during treatment & follow up. Slope significantly steeper during treatment than follow up * Decrease in GPS during treatment & follow up, however the rate of change was not significantly different between treatment & follow-up * Significant increase in interpersonal relatedness during treatment but not at follow up * Significant increase in felt safety during treatment but not at follow up * Reflective functioning, no linear increase during treatment or follow up	* 73% continued with some form of psychotherapy (psychoanalytically orientated) after discharge. * Small sample size * Homogenous treatment settings & therapy * Co-morbidity with axis I & II disorders * No control group Future Recommendations Investigate whether high rates of psychotherapy after intensive treatment differs from pre-treatment psychotherapy seeking
Author, Country & Aim	Methodology	Outcomes Assessed	Outcome/s	Methodological Strengths & Limitations
*Vermote et al (2011) Belgium Assessing changes	n=44 70% inpatient 30% day treatment	<i>Personality Organization</i> - Developmental level of representations of self & Others - <i>DR-S</i> -Metallization – Reflective	* 2 clusters identified : A= fluctuating cluster B= Stable cluster * Scores on SCID higher for fluctuating cluster than for the	*longitudinal, multi-wave design * Naturalistic design * Inpatient & outpatient treatment utilised in study * Correlation nature does not allow

<p>in personality organization (PO)</p>	<p>May 2001 – July 2002</p>	<p>functioning scale (RFS) & GRID</p> <ul style="list-style-type: none"> - Levels of felt safety – Felt safety scale (FSS) <p><i>Symptom Severity</i></p> <ul style="list-style-type: none"> -Self harm Inventory -Symptom checklist-90 -Spielberger state trait anxiety inventory - Spielberger state trait anger inventory -Beck depression inventory <p><i>Personality Characteristics</i></p> <ul style="list-style-type: none"> - SCID-II disorders questionnaire - Inventory of personality organization (IPO) - Inventory of Interpersonal problems (IPP) 	<p>stable cluster</p> <ul style="list-style-type: none"> * Global Personality Score (GPS): - A significant decrease from the start of treatment to follow up - No significant main effect of cluster or interaction between time and cluster * Global symptom score (GSS): - A significant decrease from the start of treatment to follow up - Fluctuating cluster showed more symptoms at the start of treatment which decreased during therapy & reached the GSS level of the stable group at discharge - Stable cluster showed fewer symptoms at the start of treatment & decreased more slowly. -GSS tended to decrease further after discharge * Stable cluster showed less progress in felt safety between 3 & 6 months in treatment * Stable cluster seem to benefit most from the treatment offered 	<p>the authors to draw causal conclusions</p> <ul style="list-style-type: none"> * Measures based on self-reporting * Does not include measures of treatment technique, adherence, competence & fidelity which limits the knowledge of the impact of the actual use of principles, interventions & their impact on outcome <hr/> <p>Future Recommendations</p> <ul style="list-style-type: none"> * Findings suggest different types of patients may benefit from different types of ingredients of treatment * Important from the start of treatment to take pre-treatment personality characteristics into account * Future research using manualized treatment & assessment of treatment adherence is required
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Author, Country & Aim	Methodology	Outcomes Assessed	Outcome/s	Methodological Strengths & Limitations
Werbart, Forsstrom & Jeanneau (2102) Sweden	n=56 1994-2008	<i>Self reported measure</i> Symptom checklist-90 (SCL-90) – GSI score	* Outcome measures (GSI, SCOS, GAF, ISOS) changed significantly at end of treatment. * Between termination & follow up only SCOS showed a significant improvement	* Only self-referred & well motivated patients were accepted – selective sampling, limits generalisability * Study does not include a window for treatment process – measure effects during treatment, unable to study the mechanism of change
Examined the long term effectiveness of a psychodynamic therapeutic community for PDs	Treatment model: combined milieu therapy & long term psychodynamic psychotherapy- individual & group therapy Pharmacological treatment was used but minimal use – at discharge most were off regular medication	<i>Expert rated outcomes</i> Global Assessment of Functioning (GAF) Strauss Carpenter outcome scale (SCOS) – global outcome measure Intergration/sealing-over scale (ISOS) – recovery style	* At a group level, patients moved from high symptom severity (GSI) in the dysfunctional spectrum to functional spectrum at end of treatment & follow up * Mean functioning level improved at discharge, being in the range of outpatients.	* Heterogeneous diagnostic group, making it difficult to identify the beneficial ingredients in the treatment * Non-random assignment, no control group * Small sample size, too small for advanced statistics
				<hr/> Future Recommendations Combination of individual, group and milieu therapy needs to be studied in different settings.

Appendix C: Quality Review Table & Quality Assessment Tool

Component Ratings		Bartak et al (2010)	Bartak et al (2011a)	Bartak et al (2011b)	Bateman et al (1999)	Bateman & Fonagy (2001)	Bateman & Fonagy (2008)	Chiesa, Drahorad & Longo (2000)	Chiesa & Fonagy (2000)	Chiesa et al (2004)
Selection Bias	1. Representation of target population	2	2	2	1	1	1	2	2	2
	2. % of individuals agreed to participate	1	1	1	2	2	2	1	2	1
	Overall Component Rating	Moderate	Moderate	Moderate	Moderate	Moderate	Moderate	Moderate	Moderate	Moderate
Study Design	1. Design	5	5	5	1	1	1	5	6	5
	2. Randomised study?	No	No	No	Yes	Yes	Yes	No	No	No
	2.1. Method of randomization described	n/a	n/a	n/a	Yes	Yes	Yes	n/a	n/a	n/a
	2.2 Appropriate method?	n/a	n/a	n/a	Yes	Yes	Yes	n/a	n/a	n/a
	Overall Component Rating	Moderate	Moderate	Moderate	Strong	Strong	Strong	Moderate	Moderate	Moderate
Confounders	1. Differences between groups prior to intervention	1	1	1	1	1	1	1	1	1
	1.1. % of confounders controlled	4	4	4	4	4	4	4	4	4
	Overall Component Rating	Weak	Weak	Weak	Weak	Weak	Weak	Weak	Weak	Weak

Component Ratings		Bartak et al (2010)	Bartak et al (2011a)	Bartak et al (2011b)	Bateman et al (1999)	Bateman & Fonagy (2001)	Bateman & Fonagy (2008)	Chiesa, Drahorad & Longo (2000)	Chiesa & Fonagy (2000)	Chiesa et al (2004)
Blinding	1. Outcome assessors aware of the intervention/exposure status of participant	3	3	3	3	3	3	1	1	1
	2. Participants aware of research question	3	3	3	3	3	3	3	3	3
	Overall Component Rating	Moderate	Moderate	Moderate	Moderate	Moderate	Moderate	Weak	Weak	Weak
Data Collection Methods	1. Valid tools	1	1	1	1	1	1	1	1	1
	2. Data collection tools	1	1	1	1	1	1	1	1	1
	Overall Component Rating	Strong	Strong	Strong	Strong	Strong	Strong	Strong	Strong	Strong
Withdrawals & Drop-Outs	1. Reports of Withdrawals/drop-outs	1	1	1	1	1	1	1	1	1
	2. % of Completion	2	2	2	1	1	1	1	1	2
	Overall Component Rating	Moderate	Moderate	Moderate	Strong	Strong	Strong	Strong	Strong	Moderate
Global Rating		Moderate	Moderate	Moderate	Moderate	Moderate	Moderate	Weak	Weak	Weak

Component Ratings		Chiesa & Fonagy(2007)	Gabbard et al (2000)	Luyten, Lowyck & Vermote(2010)	Spitzer et al (2012)	Vermote et al (2009)	Vermote et al (2010)	Vermote et al (2011)	Werbart, Forsstrom & Jeanneau (2012)
Selection Bias	1. Representation of target population	2	2	1	2	2	2	2	2
	2. % of individuals agreed to participate	1	2	5	1	2	1	1	1
	Overall Component Rating	Moderate	Moderate	Moderate	Moderate	Moderate	Moderate	Moderate	Moderate
Study Design	1. Design	5	5	5	5	5	5	5	5
	2. Randomised study?	No	No	No	No	No	No	No	No
	2.1. Method of randomization described	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	2.2 Appropriate method?	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	Overall Component Rating	Moderate	Moderate	Moderate	Moderate	Moderate	Moderate	Moderate	Moderate
Confounders	1. Differences between groups prior to intervention	1	1	1	1	1	1	1	1
	1.1. % of confounders controlled	4	4	4	4	4	4	4	4
	Overall Component Rating	Weak	Weak	Weak	Weak	Weak	Weak	Weak	Weak

Component Ratings continued		Chiesa & Fonagy (2007)	Gabbard et al (2000)	Luyten, Lowyck & Vermote (2010)	Spitzer et al (2012)	Vermote et al (2009)	Vermote et al (2010)	Vermote et al (2011)	Werbart, Forsstrom & Jeanneau (2012)
Blinding	1. Outcome assessors aware of the intervention/exposure status of participant	1	1	1	1	1	1	1	1
	2. Participants aware of research question	3	3	3	3	3	3	3	3
	Overall Component Rating	Weak	Weak	Weak	Weak	Weak	Weak	Weak	Weak
Data Collection Methods	1. Valid tools	1	1	1	1	1	1	1	1
	2. Data collection tools	1	1	1	1	1	1	1	1
	Overall Component Rating	Strong	Strong	Strong	Strong	Strong	Strong	Strong	Strong
Withdrawals & Drop-Outs	1. Reports of Withdrawals/drop-outs	1	1	3	3	1	1	1	1
	2. % of Completion	1	1	4	4	1	2	2	1
	Overall Component Rating	Strong	Strong	Weak	Weak	Strong	Moderate	Moderate	Strong
Global Rating		Weak	Weak	Weak	Weak	Weak	Weak	Weak	Weak

APPENDICES: EMPIRICAL PAPER

“How do psychologists’ make sense of and understand their engagement with service users in a medium secure unit?”

APPENDIX A: INTERVIEW SCHEDULE

1. STUDY INTRODUCTION

- Brief outline of study, interview schedule
- Confidentiality, consent

2. INTRODUCTION

- Can you tell me how you came to work in a medium secure unit?
 - i. When did you start?
 - ii. What drew you to the position?
 - iii. What were your expectations?
 - iv. What's the best thing about working here?
 - v. What's the most challenging part of your job?

3. PSYCHOLOGISTS' EXPERIENCES OF ENGAGEMENT

- Can you tell me about the kinds of relationships you have with service users in this setting?
 - i. What facilitates a good therapeutic relationship?
 - ii. Are there any particular challenges that you would associate with working psychologically with service users in a medium secure unit?
 - iii. How do you manage those challenges?

- Could you talk about the process of engagement in this particular setting?
 - i. What characterises the first few sessions of therapy?
 - ii. What do you think promotes / doesn't promote engagement?
 - iii. How do you/your team work with engagement issues in psychological therapy? How does this impact engagement with psychological work? Do you do anything differently here compared to psychologists in other settings?
 - iv. How does the context of the secure unit deal with engagement issues? How does this impact engagement with psychological work? Can you say anything about issues of risk or coercion?

- Can you talk about any experiences you have had of clients wanting to disengage from psychological intervention?
 - i. Were there particular things that you did to help at this point? If so, what were they?
 - ii. Were there particular things about the team or the context that helped at this point? If so, what?
 - iii. Are there things that don't help in such a situation?

4. DEBRIEF

- Process of the interview
- Further details about the study
- Contact details for research team

Appendix B: Information Sheet: How do Psychologists' make sense of and understand their engagement with service users in a medium secure unit?

Participant Information Sheet

I am a Trainee Clinical Psychologist studying at University of Birmingham and I am facilitating a research project to explore engagement and delivery of psychological therapies in Medium Secure Units (MSU) by conducting semi-structured interviews with individuals working within the Psychology department. Before you decide whether or not to take part, it is important for you to understand why the study is being done and what it will involve. Please take time to read this information sheet carefully and discuss it with others if you wish. You can also contact me on the telephone number below if there is anything that is not clear or if you would like more information.

The purpose of this research

The aim of the research is to explore how Psychologists engage service users residing in a MSU in psychological therapies by using a qualitative method.

Why have I been invited to take part?

We are asking all individuals working within the Psychology departments to take part in the research project. This includes Assistant Psychologists, Trainees and qualified Psychologists. We require participants to have at least one years' experience of working with service users in secure setting and be currently working within a MSU. Overall, we are looking for 4 to 7 participants.

Do I have to take part?

No, it is entirely up to you whether you take part or not. If you do not to take part this will not affect your personal and professional position. If you do take part, you are still free to withdraw without giving a reason. However, after data analysis has commenced you will not be able to withdraw from the study. Data analysis is scheduled to take place approximately five months after interview.

What will happen to me if I take part?

If you do decide to take part in the study, you will first be asked to contact a member of the research team at least 24 hours after you have been informed of the study. A interview will be arranged at your base and interview date will be arranged around your availability. You will be asked to sign a consent form at the start of the interview to confirm that you are willing to take part. You will then be asked to complete a 60 to 90 minute semi-structured recorded interview in which you will be asked questions about your experiences of engaging clients in psychological therapies. The information from the interviews will be anonymised and analysed together.

Will my data be kept confidential?

Yes under normal circumstances, all the information collected as part of the research will be kept in a locked filing cabinet at the University of Birmingham. Any information from you or about you will have your name, address and any other identifying features removed so you cannot be recognised from it. This means that your anonymity will be preserved at all times during and after the research. The BSMHFT information government policies will also be adhered to.

However, any information that is disclosed that may cause harm to others or yourself will be reported to your supervisor as the research team have a duty of care to protect their participants and service users.

Richard Bennett and Louise Pearson will be the supervisors, they also have a clinical role within the MSUs, therefore to ensure participants are not identified, they will not have access to the raw data.

Will I receive expenses and payments?

Unfortunately, we cannot offer expenses or payments, however all interviews will be conducted during working time hours and at your base in order to minimise expenses.

What will happen to the results of the research study?

The results of the survey will be written up as a part of a thesis chapter and also presented to service users. I will also send those people taking part in the survey a written summary in the post. If you do not wish to receive this, you can let me know.

What happens if I have any further concerns?

You can contact Asha Patel, Trainee Clinical Psychologist, on XXX to discuss any concerns you may have, and alternatively, you can e-mail XX

If you would like to discuss any aspect of this research please contact:

Asha Patel - Tel: XX Email: XX

Richard Bennett - Tel: XX Email: XX

Post: The University of Birmingham, School of Psychology, Frankland Building, Edgbaston, B15 2TT: *Research Team*: Asha Patel (Principal), Richard Bennett and Louise Pearson

Thank you for your time

Appendix C: Consent Form

Project Title: How do Psychologists' make sense of and understand engagement with service users in a medium secure unit?

Medium Secure Unit you are working at:

Participant Identification Number (*completed by research team*).....

Preferred contact details: Telephone number:E-mail address:

Please initial box

1. I confirm that I have understood the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time during the research interview, without giving any reason and without it having an effect on my professional and/or personal roles.

3. I understand that the research interview will be audio-recorded

4. I understand that following the research interview I will have a five month period for reflection and the right to withdraw from the study before data analysis commences, without giving any reason and without it having an effect on my professional and/or personal roles.

5. I understand that the data collected during this study will be looked at by the chief investigator and relevant others at the University of Birmingham to ensure that the analysis is a fair and reasonable representation of the data. Parts of the data may also be made available to my supervisor and/or line manager if the research team are concerned that I have disclosed information that relates to malpractice and unethical conduct (BPS Ethical Guidelines).

6. I understand that direct quotes from my interview may be published in any write-up of the data, but that my name will not be attributed to any such quotes and that I will not be identifiable by my comments

7. I agree to take part in the above study.

.....

.....

.....

Name of participant

Date

Signature

Please return the form to: Asha Patel, Post: The University of Birmingham, School of Psychology, Frankland Building, Edgbaston, B15 2TT

Appendix D: Debrief Contact Form

Thank you for participating in the study, if you wish to make contact with a member of the research team please do not hesitate.

Asha Patel (Chief Investigator)

Email: XX

Post: The University of Birmingham, School of Psychology, Frankland Building,
Edgbaston, B15 2TT

Dr Richard Bennett (Academic Supervisor)

Email: XX

Post: The University of Birmingham, School of Psychology, Frankland Building,
Edgbaston, B15 2TT

Dr Louise Pearson (Clinical Supervisor)

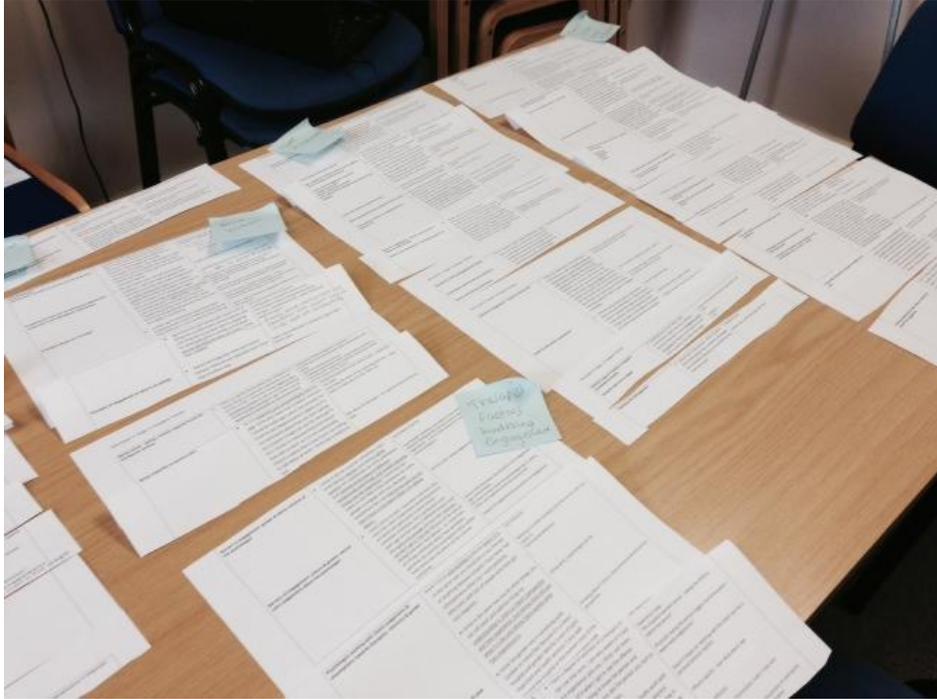
Email: XX

Appendix F: Data Analysis – Stages 1 and 2: Janice

<p>About being transparent, don't really have an agenda, being transparent if you do have a certain purpose is helpful. About being human with the level of self disclosure.</p> <p>Important to think about how much you self disclose you give in forensic services, it's really helpful to build a relationship, this is being human.</p> <p>Talk about own experiences like watching a film, I have felt paranoid. Normalising speech can be helpful.</p> <p>Have to maintain boundaries & it's a fine line. Know how much you can disclose & at what point is</p>	<p>R: well I think it is about <i>being transparent</i> with people in terms of you know, you don't really have a agenda, but if you're going to speak to someone about a certain purpose, you be transparent with them, that's <i>always helpful</i>, about the reason why you have come to see them, and that kind of thing, but also <i>being human</i> in terms of the level of self disclosure, and I think that is a <i>important thing to think about with me</i>, especially in forensic services, about how much self disclosure do you give because I <i>think some is really helpful to build a relationship</i> with someone, <i>being human</i>. Like talk about your own experiences, like oh I watched a film at the weekend, you know it could be at that level, errm or you could say 'sometimes I have felt paranoid', you know <i>normalising speech</i>, I think it can be quite helpful in that respect to show some self-disclosure, but I think obviously you have to <i>maintain your boundaries</i> as well, I think, I think it's about a <i>fine line</i> actually, but I think it is <i>an important line to have in your head</i> about at what point do I be careful about what I am disclosing about myself, at what point is inappropriate and at what point am I trying to be human and trying to build a relationship. <i>I think that was a part of the process before I started clinical, I was able to do that, find that balance</i></p>	<p><u>Object of concern:</u></p> <p>Being transparent</p> <p><u>Experiential Claim</u></p> <ul style="list-style-type: none"> • 66- <i>always (definite) helpful,</i> • (It's about '<i>being</i>' those things as a therapist) • (Procedural language on the process of being transparent- how to do it) Lines 63-67 <p><u>Object of concern:</u></p> <p>self-disclosure</p> <p><u>Experiential Claim</u></p> <ul style="list-style-type: none"> • (Importance of self-disclosure, something she can relate to? Experienced positive results?) - <i>I think that is a important thing to think about with me</i> - <i>I think some (limit) is really helpful to build a relationship with</i> - (Used to normalise clients experiences/ demonstrate P.S. can emphasis/understand/ listening to the client?), <i>you know nominalising speech+</i> Lines 74-76 <p><u>Object of concern:</u></p> <p>Professional /formal considerations of being human</p> <p><u>Experiential Claim</u></p> <ul style="list-style-type: none"> • (Professional/clinical
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Stage 3: Emergent themes for Janice	Transcript Quotes	Exploratory comments
<p>Personal positive characteristics to aid engagement/ Facilitators of a good relationship</p> <p>Genuine</p> <p>Enthusiasm</p> <p>Resiliency</p> <p>Approachable</p> <p>Use humour</p> <p>Interested in the person</p> <p>Being warm</p> <p>- difficult to express 'how' to be warm</p>	<ul style="list-style-type: none"> • err [pause] • genuine with people. I always try to be honest with people about discussions that we have had • Enthusiasm as well, maybe it will change though I have only just become qualified, I feel quite enthusiastic at the moment about getting involved in things and if somebody doesn't want to engage with me I am probably willing to go down there the same time every other day or whatever • resiliency is a really big one actually the more I think about it because you are getting completely shouted at by people and feeling that you are getting <u>undermined</u> and all of those kinds of <u>horrible</u> things and yet going back and being resilient enough to take it and go back • about being approachable • be able to use humour appropriately • be able to show that you are interested in people, what they are talking about, a film they have watched or something you know, just being interested, I think that I am generally am, not trying to be a false self • But I think to engage someone initially it is probably about being warm as much as you can be • I like to think that I was quite warm and that helps • well how do you do that [pause] it is difficult isn't it. • I'm not sure, it is difficult to put into words isn't it 	<p>Difficulty with expressing/identifying her characteristics 'like to think' a good quality to have being transparent, open</p> <p>dynamic factor-dependent on circumstances</p> <p>'at that moment' – anticipating it will change</p> <p>consistent, determined, flexible</p> <p>nature of MSU, has the biggest emotional impact, takes strength and determination</p> <p>being there emotionally & physically for others</p> <p>Interested in the person themselves, not just their illness/offence</p> <p>a genuine interest</p> <p>Warmth attracts the client to engage, sense of containment, safety, someone they can seek help from, the more 'warmth' the better? thinking process</p> <p>it's hard to verbally express</p>

Stage 4 of Data Analysis



Appendix G: Supporting Quotes

Super-ordinate Theme 1: Being human together	
Sub-ordinate theme 1.1: Reciprocity- Being a-tuned	
Monica	<p>L263: And, I think it's about being as human as possible, erm sometimes I think therapists/psychologists try too hard to be perfect and right and to be good all of the time.</p> <p>277: So I suppose there's an element of my background and upbringing, you know if you are late or you do something you need to apologise for it. But also just letting them see that I am also just human, and therefore if things don't go right for them then it's because they are just human as well.</p>
Rachel	<p>L80: I think time actually, the time thing really helps you to start get to know somebody before do something really challenging. I don't think you can get straight in there in this service and hope for best. Whereas you can spend time with people and meet people to talk about their interests and their goals etc and slowly build that relationship up to build a therapeutic foundation to do some of the more challenging therapeutic work.</p> <p>L118: I guess the only individuals that I find it particularly difficult are perhaps the more psychopathic traits where I am not quite sure erm [pause] that what we are doing is genuine or helpful or if they are fully engaged in the process, but that is quite a challenge.</p>
Phoebe	<p>L26: Erm but also demonstrating an understanding and empathy towards the patient and trying to facilitate them telling their story rather than me just going from what I have heard from other people or going from what is written in the notes.</p> <p>L60: I guess issues around personality disorders, people who are quite rigid in their thinking, people who aren't able to see things from other people's point of view, they are not able to reflect on their own problems, they have an external locus of control [pause] They are quite antisocial in their attitudes so they have quite negative views about services</p> <p>L115: And I asked him why he hadn't engaged with people and what was different about him starting to engage with psychology and his responses was that "I'll talk to you because you're not up yourself, or not posh" something like that. Some sense of me being on a level, being able to kind of a-tune to him and being more on a level he felt other people had been. He felt people had talked down to him and been quite condescending, he felt we had a more reciprocal balance and equal relationship I guess.</p>

<p>Janice</p>	<p>L32: I probably had all these set session plans and coming up a lot of resistance but actually realising that isn't helpful often and it's about spending time with someone and being human with them really, and building up that, you know the initial relationship which takes a lot longer than other services I think.</p> <p>L37: well I think it is about being transparent with people in terms of you know, you don't really have a agenda, but if you're going to speak to someone about a certain purpose, you be transparent with them, that's always helpful, about the reason why you have come to see them, and that kind of thing, but also being human in terms of the level of self disclosure</p> <p>L53: Yeah I think I have, I like to think I have, you know people will ask you personal questions and I know that I would not answer not personal questions, but I will if it is in terms of normalising a experience or building a relationship with someone, by talking about I don't know, a film you have watched or a common interest you might have, I think you can do that, but you have to be careful if you feel they might be pushing the boundary</p>
<p>Erica</p>	<p>L96: I think being willing to admit your errors or mistakes when things don't go quite right and again I think that is because the service can sometimes feel quite rigid quite defensive so I think that helps engagement actually, the degree of honesty, if you get caught in traffic and you are late one day then just saying that it could not be helped, being open that these things sometimes happen.</p> <p>L231: There are certain personality constellations which will lend themselves to a more cautious stance or people who might be anxious about other peoples' motives themselves, those things can make it more difficult.</p>
<p>Emma</p>	<p>L53: so I might spend regular periods of time up on the ward, casually interacting with them so it is non-confrontational, non-intrusive. It might be trying to engage them in a game of cards or just sitting watching TV with them or something just to help them feel comfortable with having me in close proximity to them</p> <p>L258: Like I said earlier, sometimes you do have to sit and watch MTV with a client and you can talk about the music artist on TV or have a bit of a joke with them or, I think that is a really key component as well, to be able to oscillate between showing a bit of yourself but also getting back to business when it is appropriate.</p>

Super-ordinate Theme 2: The matryoshka doll of containment	
Monica	<p>L37: there's always supervision [pause] and opportunities for training. And I think because quite a few of us have been working here for a number of years erm most of us have come across the things our service users present with, so even if you can't think of a way to work with them most of your colleagues might have faced that before so there's lots of sharing of knowledge and support.</p> <p>L239: It's about having a balance of all the warm fluffy bits of being there, being empathic, of being supportive but then also realising that I am here to do a job and I will push them forward and help to progress if that's what they want to do.</p> <p>L408: I do find that hard, I kind of come back and think 'why can't I get a connection with this person', you start to do that, 'oh I must be a really bad therapist', and then it's using your peers and using supervision to say sometimes we just have service users who aren't in the right place at the time, but it is hard, it is really hard.</p>
Rachel	<p>L102: I guess they were able to feel safe after a certain amount of time and that is when you can start doing therapy work, therapeutic interventions.</p> <p>L177: It is tough, within my team we have a reflective practice group session every week, which I think itself it could be developed a bit further, it is not reflective practice as perhaps as I know it. But I think it is a really good start to talk about some dynamics and difficulties erm, also using supervision, and as I said earlier working in a psychology department is fantastic because he can speak to another psychologist about how they handled a similar difficulty, about what the different processes are where you can go from here</p>
Phoebe	<p>L17: we get regular supervision</p> <p>L166: yes, I tried to be quite consistent in that even though the client said they wanted to disengage, I made clear that the offer to reengage was always there, so there was always an option to reengage, this will be the way how to do it.</p>
Janice	<p>L100: Suppose I am supported through colleagues and supervision</p> <p>L160: I think it's about being consistent, going back at the same time for the appointment, not being phased by it. So no matter how much they shout at you, you get back and be consistent. I think that is important</p>
Erica	<p>L95: A degree of openness, a sense of containment which can be achieved by all sorts of things, partly being predictable and reliable and it comes with openness but honesty</p>

Emma	L19: I think, one of the best things is the strong emphasis on team working, so you apart of a MDT so when you are working with an individual you have got very different perspectives within a team environment and also the high levels of support you receive with working with quite distress and complex client group. So there is lots of team working and support are the key things.
Super-ordinate Theme 3: The Psychologist as an empower in a disempowered system Sub-ordinate Theme: 3:1 Being in a disempowered system	
Monica	L502: I guess there's a element for me that there are other things that I can do more about to change than to sit and worry about the fact that I have to carry a set of keys around with me, I can't do much about that, I'm trying to be pragmatic.
Rachel	<p>L59: Ermm and I am always thinking about areas like repression and empowerment. Because obviously in an inpatient service where people have restriction placed upon them for example from the ministry of justice for the offending plus they are sectioned so it is a really disempowered place to be. So it can be quite challenging motivating people, working with people who are really pretty disempowered.</p> <p>L108: or someone for whatever reason might be angry about being here and feel quite coerced into interventions. This can obviously this can cause some disruption with the clinical team and therapeutic relationships with those that feel forced to do it, this will be a barrier</p>
Phoebe	<p>L74: it's quite difficult to actually physically get a client in the room with you because limits on therapeutic time so the regime here is quite fixed, it has to be fixed so people get to meal times at the right times and the risk issues are managed and dealt with.</p> <p>L136: Although there is an expectation everyone will engage in some way. Suppose one of the main issues is that people really have to engage or supposed to engage as a part of their treatment, it apart of what of what will get them out of hospital, so the motivation is sometimes questionable.</p>
Janice	L119: I feel that it can be a real difficulty, one of the difficulties in working in a forensic mental health setting is that you are actually balancing a therapeutic relationship with risk. You know essentially it is about controlling, your confound to the hospital, your also trying to build a therapeutic relationship and wanting them to move on, I think that is a real balancing act and it is what makes building a relationship up quite difficult

	<p>L141: One client, I wrote something and my supervisor was going to a tribunal and my report was feeding into her report and we together feedback the tribunal reports to him and that really affected our relationship because basically we was saying we did not feel he was ready for discharge. I think it probably what psychiatrists do all the time, they do don't they, and I think for psychologists it is a difficult thing to do and try to maintain that therapeutic relationship whilst you also do tribunal reports,</p>
<p>Erica</p>	<p>L34: I think this is a harsh thing to say, and I don't think this will be true of all MSUs, I think there is quite a strong medical view, it still happens here. Compared to some of my colleagues who don't work in forensic settings and work in other teams I think the wider staff team and MDT are much more accepting for psychological interventions and are much more willing to hear a psychological view point or implement a behavioural strategy or something a Psychologist might recommend to them, or some other areas. But I think the ethos of the service model and it feels like a lot of the people who have the loudest and more authoritative voices come from quite a medical stand or view point. I think that is gradually shifting to more modern ways of thinking about health care, more recovery orientated approaches and that sort of thing.</p> <p>L44: it is a secure environment and when you are trying to deliver therapy to people, all the time what you are trying to do is meet them on a level playing field if you like and you are trying to get somebody as a equal partner and that piece of work and it is very hard to do when you walk into a room wearing a bunch of keys that are never allowed to go near and when they are certain rules that have to be maintained. I think that is a bit of a challenge sometimes</p> <p>L52: straight away your in a real difficult power dynamic and whatever you do to try and level that off there are always going to be things that can't do, things they can't try out, a degree of stuckness until a certain point</p> <p>L409: I think people being told they must engage is not a helpful way of engaging people and that happens in services like this</p>
<p>Emma</p>	<p>L225: Well I think I am very patient, I think that is very important, I think particularly under the stress of things like payment by results coming into play and a lot more pressure on services to deliver treatments fast</p>

3:2: Psychologist being an empowerer	
Monica	<p>L414:so if we have got somebody who will completely not engage at all I think the clinical team have learnt to accept my conclusions, my judgements about not badgering people to engage and it has taken a lot of time, I feel like to a certain extent I have had to condition my clinical team</p> <p>L435: sometimes it's about teaching and supporting the clinical team to look differently at the service users engagement so being there at the clinical team meetings when issues come up,</p>
Rachel	<p>L96: I think that those that have been really successful, it was about spending time with them and going at their own pace. So I explained what I did, but then asking them to talk to me about what was going on for them in the here and now, rather than going on about their past again which they had done the previous psychologists. And then over time they were able to tell me about it and the work they had done before, but doing it at their own pace seemed to have worked well, developed a good relationship.</p> <p>L230: we've got a really good comprehensive risk assessment here, a holistic assessment. Which is a positive, looking strengths, protective factors, so it is more valid so I think that makes it feel a bit better, so you are not just looking at someone's deficits, you are looking at their strengths as well, and putting it all together to generate a comprehensive formulation. I think that makes a difference really.</p>
Phoebe	<p>L50: Try to be quite empathic and being understanding about the individuals problems. And trying to work collaboratively around understand where they got to where they are rather than focusing on the offence and what happened, try to think about the build up and think about what contributed to that, and developing shared formulations</p>
Janice	<p>L181: I think being human is a part of it, suppose seeing what is important to them at that time. So there at a point where they need to be just stable, you know they need some containment so you have to see where they are at that point and work with that point.</p>
Erica	<p>L14: So right from first admission through to discharge and seeing people actually making changes to their lives and achieve some of their goals</p> <p>L152: so collaboratively finding something to work on because I think sometimes again people are told this is something that you got to work on, you have got to work on your offending behaviour for example but actually they might be traumatised by who knows what in their life or maybe the offence itself or they might be really</p>

	<p>struggling, upset or just in a really low mood things like that, all of which will probably make it more difficult and challenging to meaningfully do some of the work, so actually if you offer some relief or something that might make life more comfortable in the short term that is probably going to be much more relevant and meaningful and hopefully help someone function to a high level at a later date, so sometimes sitting down with somebody and thinking about what is helpful to them right now</p> <p>L410: Erm I think an awareness of what somebody actually wants and how you can meet those needs is probably a more useful way of engaging people in anything now, psychology, or OT or if its education based things or anything, anything that will help that person or goal directed behaviour is more helpful, rather than just being told you must do it</p>
Emma	<p>L43: I think also the 1:1 sessions helping the individual understand that life can be a lot more positive and guide them to understand that actually they don't have to remain in such distress</p> <p>L149: I feel that is a big responsibility for me, to help them understand how not to get to that point again. So developing their formulation in a way to help them understand that it is not just the system that is making them do this work. And I always say to my clients that no one can make them do psychology, they have got to want to do it, they have to understand that there is a commitment from their point of view to do it as well.</p>

INSTRUCTIONS FOR AUTHORS

Journal Details: International Journal of Forensic Mental Health

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<http://www.tandfonline.com/action/authorSubmission?journalCode=ufmh&page=instructions>

Journal Details: Psychodynamic Practice

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