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How do women with a diagnosis of Borderline Personality Disorder detained in secure and locked services perceive recovery? A Grounded Theory.

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Thesis Abstract

Introduction: The topic of recovery is increasingly becoming adopted into practice in mainstream mental health services. Drawing upon principles of connectedness, hope, identity, meaning in life and empowerment, recovery principles aim to enable service-users to achieve satisfying lives in spite of the limitations caused by experiences of mental health difficulties. Despite its widespread implementation in mainstream services, recovery has been met with challenges in specialist services and among particular client groups. There is limited understanding as to how recovery is experienced by individuals in forensic services, particularly those with diagnoses of personality disorder for whom many challenges of traditional recovery approaches may be encountered.

Objectives: The study aimed to explore how women with a diagnosis of Borderline Personality Disorder detained within secure and locked rehabilitation services experience recovery. The study further aimed to generate a theoretical model of recovery grounded in the data to provide a framework of understanding of this experience.

Method: Seven women diagnosed with Borderline Personality Disorder participated in this study. Semi-structured interviews were completed, transcribed verbatim and analysed according to constructivist grounded theory methodology. This is in line with the social constructionist epistemological position of the researcher.

Results: Participants described recovery as an ongoing process comprising five sequential stages; existing, being stuck in the system, turning point, actively engaging, and transitioning to discharge. The process of recovery was influenced by factors which acted as both barriers, and facilitators of recovery including relationships, participant coping skills, readiness for recovery and the management of risk. As participants progressed, they made many psychological adjustments towards recovery but also experienced setbacks returning them to earlier stages. Constructs of coping and self-management were reflected as key recovery objectives.

Discussion: Recovery for this client group was a complex process heavily influences by relationships. Establishing safety in the secure environment and relational safety enabled the women to feel sufficiently contained to begin recovery tasks such as therapeutic interventions. The absence of relational safety disempowered participants and impacted upon motivation and their perceived ability to recover. The experience of recovery was related to

existing theories and literature relating to recovery as experienced by those diagnosed with BPD, recovery in the mainstream and recovery in forensic services. Clinical implications include the significance of relationships with staff as resources to support recovery and the identification of periods within which staff may intervene to support recovery. The model extends beyond previously established change models by locating progression through stages as a function of relationships. Findings of the research could be strengthened through follow-up studies in the community post-discharge and recommendations are made for longitudinal studies mapping recovery progress over time.

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Firstly, I would like to extend my appreciation to the women who chose to take part in this research. Your choice to share your experience with me has enlightened me in many ways, and I truly appreciate your time, openness and the trust you placed in me.

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Statement of Contribution

I, Louise Canacott, declare that this research is the product of my original work conducted as part of the Trent Doctorate in Clinical Psychology. The project was designed in consultation with my research supervisors, Dr Anna Tickle, Dr Mark Gresswell and Dr Louise Braham. Field supervisors, Dr Rebecca Lawday, Dr Alex Barrow, Dr Emily Fox and Dr Hannah Clements, supported and assisted in the recruitment of participants for this study. I was fully responsible for reviewing the pertinent literature, seeking ethical approval, collecting, transcribing and analysing the data, and the final write up with supervision from Dr Anna Tickle and Dr Mark Gresswell.

I declare that the systematic review was my own work. I was supervised by Dr Anna Tickle who was the second author and completed independent quality appraisals and assisted in some manuscript preparation. Dr Nima Moghaddam, the third author, assisted in offering supervision and supporting the manuscript preparation.

Table of Contents

Thesis Abstract 2

Acknowledgements 4

Statement of Contribution 5

Systematic Review 11

Journal Paper 55

Extended Paper 103

1. Extended Introduction 104

1.1. Recovery 104
1.1.1. Origins of recovery. 104
1.1.2. Processes and stages of recovery. 105
1.1.3. Recovery in policy and practice. 106

1.2. Women and Mental Health 109

1.3. Borderline Personality Disorder 110
1.3.1. Social constructionism and BPD. 111
1.3.2. Treatability of personality disorder. 113
1.3.4. Attachment theory and BPD. 115
1.3.5. Interventions for borderline personality disorder. 118

1.4. Personality Disorder and Recovery 120

1.5. Forensic Mental Health Services 122
1.5.1. Women and secure services. 124
1.5.2. Attachment and secure services. 125
1.5.3. Recovery in secure services. 128

1.6. Theories of change 131
1.6.1. The Transtheoretical Model of Change 131
1.6.2. Treatment readiness model for personality disorder. 133
1.6.3. Theory of Human Motivation 134

2. Extended Methodology 135

2.1. Ontology and Epistemology 135
2.1.1. Researcher position. 136

2.2. Rationale for Qualitative Methodology 137

2.3. Grounded Theory 138
2.3.1. Critique of grounded theory. 140

2.4. Alternative qualitative approaches 141
2.4.1. Thematic analysis. 141
2.4.2. Interpretive Phenomenological Analysis (IPA). 142

2.5. Sampling and participants 143
2.5.1. Theoretical saturation and sufficiency. 143
2.5.2. Sample size. 143
2.5.3. Eligibility criteria. 144

2.6. Participant Recruitment *145*
2.6.1. Procedure. 145
2.6.2. Participant withdrawal. 146
2.7. Ethical Considerations *146*
2.8. Data Collection *147*
2.8.1. Socio-demographic data. 147
2.8.2. Semi-structured interviews. 148
2.8.3. Interview schedule. 149
2.9. Analysis *149*
2.10. Quality Assurance Methods *152*
2.10.1. Constant comparative analysis. 152
2.10.2. Reflexivity. 153
2.10.3. Memo-writing. 154
2.10.4. Supervision. 154
2.10.5. Evaluation. 154
3. Extended Results **156**
3.1. Time *156*
3.2. Relationships *158*
3.2.1. Trust. 158
3.2.2. As a source of de-stabilisation. 162
3.2.3. As a secure base. 167
3.3. Stages of recovery *168*
3.3.1. Existing. 168
3.3.2. Being stuck in the system. 176
3.3.3. Turning point. 181
3.3.4. Actively engaging. 189
3.3.5. Transitioning to discharge. 195
4. Extended Discussion **200**
4.1. Attachment *200*
4.1.1Attachment as empowering. 200
4.1.2. Attachment and connectedness. 204
4.2.1. Identity *206*
4.2.2. Identity and self-discovery. 208
4.3. Coping and control *209*
5. Strengths *212*
6. Limitations *213*
7. Clinical implications and recommendations for future research *214*
8. Reflections- learning from the process *214*
8.1. Reflecting on epistemology. 214
8.2. Reflecting on the process. 215
8.3. Reflections on interview process. 216
8.3. Reflections on analysis. 216
References **217**

Appendices **240**

Academic Poster **279**

List of Tables and Figures

Table 1. General characteristics and key findings……25

Table 2. Methodological quality of quantitative studies……..32

Table 3. Quality appraisal of qualitative studies……..37

Table 4. Themes identified from thematic synthesis……38

Table 5. Participant demographics……..…….....69

Table 6. Processes of recovery (CHIME Model)……...106

Table 7. Evaluation of study against Charmaz (2014) criteria……...155

Figure 1. PRISMA diagram outlining selection process……..23

Figure 2. Effects of WRAP on overall clinical symptomology……...33

Figure 3. Effects of WRAP on symptoms of anxiety……...34

Figure 4. Effects of WRAP on symptoms of depression…….35

Figure 5. Effects of WRAP on standardised recovery questionnaires…….35

Figure 6. Grounded Theory Model…….....72

Figure 7. Transtheoretical Model of Change…….....131

Figure 8. Treatment Readiness Model for Personality Disorder (TReMoPeD)…….133

Figure 9. Maslow's Hierarchy of Need…….....134

List of Appendices

Appendix i. Participant information sheet……..241

Appendix ii. Consent forms……245

Appendix iii. Ethical approval documents……..249

Appendix iv. HRA approval following non-substantial amendment……..257

Appendix v. HRA approval following substantial amendment……...260

Appendix vi. Demographic information sheet…….261

Appendix vii. Development of interview schedules……262

Appendix viii. Examples of coding…….268

Appendix ix. Example memo…….….275

Appendix x. Charmaz quality criteria……..276

Systematic Review

Does the Wellness Recovery Action Plan (WRAP) contribute to clinical and personal recovery? A systematic review.

Abstract

Objective

The Wellness Recovery Action Plan (WRAP) is a structured approach to illness self-management that is widely used within mental health services. This systematic review identifies, appraises, and summarises the evidence for effects of the WRAP on clinical recovery, assessed using standardised clinical outcome measures, and personal recovery, assessed using recovery outcome measures and qualitative analyses of data from adults with diagnosed mental health difficulties.

Methods

A systematic strategy was used to search six electronic reference databases (Medline, CINAHL, EMBASE, PsycINFO, PsycArticles, The Cochrane Library) using full-text, keywords, and Medical Subject Headings (MeSh)/Thesaurus headings terms. Unpublished research was identified using the same strategy in the EThOS database. Studies were assessed for quality. Meta-analyses were applied to quantitative data to establish the effects of WRAP on outcomes of interest. Thematic synthesis was applied to qualitative data to elucidate findings of personal experiences of attending WRAP training.

Results

From a pool of 253 studies, 12 reached criteria inclusion; six quantitative and six qualitative. Analyses revealed that the WRAP was no greater than other passive interventions at reducing clinical symptomology, although restriction to randomised controlled trials revealed one small effect favouring WRAP. WRAP demonstrated a positive effect in improving self-perceived recovery and communication with professionals.

Conclusions and Implications for Practice

Participation in WRAP has positive outcomes for participants. The results support a move to a broader measurement of outcomes within mental health, away from a reliance on clinical outcome measures. Recommendations for further research are made.

Keywords: Recovery, Wellness Recovery Action Plan, WRAP, illness management, mental health.

Impact

The current paper synthesised studies into the effectiveness of the Wellness Recovery Action Plan (WRAP) in adult mental health settings and people's experience of using WRAP. The findings support for a broader conceptualisation of 'outcomes' than clinical symptom measurement, support for peer-delivered services. Findings also suggest a need for professionals to consider how to promote honest and open communication with service users.

Introduction

Recovery-oriented healthcare services depart from traditional understandings of recovery as a clinical concept, instead, understanding it as a personal journey (Slade, 2009). Traditionally, within a biomedical model, recovery has been viewed as a reduction in clinical symptomatology. This was challenged by a disparity with subjective accounts of personal recovery (e.g. Deegan, 1996), which highlighted power imbalances within mental health services, limitations on autonomy and the subjugation of service-user views and the central roles of hope, identity, empowerment and independent living in the process of recovery (Lester & Glasby, 2010). Such accounts led to recovery being commonly understood as "*a way of living a satisfying, hopeful, and contributing life even within the limitations caused by illness" (*Anthony, 1993, p.527).

Transdiagnostic recovery principles of empowerment, personal control, the development of positive identities, connectedness, hope for the future, and finding meaning in life (Tew et al., 2011) have now been adopted into mainstream approaches in mental health services (Slade, 2009) and recovery is viewed as a core component of meaningful working with individuals with mental illness (Royal College of Psychiatrists, 2008; Shepherd, Boardman & Slade, 2008).

Peer-support

Mental health peer-support has proliferated in line with the development of recovery-oriented services (Davidson, Chinman, Sells & Rowe, 2006), where "peers" are individuals considered as living successfully with mental illnesses who support others with mental health issues. Peer-led services may enhance care by allowing individuals with similar difficulties to meet and discuss their issues, receive empathy and suggestions from others who have faced similar challenges (Davidson et al., 2006).

Many services now have peer-employees: peers who are hired into mental health positions (Solomon, 2004). The role is complex, as peer support workers hold multiple identities, which must be negotiated both by them (Dyble, Tickle & Collinson, 2014) and those they support (Bailie, Tickle, & Rennoldson, 2016). Evidence suggests employment as a peer support worker can be both facilitative and detrimental to personal recovery, although the quality and extent of research is limited (Bailie & Tickle, 2015). However, a systematic review of peer-support for individuals with severe mental illness reported a moderate degree of effectiveness, including improvements in service-user empowerment, self-advocacy, hopefulness, engagement, and relationships with providers, as well as reduced inpatient admissions (Chinman et al., 2014).

Self-management

Illness self-management aims to enable the individual to gain control of their symptoms, recognise triggers, set goals, problem solve, share decision-making and develop relapse prevention strategies (Bodenheimer, Lorig, Holman & Grumbach, 2002). Various forms of self-management exist, including group or individual sessions with professional input and online or self-help resources (Doughty, Tse, Duncan & McIntyre, 2008), although a review found little evidence for the use of such strategies in mental health services and a lack of clarity in terms of how this could be promoted (Singh & Ham, 2006).

The Wellness Recovery Action Plan (WRAP).

The WRAP (Copeland, 1997) is a structured peer-based, group programme approach to illness self-management which may be applied to the management of physical and mental well-being (Copeland, 2001), based on Copeland's personal experiences. The WRAP is facilitated by peers in recovery trained in WRAP by the Copeland Centre for Wellness and Recovery, and receiving mentoring from advanced WRAP facilitators (Copeland, 1997). Key

objectives are for participants to identify internal and external resources for facilitating recovery through the development of a personalised wellness plan (Copeland, 1997). A typical WRAP series comprises 8-10 weekly sessions of group education to enable participants to improve their ability to take responsibility for their wellness, manage mental health symptoms using self-help strategies and identify and utilise sources of support (Copeland, 1997; 2004).

Preliminary evaluations suggest potentially beneficial outcomes of the WRAP in multiple areas, including increased self-advocacy, reductions in service need and usage, reduced symptomatology, increased recovery-knowledge and increased hopefulness and quality of life in individuals with persistent mental illness (Copeland Centre for Wellness and Recovery, 2014). Qualitative studies have demonstrated similar findings as well as high levels of satisfaction with the WRAP both for consumers and facilitators (Doughty et al., 2008).

Given that individuals with chronic mental health conditions may become frequent users of services (Naylor et al., 2012), there is a need to consider alternative self-management approaches to living with mental illness. The WRAP represents one such alternative and has been recognised by the United States Substance Abuse and Mental Health Services Administration (SAMHSA) as an evidence-based programme, despite no synthesis of available literature. Its implementation is expanding internationally: studies report positive outcomes in Canada (Allott, Loganathan & Fulford, 2002), China (Zhang, Li, Yeh, Wong & Zhao, 2007), USA (Buffington, 2003), Ireland (Higgins et al., 2010), New Zealand (Doughty et al., 2008), Scotland (Pratt, MacGregor, Reid & Given, 2013), and the United Kingdom (Davidson, 2005). It is timely to evaluate and critically appraise the evidence base for its effectiveness.

Objectives

The review aimed to answer the questions: 'Does the Wellness Recovery Action Plan (WRAP) contribute to clinical and personal recovery?' and 'What is the quality of the existing literature evaluating WRAP?'. The objectives were to:

1) Systematically identify and assess the quality of papers investigating outcomes for or experiences of individuals with mental health difficulties receiving WRAP training.

2) Use meta-analysis to investigate quantitative evidence for the effects of the WRAP on clinical symptomology and self-perceived recovery for individuals with mental health difficulties.

3) Use thematic synthesis to synthesise existing qualitative evidence for the effects of the WRAP, as perceived by those using it.

Methods

Searching

Six electronic reference databases (Medline, CINAHL, EMBASE, PsycINFO, PsycArticles, The Cochrane Library) were searched on 07/09/2017 using full-text, keywords, and Medical Subject Headings (MeSh)/Thesaurus headings terms as follows: 1) ((well* OR health*) (recover* OR recuperate*) (action* OR plan*)); 2) "Wellness Recovery Action Plan"; 3) "WRAP"; 4) exp. Mental Health; 5) 3 AND 4; 6) 1 OR 2 OR 5. No date restrictions were set. To locate other eligible research articles, such as unpublished research, the same search strategy was entered into the EThOS database. Additional peer-reviewed literature was identified through hand-searching the reference lists of review articles. The Psychiatric Rehabilitation Journal, which publishes many articles relevant to the area of recovery in mental health, was also hand-searched to identify further articles.

Study selection

The primary outcome of interest of this review was clinical symptomatology, most reliably measured using standardised assessment tools. The second outcome of interest was personal recovery as an outcome of WRAP training, assessed using measures or through qualitative evaluation, in line with recovery literature which identifies that current outcome measures of recovery often fail to capture the idiosyncrasies of personal recovery (Andersen, Caputi, Oades, 2010). A mixed-methods approach was therefore considered most appropriate to address the research questions.

The inclusion criteria are that studies must:

- be published in the English language in peer-reviewed journals or "grey literature".
- investigate the WRAP as delivered to adults with mental health difficulties (e.g. depression, anxiety, psychosis), but not restricted to those who have acquired a specific formal diagnosis.
- assess either the effects of the WRAP (using quantitative or qualitative methods) on clinical symptoms or personal recovery or the experiences of the WRAP, from the perspective of those using it.
- employ a controlled design if using quantitative methods to investigate WRAP outcomes (waiting list control group, treatment as usual control group, or randomised controlled trials).

Studies were excluded if they:

- did not separate the views of those with mental health issues and other participants, such as mental health professional or peer facilitator.

- investigated multiple self-management programmes and did not distinguish between programmes in the study outcomes (if researchers were contacted and did not provide the necessary data).
- used a quantitative design but did not include a validated outcome measure of either recovery or clinical symptomatology.

After selection, each paper was read in detail and key data extracted.

Quality Appraisal

It is important to assess the quality of included studies, to support consideration of the weight that should be accorded to findings and inform the quality of future studies through critical appraisal of existing research. There are some standardised measures to achieve this, but research has demonstrated a low-level of inter-rater reliability in quality assessments using such tools (Juni et al., 1999). The Quality Assessment Tool for Quantitative Studies developed by the Effective Public Health Practice Project Canada (2004) was used to determine the quality of quantitative papers because it can be used to assess the quality of RCTs, Quasi-experimental, case-control and prospective studies.

Similarly, some tools are available for appraising qualitative studies. The Critical Appraisal Skills Program (CASP, 2017) was chosen, as it is widely recognised and met the purposes of the present review.

Analysis of quantitative data

For each outcome of interest, meta-analyses were completed as a means of pooling outcomes across studies to increase power and improve the precision of establishing whether the intervention had a significant effect on outcomes of interest. Standardised mean differences were obtained with 95% confidence intervals for continuous outcomes to obtain a

measure of treatment effect. The I^2 statistic was employed to assess for heterogeneity (Higgins, 2001) statistically. Further scrutiny was applied to studies in which the I^2 statistic exceeded 50%.

As recommended by Higgins (2001), data obtained from ordinal outcome measures were treated as continuous data. Standardised mean difference was used as a summary statistic as studies used a range of outcome measures to assess symptomology (depression and anxiety) and personal recovery. Based on the heterogeneity of the data, random-effects models were used. Sensitivity analyses were conducted to test whether findings were robust to decisions made about study inclusion. Specifically, it was considered apt to test whether overall effect estimates (and study homogeneity) were influenced by the inclusion of non-randomised trials (quasi-experimental designs; which may be considered to produce a lower grade of evidence/control over threats to internal validity): this was accomplished by rerunning analyses (for each outcome variable) with restriction to data from RCTs alone.

Analysis of qualitative data

Qualitative data was copied into Microsoft Excel, and thematic synthesis (Thomas & Harden, 2008) was used to analyse the data. Thematic synthesis involves coding text line-by-line to create descriptive themes. Themes are then further analysed into analytical themes.

Results

Search Results

Figure 1 outlines the selection process, which identified 12 articles for inclusion.

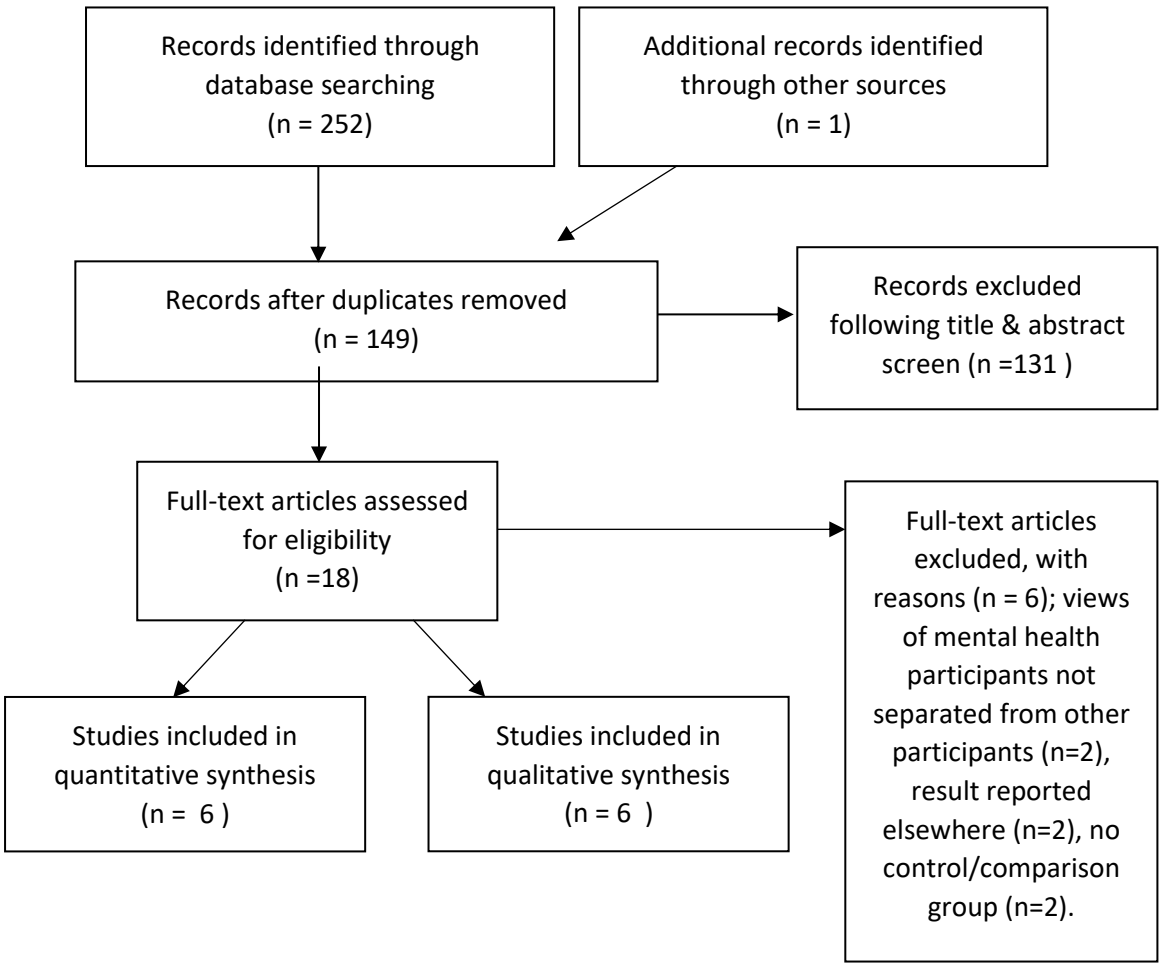


Figure 1. *PRISMA diagram outlining selection process.*

Data abstraction and analysis

Table 1 outlines the key characteristics of selected studies. Each study is assigned a number (1 – 12), used for brevity within the results section.

Quantitative Studies

Study Characteristics and Key Findings

Six studies were selected for quantitative analyses (1-6), from the USA (n=3), Republic of Ireland (n=2) and China (n=1). Three (1, 2, 5) reported two randomised controlled trials (RCTs) (with 1 and 2 reporting different outcomes from the same trial), the remainder employed quasi-experimental methods (matched-controlled samples). Control samples were either receiving treatment as usual (n=4; studies 1, 2, 3, 6), or a waiting list control condition (n=2; studies 4, 5).

The total number of participants across the six studies was 845 comprising 37% males and 63% females. One RCT produced two papers (1, 2) and the number of participants in this study are included only once in the above total figure. Sample size ranged from 36 (5) to 519 (1, 2). The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Revised (DSM-IV-TR) was used in three studies (1, 2, 3) to specify diagnostic criteria. The International Classification of Diseases-10 was used in one study (5), and two studies

Table 1. *General Characteristics and Key Findings*

Author(s), Year and Location	Design	Study Sample N=Total (Female: male)	Research Aims	Methodology	Clinical Outcome Measures	Recovery Outcome Measures	Summary Points and Key findings
1. Cook et al., 2012a, USA	RCT	N=519 (342:177), outpatient sample, with a documented DSM-IV-TR diagnosis of mental disorder	To compare symptomology of anxiety and depression and self-perceived recovery among those receiving the WRAP versus those receiving TAU	**Quantitative** Questionnaires **Analysis** Inferential Statistics	Brief Symptom Inventory depression and general anxiety subscales (Piersma et al., 1994).	Recovery Assessment Scale (Giffort et al., 1995)	• WRAP participants reported significantly greater symptom reduction in anxiety (r=.44*). and depression (r=.48***) scales • WRAP participants reported significantly greater self-perceived recovery (r=.52*).
2. Cook et al., 2012b, USA	RCT	N= 519 (342:177), outpatient sample, with a documented DSM-IV-TR diagnosis of mental disorder	To determine the efficacy of the WRAP in symptom reduction, increased hopefulness and increased quality of life versus TAU	**Quantitative** Questionnaires **Analysis** Inferential Statistics	Global Symptom Severity Index of the Brief-Symptom Inventory (Piersma et al., 1994). Positive Symptom Total of the Brief-		• WRAP participants reported significantly greater symptom reduction (r=.2*) • WRAP participants reported significantly increased rates of hope (r=.2, *) and quality of life (r=.1***) versus controls. • Decreased symptomology was associated with increased number of

					Symptom Inventory (Piersma et al., 1994).		WRAP sessions received.
3. Fukui et al., 2011, USA	Quasi-experimental (matched comparison group)	N=114 (71:43), community sample with severe and persistent mental illness.	To examine the effects of WRAP participation on psychiatric symptoms, hope and recovery outcomes	**Quantitative** Questionnaires **Analysis** Inferential statistics	Modified Colorado Symptom Index, (Conrad et al., 2001)	Recovery Markers Questionnaire (Ridgway et al., 2003)	• Significant improvements for experimental group in symptomology (r=.33***) and hope (r=.58*) No significant interaction effect reported on recovery outcome measure (no figures provided).
4. O' Dwyer, 2014, Republic of Ireland	Quasi-experimental (non-equivalent, waiting list comparison group)	N=57 (35:23†), Participants with mental illness or acquired brain (AB) injury receiving support from community service.	To examine the effects of the WRAP on anxiety, depression and recovery in clients an adult mental health population and an acquired brain injury population.	**Quantitative** Questionnaires **Analysis** Inferential Statistics	Hospital Anxiety and Depression Scale (Zigmund & Snaith, 1983)	The Mental Health Recovery Measure (Young & Bullock, 2003)	• Statistically significant differences in anxiety and depression scores for mental health group compared to controls. • More pronounced differences for mental health group than AB group.

							Statistically significant increases in recovery knowledge in both groups.
5. O'Keeffe et al., 2016, Republic of Ireland	RCT	N=36 (19:17), Participants from inpatient and outpatient mental health settings	To evaluate the effect of WRAP on personal recovery, quality of life, and self-reported psychiatric symptoms.	**Quantitative** Questionnaires **Analysis** Inferential Statistics	Hospital Anxiety and Depression Scale (Zigmund & Snaith, 1983)	The Mental Health Recovery Measure (Young & Bullock, 2003)	• Positive outcomes of WRAP in domains of addictive behaviours and identity and self-esteem • No significant effect of WRAP on personal recovery, quality of life or psychiatric symptoms
6. Mak et al., 2016, China	Quasi-experimental (matched comparison groups)	N=118 (68:50) Service-users of residential and vocational rehabilitation services	To evaluate the effect of WRAP on symptom severity and recovery.	**Quantitative** Questionnaires **Analysis** Inferential Statistics	Modified Colorado Symptom Index, (Conrad et al., 2001)	Recovery Markers Questionnaire (Ridgway et al., 2003)	• Significant increase in perceived social support for WRAP group. • No significant change in symptom severity or recovery for WRAP group.

7. Wilson et al., 2013, USA	Cross-sectional	N=26 (13:13) (quantitative), N=18 (qualitative). Outpatient community mental health sample.	To investigate participant satisfaction with WRAP	**Qualitative** One-to-one interview **Analysis** Content analysis	• Qualitative themes: 1) Retrospective desire for early WRAP introduction 2) Pay it Forward 3) Unconditional Relational support 4) It Takes Time
8. Jones et al., 2013, USA	Cross-sectional	N=54 (34:17 ††), mental health consumers in a community setting	To examine the relationship between participation in the WRAP and self-determination in service use, medication adherence and engagement with treatment providers.	**Qualitative** Focus groups	• Qualitative themes: 1) Self-determination and adherence/compliance are mutually opposed 2) Self-determination and adherence/compliance can be complimentary 3) Compliance/adherence are sometimes necessary 4) Increased self-determination 5) Increased awareness 6) Increased self-advocacy with providers

9. Cook et al., 2010, USA	Quasi-experimental (single-group pretest-posttest)	N=381 (247:134), mental health consumers/ survivors in a community setting	To evaluate the outcomes of two statewide initiatives teaching self-management	**Qualitative** Questionnaire **Analysis** Constant Comparative Analysis (Glaser & Strauss, 1967)	Self-reported attitudes, skills and behaviours survey	• **Qualitative themes** 1) Wellness as an attainable and ongoing process 2) Wellness influenced by the support of others 3) Increased recognition and success in managing stressors and symptoms. 4) Less perceived social isolation 5) Application WRAP strategies in everyday life 6) The value of consumers as facilitators
10. Zhang et al., 2007, New Zealand	Cross-sectional	N=13 (11:2), Chinese consumers with mental health diagnoses of a self-help organisation.	To examine the acceptability, applicability and effectiveness of the WRAP	**Qualitative** Individual interviews focus groups **Analysis** Not reported		**Qualitative themes** 1) Knowledge of WRAP 2) Utilisation of WRAP 3) Influences of WRAP 4) Sharing the WRAP plan 5) Suggested changes
11. Pratt et al., 2013, UK	Cross-sectional	N=21 (focus groups), N=11	To assess the relevance and impact of the	**Qualitative**		**Qualitative themes** 1) Group participants experience

		(individual interview†††) Gender breakdown not reported.	WRAP as a tool for self-management and wellness planning	Individual interviews, focus groups **Analysis** Thematic analysis	2) Perceived benefits of WRAP 3) Group setting 4) Integration of WRAP in daily life 5) Challenges
12. Ashman et al., 2017, UK	Cross-sectional	N=6 (4:2), Individuals who had used mental health crisis resolution and home treatment teams	To explore the WRAP as a supporting resilience-building and maximising opportunity potential of a crisis	**Qualitative** Individual interviews **Analysis** Interpretive Phenomenological Analysis	**Qualitative Themes** 1) The meaning of crisis 2) Engaging with the WRAP process 3) WRAP and self-management 4) Changes and transformations

Note: For quantitative studies the following significance indicators are used: *p<0.05, **p<0.01, ***p<0.001. TAU: Treatment as usual, ABI: Acquired brain injury.

† Demographics are described for a sample of N=58 however outcome data were reported for 57 participants.

†† This paper acknowledges that full data were not available for all participants.

††† Eleven participants from focus groups subsequently completed in individual

provided demographic, diagnostic information without specifying diagnostic criteria (4, 6). Diagnoses included depression, anxiety, obsessive-compulsive disorder, schizophrenia, psychosis, bipolar disorder, schizoaffective disorder and others (as classified by the DSM-IV-TR) and psychoactive substance use disorders, schizophrenia, schizotypal and delusional disorders, affective disorders and neurotic and somatoform disorders (as classified by the ICD-10). Clinical symptomatology was assessed using the Brief Symptom Inventory (n=2; 1, 2), Colorado Modified Symptom Index (n=2; 3, 6) and the Hospital Anxiety and Depression Scale (n=2; 4, 5).

Quality appraisal of quantitative studies

Table 2 outlines the quality appraisal of quantitative studies.

Most samples appeared to be representative of adults receiving community-based adult mental health services, comprising various diagnoses and educational backgrounds, with inclusion in some studies of participants from various minority groups. The sample in one study (5) consisted of inpatients and outpatients and results were not differentiated by inpatient status. Representativeness is limited in each study due to the nature of voluntary participation.

Participants were not blind to the intervention in any of the studies, which would be practically difficult to achieve given the nature of the WRAP. Randomised controlled trials were considered to have reduced allocation bias through appropriate and clearly stated random allocation methods in addition to concealed allocation. All papers which compared samples reported no significant differences between experimental and comparison groups. Four studies reported participant attrition and from these studies between 80 and 100% of participants completed the intervention and outcome assessments. Intervention fidelity was assessed in four studies (1, 2, 5, 6) and deemed to be sufficient (86-100%).

Table 2. *Methodological Quality of Quantitative Studies*

Study	Participant Demographics	Sample representativeness	Inclusion & Exclusion criteria	Blinding	Standardised Measures	Overall Quality Rating
1. Cook et al., 2012a	Yes	Yes	Yes	No	Yes	Strong
2. Cook et al., 2012b	Yes	Yes	Yes	No	Yes	Strong
3. Fukui et al., 2011	Yes	Yes	Yes	No	Yes	Strong
4. O'Dwyer, 2014	Yes	Moderate	Yes	No	Moderate	Moderate
5. O'Keeffe et al., 2016	Yes	Yes	No	Yes	Yes	Moderate
6. Mak et al., 2016	Moderate	Yes	Yes	No	Yes	Strong

Note. *(1).* ***Sample representativeness: Yes,*** *participant demographics are clearly reported, Moderate, participant demographics are partially reported; No, participant demographics are not adequately reported. (2).* ***Sample representativeness.*** *Yes, sample represents a range of mental health service-users; Moderate, sample represents a limited range of mental health service-users, for example, focussing on one diagnosis only; No, sample has poor representation. (3).* ***Inclusion and Exclusion Criteria:*** *Yes, inclusion and exclusion criteria are clearly reported; Moderate; inclusion and exclusion criteria are partially or indirectly reported; No, inclusion and exclusion criteria are not reported. (4).* ***Blinding.*** *Yes, participants were blind to the purpose of the study; Moderate, participants were blind to some aspects of the study; No, participants were not blind to the purpose of the study. (5).* ***Standardised Measures.*** *Yes, appropriate and standardised measures were utilised; Moderate, appropriate but modified measures are utilised; No, no standardised measures are utilised. (6).* ***Overall Quality Rating.*** *Based on guidance from the Effective Public Health Practice Project.*

Results of quantitative studies

Clinical Symptomatology

Six studies assessed clinical symptomatology as an outcome of attending WRAP training. Three investigated symptomatology as an overall construct (2, 3 6), while three assessed anxiety and depression independently (1, 4, 5). The effects of WRAP in relation to overall clinical symptomatology, symptoms of anxiety and symptoms of depression will each be discussed below.

Overall Clinical Symptoms

Three studies assessed the effects of the WRAP on overall clinical symptomology (2, 3, 6). Two studies (3, 6) used the Modified Colorado Symptom Index (MCSI), and one (2) used the Brief Symptom Inventory (BSI). When combining study results, there was no significant effect of WRAP intervention on overall clinical symptomatology (standardised mean difference (SMD) of 0.01 (95% CI -0.30 to 0.33; P= 0.94). (Figure 2). However, it was notable that limiting to the single RCT reporting on this outcome (2) would suggest a small but significant effect favouring the WRAP intervention over treatment-as-usual (SMD -0.19; 95% CI -0.38 to -0.01; P=0.04). Restriction to RCT evidence leads to a substantive change in estimates for this outcome.

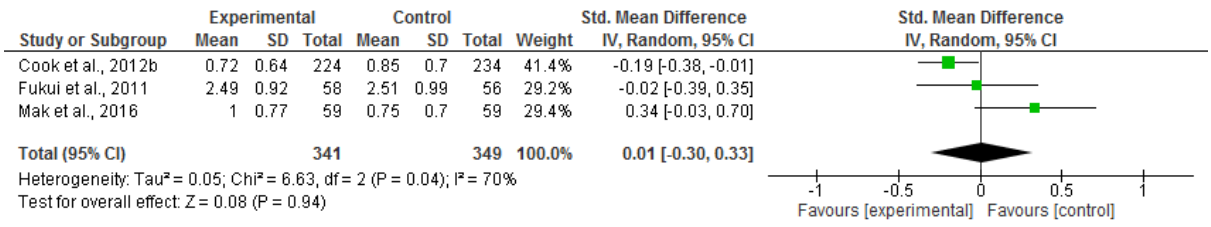


Figure 2. Effects of WRAP on overall clinical symptomatology

Anxiety

Three studies (1, 4, 5) examined the effect of the WRAP on symptoms of anxiety in comparison to inactive control conditions (treatment as usual or waiting list). Two studies (4, 5) used the Hospital Anxiety and Depression Scale (HADS) and one study (1) used the anxiety scale of the BSI. No significant effect of treatment condition on symptoms of anxiety was observed: SMD -0.21 (95% CI -0.65 to 0.23) P= 0.36. This overall finding appeared to be robust to the inclusion of non-RCT evidence: in a sensitivity analysis, removal of O'Dwyer (2014) did not substantively alter the magnitude or non-significance of the overall effect (SMD -0.14; 95% CI -0.32 to 0.04; P=0.12), and heterogeneity remained substantial (53%).

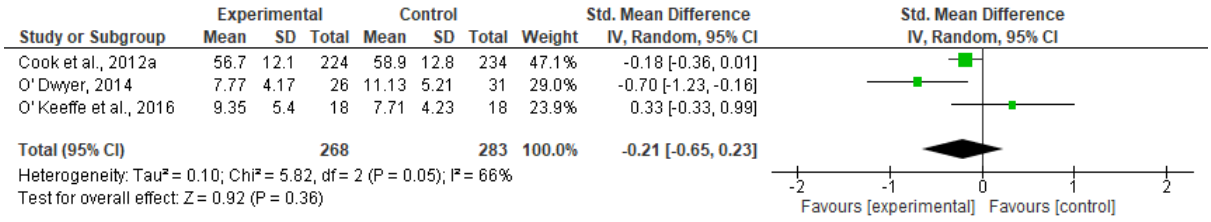


Figure 3. Effects of WRAP on symptoms of anxiety.

Depression

Three studies examined the effects of WRAP on symptoms of depression (1, 4, 5). Two studies used the HADS as a measure of depressive symptoms (4, 5). No significant effect of intervention type on symptoms of depression was observed (SMD -0.17; 95% CI -0.50 to 0.17; P= 0.34). This overall finding appeared to be robust to the inclusion of non-RCT evidence: in a sensitivity analysis, removal of O'Dwyer (2014) reduced heterogeneity (I^2 = 0%) but did not substantively alter the magnitude or non-significance of the overall effect (SMD -0.09; 95% CI -0.27 to 0.09; P=0.32).

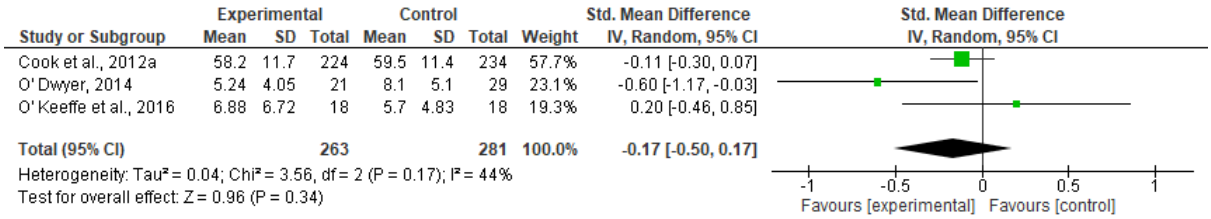


Figure 4. Effects of WRAP on symptoms of depression.

Recovery

Five studies assessed recovery using standardised questionnaires (1, 3, 4, 5, 6). Three studies used the Mental Health Recovery Measure (MHRM; 4, 5, 6), one study used the Recovery Assessment Scale (RAS; 1), and one study used the Recovery Markers Questionnaire (RMQ; 3). There was an overall significant effect favouring the WRAP intervention (SMD 0.24; 95% CI 0.06 to 0.42; P= 0.01). This effect was of small magnitude but indicated that WRAP was effective in improving recovery outcomes (relative to inactive control conditions). Limiting the meta-analysis to the randomised trials (Cook et al., 2012a; O'Keeffe, 2016) reduced heterogeneity (I^2 = 0%) but did not substantively alter the magnitude or significance of the overall effect (SMD 0.24; 95% CI 0.02 to 0.37; P=0.03). Thus, results appeared robust to the inclusion of non-RCT studies.

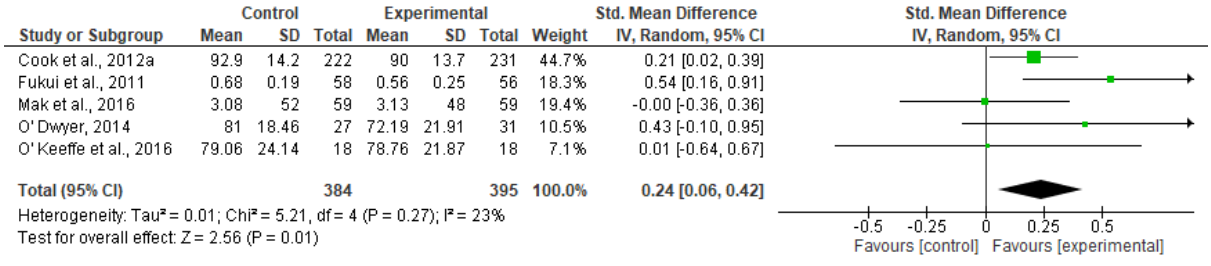


Figure 5: Effects of WRAP on standardised recovery questionnaires.

Qualitative Studies

Study Characteristics and Key Findings

Six studies used qualitative methodology, employing a range of data collection methods including focus groups, individual interviews, telephone interviews and written responses to questionnaires. Analysis methods included Constant Comparative Analysis, Social Constructionist Grounded Theory, and Content Analysis.

Quality appraisal of qualitative studies

Table 3 outlines the quality appraisal. Generally, the aims, method, design and recruitment of studies appeared appropriate. A key issue that was not well addressed was the relationship between the researcher and participants. It is also interesting that one study did not appear to have considered ethical issues, but this is likely to be an omission in reporting. It is also noteworthy that in four for of the six studies, it was not possible to determine whether analysis was sufficiently rigorous.

Synthesis of qualitative findings

Table 4 identifies the four themes, and subthemes, relating to outcomes of attending WRAP training, and the occurrence of these themes per study, indicated by *.

Changes in how individuals related to mental health problems:

Participants in all studies highlighted changes in how they related to their mental health problems. Ashman et al. (2017) describe the impact of the WRAP on participants as profound, echoing the view of a participant in Pratt et al.'s (2013) study that WRAP training

Table 3. *Quality appraisal of Qualitative Studies (n=5)*

Question from CASP	Study					
	Wilson et al. (2013)	Jones et al. (2013)	Cook et al. (2010)	Zhang et al. (2007)	Pratt et al. (2013)	Ashman et al. (2017)
Is there a clear statement of the aims of research?	2	2	2	2	2	2
Is a qualitative methodology appropriate?	2	2	2	1	2	2
Was the research design appropriate to the aims?	2	2	2	1	2	2
Was the recruitment strategy appropriate to the aims?	2	2	2	2	2	2
Was the data collected in a way that addressed the research issue?	1	1	2	1	2	2
Has the relationship between researcher and participants been adequately considered?	0	1	2	1	0	1
Have ethical issues been taken into consideration?	2	0	1	2	2	2
Was the data analysis sufficiently rigorous?	1	1	1	0	2	2
Is there a clear statement of findings?	2	2	2	1	2	2
How valuable is the research?	2	2	2	1	2	2
Total (maximum = 20)	16	15	18	12	18	19

Key: *Score 0 = little or no justification or explanation. Score 1= study addressed the issue but did not fully elaborate on it. Score 2 (strong) = article extensively justified and explained the criteria.*

Table 4. *Themes identified from thematic synthesis*

	Study					
Theme Subtheme	Ashman et al. (2017)	Cook et al., (2010)	Jones et al., (2013)	Pratt et al., (2013)	Wilson et al., (2013)	Zhang et al., (2007)
Changes in how individuals related to mental health problems:						
Better understanding of mental health and recovery	*	*	*	*	*	*
Acceptance			*	*		*
Increased control, self-efficacy and assertiveness	*		*	*		*
Recognition of the role of social support		*	*		*	*
More open and honest communication, especially with professionals	*		*	*		*
WRAP processes supporting change:						
Development and use of action plans and tool boxes	*	*		*		*
The group process	*			*	*	
The importance of peer facilitators and contrast with professionals	*	*	*			

led to a fundamental, ‘almost a seismic shift in thinking’ (p.4). Four subthemes were constructed:

Better understanding of mental health and recovery

All studies highlighted the important educational role of WRAP training. A better understanding for some was about the process of recovery, e.g. that “recovery and health happen by degrees, with steady effort…’ (9, p. 118). For many, it was about an increased understanding and recognition of triggers or early warning signs (e.g. 9, 10, 11) and coping skills to respond (11). Such knowledge could lead to alternative responses, e.g. “I now use my response to triggers and early warning signs when before, I thought they were [signs I was already in] crisis” (9, p.118). Participants in one study (7) indicated the broad relevance and importance of the knowledge provided by WRAP, e.g. “I wish I could have learned earlier in life about WRAP and my wellness tools. Everyone should take up WRAP” (p.851) and “I feel like this should be in public school” (p.851).

Acceptance

Three studies (8, 10, 11) identified the theme of acceptance; of living with mental illness, of support and of managing uncertainty in the future. A number of participants reported that WRAP changed their relationship with their illness, such that living a life alongside their illness became an option, in contrast to previous challenges in accepting mental illness, e.g. “I wonder if an acceptance of the fact that sometimes your life will be in crisis, and that knowing that there’s another side storm. You come out the storm.” (11, p. 4).

Increased control, responsibility, self-efficacy and assertiveness

These and related concepts, such as autonomy, ownership, confidence and self-advocacy arose in four studies (8, 10, 11, 12), sometimes related to the content of WRAP and at other times the process. There seemed to be a shift towards greater personal responsibility for mental health, e.g.:

"I always vow never to go back up there (acute inpatient ward), but I end up being back there, and I think I actually have to try and take the control more into my own hands, and I think obviously WRAP is one way that I can take back that control…" (11, p.5).

For some, this included a shift away from professional views, e.g. "To focus on my own recovery rather than what's dictated by professionals, and to take ownership for myself" (8, p.212)

It seemed that increased understanding of mental health and recovery (i.e. the content of WRAP) enabled greater self-efficacy and control over those things that can be managed, e.g. triggers and warning signs. In addition, the process of WRAP perhaps helped to develop the confidence to take more control, e.g. "I got a little bit of esteem from WRAP, and that was able to help me speak up" (8, p.213).

Recognition of the importance of social support

Four studies recognised the importance of social support, not only in terms of receiving it but also providing it to others. Within WRAP training, 'unconditional relational support' was identified by Wilson et al. (2013) with one participant stating, "They are my second family" (p. 851) and another declaring "I'm not alone. We're all together and all support each other" (p. 851).

As a result of WRAP training, some participants reported more actively seeking help from family members, professionals and other members of the group (10) but also valued social support more generally, e.g. "…that supporting and being supported by friends, etc. is really just one of the most integral parts of anyone's life" (9, p. 118).

In addition, participants in one study (7), spoke of wanting to 'Pay it Forward' and offer support to others using their own stories to introduce others to the hope of recovery. Contributing to the lives of others provided a sense of self and a sense of purpose, thus supporting recovery (12).

More open and honest communication, especially with professionals

Four studies (8, 10, 11, 12) found that participation in WRAP increased openness and honesty in communication about mental health, particularly with professionals, e.g.

"WRAP gave me the idea of taking my list of wellness tools to the psychiatrist's office and using it to discuss [things]…. [It] made me bring up and talk about a lot of things that I wouldn't have otherwise" (8, p.212). One explicitly stated "WRAP has made me more honest. I often still feel they (psychiatrists) don't really understand, but I lie to them less than I did. Now I am more assertive because of WRAP" (8, p.213). Professionals interviewed by Zhang et al., (2007) also identified that individuals who had completed WRAP training became more confident to ask for help, assert their needs and 'strive for rights and medication' (p. 6).

Some participants (10, 11) also spoke of communicating more honestly with friends and family, sometimes sharing difficulties for the first time and describing no longer having to live a "secret life" of managing mental illness (11, p. 4).

WRAP processes supporting change:

Development and use of action plans and tool boxes

The development of action plans and tool boxes was cited as a key beneficial process within WRAP training as this enabled the application of strategies and skills to manage mental health, e.g. "Doing my Daily Maintenance and items in my Toolbox has been the most helpful" (9, p.118). One participant powerfully described their plan: "I used my WRAP plan like a bible… that was my foundations… everything else what I were feeling I had to cope with…, but I felt, like, [WRAP] were my foundations that kept me safe to go through it…' (12, p.574).

Ashman et al. (2017) emphasised the potential for the crisis planning element within the WRAP plan to prevent a crisis but also described one participant's view that using WRAP led to crises being shorter and less intense.

The group process

In addition to the content of WRAP plans, the group process was viewed as key by participants in three studies (7, 11, 12). Some thought that "undertaking the WRAP in a group, compared with undertaking WRAP one to one, would be more supportive, less intense, and had the potential to offer mutuality and the ability to learn together", which was seen to increase the likelihood of engagement (11, p. 3). The group process was seen to provide unconditional relational support, positive feedback and reduced isolation (7, 12), e.g.

"It was nice to reveal my problems to other people that weren't gonna judge me and to know that you're not the only person in the world that has this kind of problem" (12, p. 573).

Engagement with the group process was gradual, and group members were not immediately comfortable, but that identification with other participants was a critical feature of WRAP learning (12).

The importance of peer facilitators and contrast with professionals

Three studies (8, 9, 12) raised the issue of peer facilitators and the impact of this on the resonance of WRAP for participants, as "No one can tell it like someone who's been through it" (9, p. 118). Not only were peer facilitators seen as valuable in their own right, but also when contrasted with 'professionals', e.g.

"When you find out the people running the group have the same issues you have, it allows you to relate to them in a way you can't with people who don't. It's very different. Not hierarchical, not like normal mental health treatment" (8, p. 212).

Jones et al. (2013) found participants who believe "it's only other consumer providers who really know how to help" (p.212) and one participant vowed never to work with non-peer professionals again. Perhaps worryingly for existing services, one participant explicitly expressed the view that psychiatrists and professionals "don't respect me as an authority like WRAP does. They're the authority, and I don't know anything – that's how they think" (8, p. 212). Others in the same study described feeling valued within WRAP and how this contrasted with low expectations they felt professionals held. Overall, this theme not only highlights the benefit of peer support, but also the shortcomings of professional services.

Conclusions and Implications for practice

Findings indicate the nuances of the effects of WRAP training, with qualitative data providing a context within which quantitative results may be considered. Results from meta-analyses show no significant effect of WRAP in the reduction of clinical symptomatology, either as an overall construct or when examining anxiety and depression independently.

While WRAP does not purport to reduce the magnitude of clinical symptoms, large-scale studies conducted in the USA have reported significant reductions following WRAP training (e.g. Cook et al., 2012a; Cook et al., 2012b; Fukui et al., 2011; O'Dwyer, 2014). Two of the three studies from outside the USA, albeit with smaller sample sizes, did not report similar findings. Whether such findings represent applicability to non-USA populations or are a result of statistical power or other variables remains unclear.

Meta-analyses do however demonstrate a small but significant effect of WRAP training on self-perceived recovery, despite participants not reporting significant decreases in their clinical symptoms. This supports a move to broader measurement of change, away from a reliance on clinical outcome measures. A focus on symptom-based clinical outcome measures and concomitant 'caseness' cut-off scores can encourage a reductive characterisation of service-users in terms of presence versus absence of illness. Results from this study indicate that there are many therapeutic benefits of managing mental illness that contribute towards personal wellbeing as a whole.

Qualitative analyses may provide some insight into mediating variables of positive outcomes, such as greater sense of control, increased confidence, and hope – i.e., many of the principal goals of the WRAP (Copeland, 1997). Individuals with enduring mental illness commonly report anxiety surrounding their prognosis and the unpredictability of mental illness (McCann & Clark, 2009) and it seems plausible that WRAP-attributed gains in perceived control, illness understanding, and hope could assuage this anxiety.

It is also possible that more open and honest communication with mental health services may have led to improved care, then reflected in recovery markers and sometimes reduced symptoms. Arguably, the qualitative synthesis highlights that there is work to be done to promote open and honest communication with professionals that could promote

recovery, even in the absence of WRAP. This perhaps fits with an increasing focus on shared decision-making within psychiatry (e.g. Davidson, Tondora, Pavlo & Stanhope, 2017). This review cannot address issues of power between psychiatrists and those they treat, but future studies should consider previous findings that psychiatrists perceive patients training in shared decision-making to be more 'difficult' (Hamann, 2011). Further, the review adds weight to the value of peer-delivered services both because of their direct benefits and the perceived contrast with professional-delivered services.

Qualitative analysis identified changes in self-perception as a result of attending the WRAP. For many individuals with severe mental illness, it is likely that at some point they have experienced stigma or unfair treatment (Corrigan & Watson, 2002) and may have a desire to become free of their illness. The premise of the WRAP opposes this and in many ways moves towards acceptance. Findings from these analyses support findings from other recovery-oriented programmes which identify acceptance of mental illness as a key outcome. It is possible that acceptance may reduce the secondary psychological battle of living with chronic illness and enable individuals to live meaningful lives. Results from qualitative analysis identify many positive outcomes which map on to many of the domains of recovery identified within the evidence-base (e.g., Slade, 2009; Tew et al., 2009). Such personal developments are likely to contribute to higher levels of self-efficacy (Bandura, 1977) and reinforce perceived control.

Overall, despite the limitations discussed, the general conclusion of this review is that participation in WRAP has many positive outcomes for participants. Reaching reliable conclusions regarding the effectiveness of WRAP on clinical symptomatology and recovery through quantitative means is limited by the variation in existing study design and quality. To reliably contribute to the evidence-base, trials comparing WRAP to other recovery-oriented, peer-led interventions may produce more reliable insight into the effectiveness of WRAP

than those comparing it to treatment targeting clinical symptoms. Follow-up data may provide greater insight into the recovery journey and whether changes in both clinical and personal recovery are sustained. Future qualitative studies regarding WRAP would benefit from consideration of quality criteria in design and reporting to overcome issues identified in this review, such as lack of reflexivity of researchers, unclear analytic methods, unreliable recording of findings, and absence of inter-rater reliability considerations. As the WRAP continues to expand internationally, further research regarding its short and long-term practice is essential to developing its position as an evidence-based intervention.

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Journal Paper

How do women with a diagnosis of Borderline Personality Disorder detained in secure and locked services perceive recovery? A Grounded Theory.

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Abstract

The principles of connectedness, hope, identity, meaning in life and empowerment (CHIME) are seen to underpin personal recovery. Studies to date have researched experiences of recovery across mental health services, including forensic services and services for individuals diagnosed with personality disorder. However, the needs of women diagnosed with Borderline Personality Disorder in secure services has not been explored. This study developed a grounded theory of the experiences of seven women. Participants described how they adjusted psychologically as they progressed through stages in their recovery. Relationships were the key facilitative factor for recovery but also a common source of setbacks.

Keywords: Borderline Personality Disorder, Recovery, Forensic

Introduction

Recovery can be considered as having two meanings, clinical and personal (Slade, Amering, & Oades, 2008), the latter of which is increasingly viewed as a core component of meaningful working with individuals with mental illness (Royal College of Psychiatrists 2008). Clinical conceptualisations place recovery within a medical model of recovery as cure. Conversely, personal recovery is often understood by this definition offered by Anthony (1993)[1];

> *"a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness. Recovery from mental illness involves much more than recovery from the illness itself.' (p.527).*

Increasingly, mental health services have embraced the concept of personal recovery in the development of services, with many mental health services now encouraged to become orientated towards collaborative definitions of recovery with service users (Department of Health, 2009)[2]. The National Health Service (NHS) England's Five Year Forward View for Mental Health (Mental Health Taskforce, 2016) aims to develop mental health services to deliver "*evidence-based, and person-centred*

[1] Please see section 1.1.1 of extended introduction for further information about recovery.
[2] Please see section 1.1.3 of extended introduction for further information about recovery in policy and practice.

care which is focused on recovery". Embedding recovery principles within mental healthcare has also been seen internationally and is a key target for change outlined by the World Health Organization (WHO, 2013).

A systematic literature review identified the key processes involved in recovery: connectedness; hope and optimism about the future; identity; meaning in life; and empowerment (CHIME; Leamy, Bird, Boutillier, Williams, & Slade, 2011). These five principles have been adopted into recovery approaches in mainstream mental health services[3]. Despite its utility, the CHIME concept fails to fully account for the wider socio-cultural context of the individual and issues of discrimination, stigma, and marginalisation in the recovery process.

Challenges in the conceptualisation of recovery have been reported among staff working in mental health settings (Le Boutillier et al., 2015) and some have questioned whether the term recovery holds any explanatory power, given its broad conceptualisations (Pilgrim, 2009). Evidence from specialist services (eating disorders, forensic, and dual diagnosis) also identifies differences in conceptualisations of recovery by service users (Turton et al., 2009). It has been suggested that mainstream principles of recovery should be adapted to facilitate the needs of specialist groups, which include those using forensic mental health services. To ensure that specialist providers are working within the recovery agenda, it is necessary to understand recovery as service-users conceptualise it.

Professionals within forensic mental health services face the difficulty of supporting service-users towards recovery while also operating within risk-oriented

[3] Please see section 1.1.2 of extended introduction for further information about the processes and stages of recovery.

services (Pouncey & Lukens, 2010)[4]. Women in forensic mental health services comprise a minority of the secure population, representing just 13% of the total population (Ministry of Justice, 2015)[5]. In comparison to men in secure services, women are more likely to have children placed into care, have histories of trauma including physical and sexual abuse, engage in self-harm or attempt suicide (de Vogel, Stam, Bouman, Ter Horst, & Lancel, 2016). Women who have committed offences against partners or children may be considered to have deviated markedly from expectations within socially-defined roles as wives and mothers, creating additional complexity for the development of positive identity and connectedness described within the CHIME framework (Leamy et al., 2011). Recommendations have been made to create services which address the complex needs of the female forensic population (e.g. Department of Health, 2002; Parry-Crooke & Stafford, 2009), though this has been met with some criticism due to concerns over discriminating against males (Adshead & Sarkar, 2005).

The role of risk is seen as a challenge to the adoption of the recovery paradigm within statutory mental health services (Bonney & Stickley, 2008), and the tension between mental health law and the humanistic philosophy inherent in recovery has been noted (Stickley & Wright, 2011). Suggestions have been made to embed recovery principles within forensic settings (Drennan et al., 2014) and although there have been calls for further research to support an understanding of recovery in forensic mental health services (Dorkins & Adshead, 2011), specific experiences of female service-users have been absent from emergent research.

[4] See section 1.5 of extended introduction for further information about forensic mental health services
[5] See section 1.2 and 1.5.1 for further information about women and mental health and women in secure services

A recent systematic review outlined key themes of recovery for service-users in forensic mental health services (Shepherd, Doyle, Sanders, & Shaw, 2016).[6] Central to recovery in this context was the process of developing a sense of personal identity which, although inherent within mainstream recovery principles, required tasks specific to this client group. The processes of making sense of past experiences (particularly trauma and childhood sexual abuse), coming to understand the diagnosis they received, and constructing a sense of self with a recognition of the separation of offending identity and personal identity were described. Recovery was considered to occur against a foundation of safety and security, and the dynamics of hope and social support were key facilitative influences. Indeed, staff and service-users in secure care describe hope as the most important factor for recovery (Corlett & Miles, 2010). Hope may act as a protective factor by enhancing engagement and enabling a belief in a positive future (Hillbrand & Young, 2008). However, the perceived need to be compliant with the forensic mental health system and lack of certainty over length of admission has been found to undermine forensic service-users' views of hope and progress (Vass, 2011). Whilst offering utility regarding the reality of the recovery approach in secure services, the review is limited in the applicability of processes which may apply to individuals diagnosed with BPD in secure services. Experiences of women and those with a diagnosis of personality disorder were under-represented within this review and of the 41 participants interviewed, the only participant with a BPD diagnosis had also received a diagnosis of schizophrenia (Ferrito, Vetere, Adshead, & Moore, 2012) thus, the experience of individuals with a BPD diagnosis remains under-researched.

[6] See section 1.5.3 of extended introduction for further information about recovery in secure services.

Another review reported similar findings (Clarke, Lumbard, Sambrook, & Kerr, 2016), drawing additional attention to connectedness in both community relationships and those with inpatient staff. While positive relationships with staff were reported as facilitating recovery, confrontational and challenging interpersonal relationships had the potential to increase social isolation and passivity about care (Ferrito et al., 2012). Thus, the forensic context presents challenges to the experiences of hope, connectedness and developing a positive identity, all central to recovery in the mainstream. Both studies, however, contained little female representation and to date, there is no published research relating to how recovery is experienced for women in forensic mental health services who are diagnosed with a disorder characterised by challenges in both identity and interpersonal relationships.

Women attract the label of Borderline Personality Disorder (BPD) at a ratio of 3:1 in comparison to men (American Psychiatric Association; APA 2013). Some, therefore, assert that the construct of BPD is subject to several shortcomings and is ultimately a gendered diagnosis, culminating in an over-representation of BPD among women (Shaw and Proctor, 2005). In addition to concern about diagnostic validity and reliability (Alterman & Cacciola, 1991; Bateman & Fonagy, 1999), the circularity of personality disorder symptoms has been argued, with the behaviours expressed by those with the diagnosis considered both the cause and the symptom of the disorder (Pilgrim, 2001). The conceptual distinction between normal and abnormal underpins many of the criticisms of BPD within a mental illness framework, and the assumption that personality disorders are distinct from other forms of personality has been rejected (Livesley, 2011). Beck argues that personality disorder is a social construction of

individual difference, used by a society which is over-concerned and over-identified with the concept of risk (Beck, 1992).[7]

There have been calls to conceptualise what is understood as symptoms of BPD as responses to complex trauma due to the comparatively higher rates of child abuse and neglect among those diagnosed with BPD when compared to other clinical groups (Battle, Tracie Shea, Johnson, Zlotnick, & Zanarini, 2004; Zanarini et al., 2011). Research on attachment implicates the role of insecure attachment in giving rise to difficulties in mentalisation, which it suggested gives rise to difficulties in regulating emotion and developing a stable sense of self (Bateman & Fonagy, 2010), all core features of the diagnosis of BPD. It has been argued that these features, in addition to interpersonal difficulties may be better conceptualised as coping responses to trauma (Herman, 1997). Having a BPD diagnosis is also associated with stigma and strong reactions from care staff, and it has been recognised that clinicians hold strong countertransferential reactions to this client group (Gunderson, Bateman, & Kernberg, 2007) with the potential for these clients to be experienced as difficult, manipulative and frustrating by staff. Thus, staff may encounter individuals with this diagnosis with difficulty, with the potential for this to create barriers in the development and maintenance of relationships. This may further exacerbate the barriers identified by Shepherd et al. (2016) rendering the recovery principle of connectedness a complex interpersonal task for individuals who have attracted a BPD diagnosis.

A recent meta-synthesis identified three qualitative studies examining recovery as experienced by those diagnosed with a personality disorder (Shepherd, Doyle,

[7] See section 1.3 of extended introduction for further information about BPD, social constructionism and BPD, treatability and treatments for BPD.

Sanders, & Shaw, 2016). Participants noted that clinical recovery implied a dichotomy of recovery positions, implying a return to a past recovered state. Here, participants questioned what they would be reverting to, given their difficulties had been present for their lifetime. Others noted the discrepancy between service-defined goals for recovery such as reduction in self-harm and self-defined recovery goals including improved interpersonal relationships (Katsakou et al., 2012). These studies (Castillo, Ramon, & Morant, 2013; Holm & Severinsson, 2011; Katsakou et al., 2012) sampled from community and specialist personality disorder services but not secure services. Thus, little is known about how women with diagnoses of BPD experience recovery within secure services.[8]

Some of the behaviours of women diagnosed with BPD could be seen as strategies they have developed in response to early experiences. This could pose unique challenges to women with BPD diagnoses who enter secure services where they are enrolled in programmes targeting features of their personality (Duggan, 2004) with the goal of reducing their risk and increasing socially acceptable behaviour. Whilst the challenges of safety and security in recovery for secure services have been recognised (Shepherd et al., 2016), challenges in creating trusting and positive relationships with staff, perpetuated by counter-transference among staff, may bring a new dimension to how these relationships are experienced and how connectedness in recovery occurs for this group. These challenges may be exacerbated for women in services who have heightened rates of traumatic interpersonal experiences. Furthermore, many individuals with PD diagnoses in secure services experience numerous iatrogenic interventions (Jones, 2007). Uncertainty about the length of their admission and the suggested

[8] See section 1.4 for further information about personality disorder and recovery.

chronicity of the disorder each too have the potential to impact upon hope, a key feature of recovery.

Aims

This study sought answers to the questions: what are service-users' accounts and views of recovery in secure settings and how might these accounts connect with existing theories of recovery and change? To achieve this, the study set out to explore the experiences and views of recovery for women diagnosed with BPD and detained in secure services; to develop a theory that contributes to understanding this recovery process, and to relate findings from these accounts to extant theory.

Methodology

Constructivist grounded theory methodology was employed, utilising the principles outlined by Charmaz (2014). Grounded theory is a means of systematically and inductively gathering, synthesising, analysing and conceptualising qualitative data allowing for researchers to construct a theory which is "grounded" in the data (Charmaz, 2011; 2014)[9].

Participant recruitment

This study employed a cross-sectional exploratory design, recruiting women from secure and locked services within the UK. A named clinical psychologist facilitated recruitment on each site, and invited prospective participants into the study.

[9] See extended methodology section 2.1 and 2.3 for further discussion of epistemology and discussion and critique of Grounded Theory.

[10]A purposive sampling strategy (Devers & Frankel, 2000) was employed to identify service-users who met the following criteria:

Inclusion criteria:

- Female
- Between 18 and 65 years of age
- Diagnosed with Borderline Personality Disorder (or Emotionally Unstable Personality Disorder; EUPD)
- Able to provide informed consent
- Able to speak and understand English
- Detained in forensic mental health services under the Mental Health Act (MHA; 1983) as amended in 2007.

Exclusion criteria:

- Currently experiencing active, positive symptoms of psychosis impacting on functioning.
- Diagnosed with a learning disability.
- Subject to transferred prisoner sections of the Mental Health Act 1983, as amended in 2007.

Procedure

Ethical approval was gained through the National Health Service Research Authority committee and the Research and Development departments of NHS and private sites.[11] Initial recruitment took place across medium- and low-secure services. Based on the emerging data from secure services, the recruitment strategy was extended to include a

[10] See extended methodology sections 2.6.1 and 2.6.2 for further information about participant recruitment and withdrawal.
[11] See extended methodology section 2.7 for further information about ethical procedures.

locked rehabilitation service. One participant was recruited from this service. In line with the Mental Capacity Act (2005) participant capacity was assumed. Responsible Clinicians (RC)[12] asserted no doubts about the capacity of potential participants who reached criteria. Therefore no formal capacity assessments were undertaken. Although capacity was assumed on this basis, the first author remained attentive to the issue of capacity and monitored this throughout. There were no concerns that participants lacked the capacity to consent or engage in any stage of the research.

The first author obtained informed consent and obtained demographic data from participants. Semi-structured interviews were conducted in a non-directive manner, using open-ended questions and prompts to explore the subjective experience of participants. Initial interviews addressed broad concepts including personality disorder, recovery, and experiences of recovery in secure services. Interviews were audio-recorded and transcribed verbatim by the first author[13] and analysed in line with grounded theory principles.

Participants

Nine participants were recruited. One withdrew consent before the interview stage, and one interview failed to record due to a technical fault. Therefore data obtained from seven interviews were analysed. Recruitment presented a number of challenges and amendments were made to extend recruitment timescales and include further sites. Data from the initial six interviewees provided rich data and directed the author towards considering the experiences of women in locked rehabilitation services as a stepping

[12] A Responsible Clinician (RC) is a professional who has overall responsibility for a person being assessed or treated under the Mental Health Act

[13] See extended methodology section 2.8 for further information about data collection.

stone in the recovery journey; therefore an amendment was submitted to recruit from one such site.

Theoretical sufficiency refers to the point of arriving at themes which are robust to the addition of new data without requiring modification (Dey, 1999).[14] While theoretical sufficiency was the objective of the study; recruitment challenges undermined the ability of the study to achieve this. Although the study was extended to a locked rehabilitation service, only one participant was recruited here. The experience of this participant developed upon similar themes from participants in secure services, however, it is possible that interviewing additional participants may have broadened emergent theory.

Participant demographics can be seen in Table 5. Two participants were receiving treatment in medium-secure services, four in low-secure services and one participant was recruited from a locked rehabilitation service. Participant ages ranged from 22 to 52 and the length of current inpatient stay ranged from 1 year to 8.5 years. Each participant had a diagnosis of either Emotionally Unstable Personality Disorder (EUPD; as defined by the ICD-10) or Borderline Personality Disorder (BPD; as defined by the DSM- V). Due to the widespread use of BPD in academic literature, this will be used to refer to both EUPD and BPD in the remainder of this report.

[14] See extended section 2.5 for further discussion of sampling and sample size.

Table 5. *Participant demographics*

Pseudonym	MHA Section	Level of security	Age	Diagnosis	Time in Services	Offence
Charlie	3[15]	Medium	51	EUPD, ASPD[16], OCD[17]	2 years, 18 months	Grievous bodily harm
Katrina	37[18]/41[19]	Medium	52	EUPD, PTSD[20]	4 years	Actual bodily harm
Sammy	37	Low	46	BPD, ASPD	1 year (previously in prison)	Making threats to kill
Amy	37	Low	35	BPD	8.5 years (previously in prison)	Child neglect
Kelly	3	Low	22	EUPD	2 years	No offence
Michelle	37/41	Low	31	EUPD, Schizoaffective disorder	6 years	Aggravated -ted armed robbery
Nicola	3	Locked Rehabilitation	34	EUPD, Bipolar Disorder	9 months (previously in prison)	Grievous bodily harm

[15] Under Section 3 of the MHA an individual can be detained for treatment for 6 months. But it can be extended for longer

[16] Antisocial Personality Disorder

[17] Obsessive Compulsive Disorder

[18] Under Section 37 of the MHA an individual is deferred from court to hospital for treatment rather than prison. Known as a Hospital Order, this may be renewed after 6 months and extended and reviewed.

[19] Section 41 refers to increased restrictions placed upon the patient and monitored by the Ministry of Justice. This is commonly done where there are concerns relating to increased risk to the public. Individuals subject to section 37/41 can only be discharged upon agreement from their RC and Ministry of Justice. There is no time limit to this section.

[20] Post-traumatic Stress Disorder

Analysis

Charmaz (2014) proposes a range of guidelines for completing constructivist grounded theory. A key feature of this methodology is the iterative process of data collection and analysis which allows for the refinement of emergent categories and pursuit of data which may extend or contend the emergent theory.

Data was coded on a line-by-line basis whereby the first researcher ascribed descriptive codes to each line of the interview transcript. Subsequent focused coding was completed whereby earlier initial codes were integrated to form analytic categories. As new interview transcripts were introduced to the analysis, the process of constant comparative analysis was initiated, involving the comparison of newly developed codes with codes which had emerged in past transcripts. A process of negative case analysis was completed whereby searching for data which did not fit with emerging concepts was completed. As new concepts began to emerge, the interview schedule was revised to pursue these areas in future interviews. Interview schedules were revised following the third and fifth interviews. In the final stage, theoretical coding, findings of the studied experience were related to extant theory through the completion of a literature review and in consultation between the first three authors.

Results

Participants described a complex recovery process occurring across several sequential stages, with the potential for participants to experience setbacks and return to earlier stages (Figure 6). Relationships were described as the most influential factor in the recovery process, enabling progression towards recovery but also creating a significant barrier to recovery, particularly in early stages. Other factors described as having

facilitative influences on recovery were also described as having the potential to inhibit recovery. Participant coping skills, the role of risk and participant readiness for recovery each exerted such dual influences. Recovery was described as an ongoing process, continuing beyond discharge. Throughout recovery, participants engaged in many forms of psychological adjustment, requiring re-appraisals of their ideas of recovery and their current position in their recovery journey as they also adjusted to the passage of time. Facilitators and inhibitors of recovery will be embedded into a discussion of recovery stages.

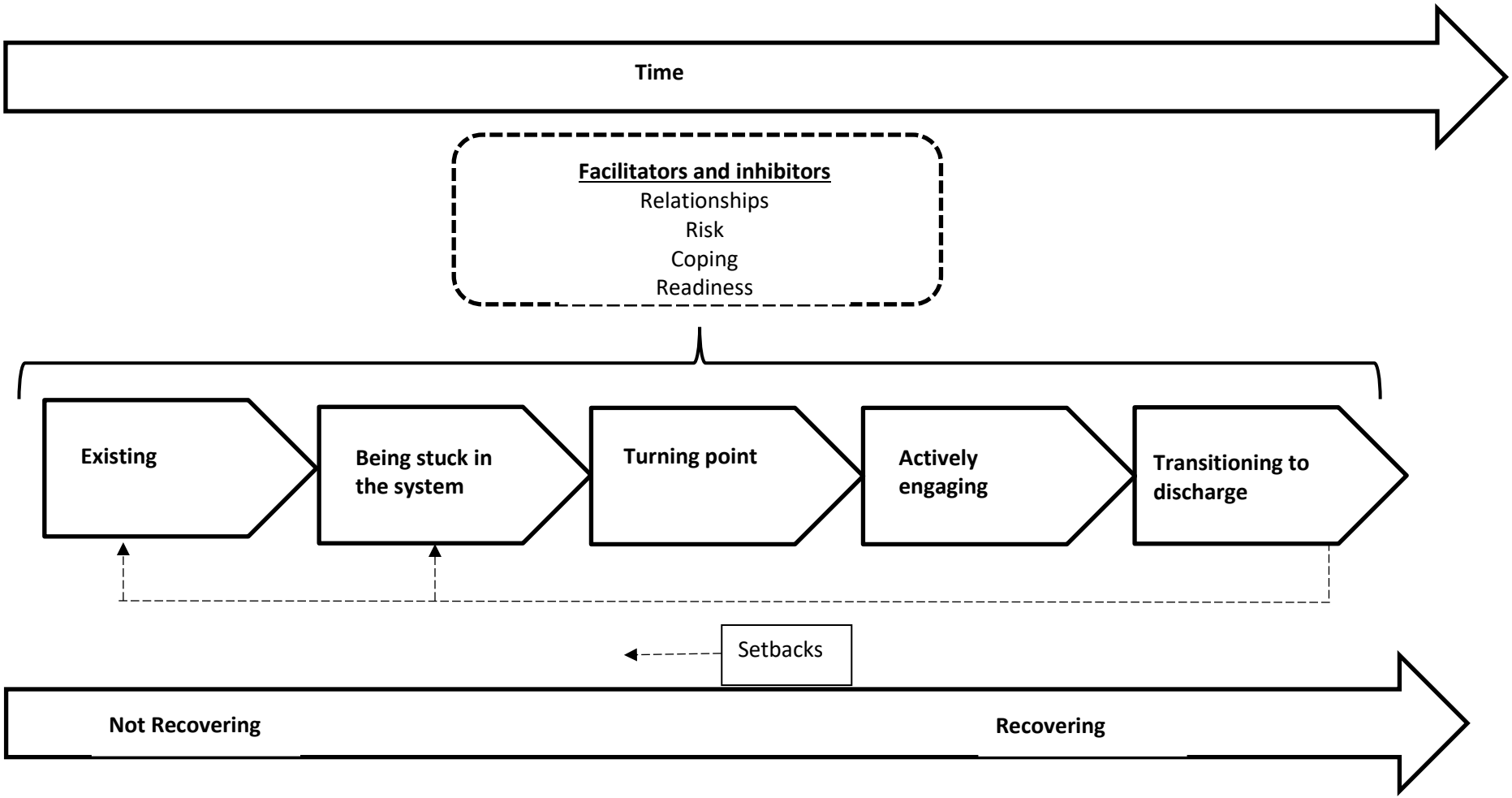


Figure 6. Grounded Theory Model[21]

[21] Further discussion of Time and Relationships are described in Extended Results sections 3.1 and 3.2

Stages of Recovery

Existing.[22] Participants described a sense of 'existing' early in their experiences in services. Receiving a diagnosis raised questions about their identity and challenged participants' self-concepts. Participants struggled to manage the intensity of their emotional experience which was impacted upon by negative self-concepts, the emotional impact of their offence and an absence of adaptive skills to manage emotion. Overwhelming feelings of guilt and shame in relation to offending were reflected upon in this stage by Amy as impacting her sense of feeling worthy of life and recovery:

> *"I didn't deserve [recovery], because of what I'd done. Back then I was just. I was a terrible person. I was a horrible person. I didn't deserve anything nice. I didn't deserve to get better, I didn't deserve to live, I didn't deserve all that"*- Amy

Though relationships were described as fundamental to recovery, in early stages where safety had yet to be established in relationships, participants described a sense of feeling unable to trust staff. Lack of trust in relationships represented a significant barrier to recovery, disabling participants from communicating their needs and creating a sense of disempowerment. This was described by Kelly whereby she felt disempowered by a lack of trust to communicate fears that staff were over-estimating her ability to cope:

[22] See extended results section 3.3.1 for further information about 'Existing'.

" they took me off 1:1 and I didn't feel ready, and I didn't know how to tell them I didn't feel ready because I didn't trust anybody enough to tell them"- Kelly

For many, the security provided by the service offered a "*safety blanket*" (Kelly) With a lack of trust with staff in this stage and minimal strategies to manage distress, participants often drew upon self-harm or the security provided by the service to contain and regulate their distress. For the majority, self-harm was a well-established strategy for managing emotion:

"I see it as a way to cope. If things get too much in my head, it's like a release of my feelings, mm…maybe it's not the best way of coping with things, but it's what I learned to do since I was quite young so…"- Kelly

Definitions of recovery underwent significant change over time, requiring an adjustment in expectations. During the 'existing' stage, initial ideas of recovery appeared difficult to grasp, and a sense of not being in recovery at all was described. The chronicity of struggles in managing emotion, and intensity of emotional experience at this time were described as negatively impacting upon hope, motivation, and readiness for recovery:

"I wasn't thinking about it to be honest. I wasn't even bothered. I didn't think I ever would recover, so I didn't put any effort into recovery… I felt kind of hopeless…for years and years I'd been in and

out of hospital and felt like I was getting nowhere so I just felt like it wasn't possible"- Kelly

Being stuck in the system[23]. Most women acknowledged the need for progress towards recovery to take place slowly, recognising the longstanding nature of their difficulties. In this sense, there was recognition of the need for support and help over time, but also the inherent frustration of perceiving limited progress:

"They [clinical team] are making the right decisions, they are doing it right it's just, frustrating because I'm moving so slow…I'm not getting anywhere, and it's frustrating because I know I'm capable of so much more, but I know I need to take it steady"- Kelly

Participants reflected on this stage as being intensely risk-focused, with tension occurring between the lack of positive risks afforded by their clinical team and their own perceived sense of ability to move forward*:*

"how can I prove to you that I can be independent if you've locked all the doors on the ward and I'm not allowed to do this. How can I prove to you that I'm independent cos I'm not getting the chance"- Amy

[23] See extended results section 3.3.2 for further information about 'being stuck in the system'.

The magnitude of restriction still placed upon participants was not only considered to impede their progression but also further impacted upon low self-worth through feeling "*degraded*" (Amy). Relationships were reflected upon as tense, due to the ongoing conflict over views of risk between participants and their clinical teams. The desire to have restrictions reduced resulted in caution and mistrust within relationships with staff whereby participants felt the need to balance a conflicted emotional world with the need to present a placid external façade to increase staff confidence in their coping skills:

> *"you're having to put on a brave face saying, 'yeah, it's working' and 'don't worry it's working' and you know deep down that it ain't, and that you still feel the same shit that you used to"*- Sammy

Concealing their emotional experience from staff was described as giving rise to a sense of disconnectedness and feeling overwhelmed. This was also reflected in peer relationships and resulted in many participants feeling isolated in their inpatient experience:

> *"And believe it or not, sitting with 30 other patients, I get fucking lonely"*- Michelle

From this point, participants came to measure recovery through levels of restriction such that having restrictions reduced (e.g. observations, level of security) became indicative of recovery. Similarly, setbacks became measured in terms of

restriction such that a setback was defined by returning to previous levels of restriction, rather than by the act itself (e.g. self-harming, aggression). The nature of restriction was related to the concept of coping, such that restrictions were modulated based upon the clinical opinion of the participants' ability to cope, assumed to be associated with their level of risk. In this stage, participants reflected the limited opportunity to demonstrate coping in new situations due to the level of restriction they were subject to. Thus, restrictions were experienced as both an external indicator and facilitator of recovery. By staff reducing restrictions, participants came to view this as an indication of staff consensus that they were recovering and through these reduced restrictions participants gained further access to opportunities which enabled them to demonstrate coping, thus facilitating their recovery. When participants became stuck, this was often due to feeling unable to escape the degree of restriction. In the instances of setbacks, they described returning to this stage and being further from their recovery:

> *"if that hadn't have happened, I would have carried on and would have got unescorted leave and been out of here 2 years ago but because something happened … I went further and further down"*- Amy

Thus, it appeared that clinicians held a view of recovery as associated with risk. However, participants did not share this view. Instead, they appeared to associate recovery with coping which, due to restriction they could not demonstrate, creating a sense of 'stuckness'.

Turning Point.[24] Participants reflected that they spent, or are currently spending, most of their inpatient admission feeling 'stuck'. Those who had managed to progress further towards their idea of recovery reflected that moving out of this stage involved a long process in which many inter- and intra-personal changes took place, often influenced by relationships with staff. The 'turning point' reflects gradual and dynamic cognitive shift which culminated in the form of a 'lightbulb moment':

> *"something that just clicked into place. It was just loads of just little things"*- Amy

The 'lightbulb' moment appeared underpinned by a decision to take responsibility and become active in recovery. Earlier experiences of hopelessness appeared to shift as staff consistently maintained hope for recovery where participants could not. As described by Michelle, one staff member was "*the light switch to the light in my tunnel".*

Reflecting upon pros and cons of engaging in recovery was described, and at this point, participants described a sense of being better able to identify how cons were no longer resonant. There was a shared recognition that engaging in recovery was a challenging and demanding endeavour, requiring commitment and desire from participants, and in contrast to previous recovery stages, participants entered into a state of readiness to begin this:

[24] See extended results section 3.3.3 for further information about 'Turning point'.

"Suppose it depends on how much you want it cos it's easy. It's so easy to fall back into … It's easier to be unwell. It's hard work getting well again. It's hard work getting to that point where people believe you're well enough to look after yourself. It's a big thing" -Amy

Most participants identified key relationships as contributing to increased motivation and shifts in self-concept, ultimately facilitating them towards recovery. For some, relationships in secure services provided the first experience of a caring relationship, creating a shift in their sense of relationships more broadly and the creation of a 'secure base':

"it's because of them [staff] I see people in a totally different light, and I see…I'm getting a bit emotional...I see the reason that people wanted to help. I've never had that all my life. My mum loves me. My mum loves me to pieces, but I never felt that from her"- Michelle

In this stage, participants described a greater sense of empowerment and agency over their recovery. This was reflected upon through experiences with their clinical team such as exerting autonomy within ward-round processes enabling them to become empowered in clinical decision-making. As participants became empowered, this was reinforced through positive risks afforded to them by staff. Successfully managing such situations provided positive reinforcement for participants, contributing to increased confidence in their abilities and motivation to engage in working towards recovery.

Actively Engaging.[25] When engaged, participants described learning in multiple contexts. Learning occurred within the interpersonal context, particularly in relationships with staff. Through the foundations of relationships established in earlier stages, participants described a felt sense of safety and security, enabling them to engage in the exploration of sensitive issues including processes of self-discovery and understanding their offence. Supportive and open relationships were described as empowering participants to be assertive, communicate openly and ask for help, with many identifying this as a key aspect of personal development and recovery:

> *"since being in hospital I've learnt different ways of doing things so instead of indirectly going around the houses asking help in a not a great way, I've learned that I can talk about things and discuss things with people and be open and honest about what I'm thinking and feeling works a lot better for me"*- Amy

The difficulty in feeling worthy in earlier stages appeared to be influenced by the emotional magnitude of the offences committed by participants. While earlier identities were consumed by totalising views of the self as a bad person and the self as unworthy; identities became reconstructed. Here, participants appeared to feel able to begin to reconstruct their identity, creating distance from past totalised views of the self and creating a more cohesive self-concept:

[25] See extended results section 3.3.4 for further information about 'Actively engaging'.

"as time's gone on, I've kind of learned that I'm not a bad person, I just made one really big mistake"- Amy

Participants engaged in processes of looking back and looking forward as they reconciled their current identity and past and preferred identities. For some participants, the sense of continued identity felt challenged due to the degree of personal change they experienced within their time in services:

"Only cos I can look back and see myself then as a different person to what I am now"- Michelle

Therapeutic interventions, most often Dialectical Behaviour Therapy (DBT; Linehan, 1993), were credited by participants as facilitating their recovery. Participants reflected upon the value of newly acquired skills which equipped them with alternative forms of coping than those previously utilised. Here, participants described a transition from externalised coping to internalised coping, drawing upon external resources such as staff and medication flexibly and autonomously as they (re)gained control over their experiences:

"...you don't need that much security around you or that much help. You know, you can persevere on your own sort of thing" – Charlie

Definitions and expectations of recovery, as a result of engaging in learning, became increasingly organised around ideas of self-management and

coping, rather than eradication of symptoms. The concept of clinical recovery and what this constituted was not considered an objective for participants:

> "*I think I'll always have it [BPD], but I think the nature and the degree of it will be a lot less. So, the way that I feel, like my feelings will still be there, but they will be easier to cope with*"- Kelly

Whilst developing positive relationships progressed participants towards recovery, relationships also represented a source of de-stabilisation and setbacks throughout the recovery process. Participants reflected on negative attitudes held by staff, the impact of their relationships outside of secure services and managing those within services as presenting many challenges along their recovery journey. Conflict with staff and loss of meaningful relationships were intensely emotional experiences, often impacting mood and challenging participant coping skills. Nicola described the impact of sudden changes to the staff team:

> *"cos the structure isn't too good at the minute…like everyone got on, like one big family. But now it's just, it's just gone innit...gone all of it. I don't know. It makes me feel like I don't want to be here anymore"*- Nicola

Such experiences had the potential to negatively impact upon participants and contribute to setbacks, i.e. returning to previous stages of recovery. Looking to the

future and experiencing setbacks resulted in participants feeling further from their recovery, creating disappointment. Many participants spoke of strategies they employed which prevented the likelihood of future disappointment, such as focusing one day at a time and managing expectations:

> *"I think I em..I just take it em just one minute to the other without trying to get too worked up… I can't cope with time very well…it feels as if I'm in a traffic jam and I can't get out of it"*- Charlie

Transitioning to discharge[26]. The concept of ambivalence arose at many points throughout participants' descriptions of progress in their recovery. However, as they became engaged in recovery and the possibility of transitioning to lower security or discharge arose, this ambivalence became more prevalent. They described feeling that the challenges they face in services feel alien to the challenges they will face upon discharge. The sense of independence required for moving on was daunting for many participants:

> *"I've been saying for a while "oh yeah, I'm going home, it's great" but I've also said "I'm shitting myself", cos I've been locked up, I've lived with 15 plus people for 10 years, and this is gonna be me on my own"*- Amy

[26] See extended results section 3.3.5 for further information about 'Transitioning to discharge'.

For some, the anxiety, which arose as they approached discharge, contributed to setbacks and returning to past recovery stages. Participants spoke about the comfort which had been provided both physically and emotionally through their experience as an inpatient and how looking to the future signified the loss of these comforts. For those participants who had long admissions, the transition felt overwhelming and impossible. One participant reflected that she could not envisage adjusting to life in the community, reflecting that she felt she had become unable to adapt to any lesser provision:

> *"Well just because I've been in places like this like and my care has been very much contained em…I can't think what it must be like at the moment to be in any less secure environment"*- Katrina

Definitions of recovery became organised around a desire to engage in '*normal*' life. Most participants reflected that recovery was not simply an internal process but involved a form of social recovery, suggesting that moving forward to the community was where they could experience true recovery as they re-integrated into their communities. Participants reflected that recovery did not end at the point of discharge, instead, describing an evolving and ongoing process:

> *"So, you have to keep working at it and working at it, and you can't just give up. You're not like one day recovered and then you have to stop working, I think you have to keep working at it"*- Kelly

Discussion

This study sought to develop a grounded theory of recovery for women who received BPD diagnoses and were detained in secure and locked services. Recovery is an idiosyncratic process. Thus, it is not expected that the production of a grounded theory model provides a definition of "what recovery is", rather, it offers a conceptual understanding of the experiences of the seven women who took part.

Participants described engaging in many psychological processes as they progressed through sequential stages of recovery. The occurrence of setbacks had the potential to return participants to earlier stages, such as the 'being stuck in the system' stage, requiring participants to overcome challenges in this stage again. Recovery appeared to occur through interpersonal relationships, with the nature of relationships exerting great influence over the recovery process. The safety provided by the secure environment in addition to the learning which occurred through relationships enabled participants to become orientated towards recovery, take responsibility and actively engage in this recovery. Participants managed the uncertainty of time on an ongoing basis, requiring re-defining of expectations for recovery and psychological adjustments to manage the impact of passing time.

The process of recovery followed a sequential progression. Models of behavioural change also offer similarly sequential models, such as the transtheoretical model of change (TTM, Prochaska & DiClemente, 1982; 1983). The process of recovery too can be mapped onto this model of change (Leamy et al., 2011). However, the TTM has been criticised for failing to account for the factors which transition individuals from one stage to the next. The proposed grounded theory model locates transition and setbacks in the interpersonal context, as reflected by participants.

The process of recovery appeared to be typified by the state of relationships along the recovery journey, and this may be mapped on to patterns of attachment security (Mikulincer & Shaver, 2007) with recovery occurring against a transition from insecure to increasingly secure attachments, particularly with staff. In the early stages of 'existing' and 'being stuck in the system' participants reflected upon relationships characterised by caution and mistrust. Such patterns of mistrust are often seen in individuals who are insecurely attached, who do not predict that others will be available or responsive to their needs (Mikulincer & Shaver, 2007). Attempts to downplay attachment needs are considered adaptive strategies to draw upon when coping with threat, frustration, and loss (Cassidy & Kobak,1988) and it may be considered that participants utilised such strategies in these stages in the absence of relational safety.[27]

Developing safe and supportive relationships with staff was reflected as a key facilitative feature in the process of recovery. Although absent from mainstream recovery literature (e.g. Leamy et al., 2011), themes of safety were found in previous studies of recovery in forensic services (Shepherd et al., 2016). Safety in these studies, however, was predominantly defined in terms of physical safety. Winnicott (1969) recognises the distinction between a 'safe container', and a 'safe base'. In this case, the secure environment may be considered the 'safe container', promoting safety through procedural security whereas safety in relationships can be considered as providing the 'safe base'. Both forms of safety appeared necessary for recovery to take place.

Whilst other studies of recovery in secure settings outline relationships as facilitative or constraining in recovery (Shepherd et al., 2016), the notion of safety in relationships as a necessary condition for recovery to take place was reflected in this study. Here, in addition to physical safety, participants required a sense of relational

[27] See extended discussion section 4.1 for further information about attachment.

safety to progress towards recovery tasks such as psychological therapy. This may be reflective of the often-complex interpersonal traumas experienced among women who not only enter secure services but also attract the diagnosis of BPD. It may also reflect the additional demands of recovering in an inpatient environment, particularly with a diagnosis that is shown to attract adverse reactions from staff (Gunderson et al., 1997) This transition from unsafe to safe relationships may be considered within a hierarchical model of need. Maslow (1943; 1970) identified the need for individuals to have basic needs such as physiological needs and the need for safety to be met before they can attend to higher-order needs such as self-actualisation. This model can be applied to the experiences of participants who described the need for both physical and relational safety to be established before they seek to become actively engaged in their recovery.

Recovery literature emphasises the role of connectedness in recovery (e.g. Leamy et al., 2011). The nature of connectedness has been raised as a key challenge for forensic service-users (Dorkins et al., 2011) and attempts have been made to encourage secure organisations towards promoting connectedness for service-users. Participants reflected what appeared to be an inverse relationship between connectedness in the secure world and connectedness in the community world. Increased detachment from their community relationships was compounded by lengthy admissions and attributing greater meaning to the secure environment as a gatekeeper to freedom. Whilst focusing on the secure world, participants developed connections with staff which often provided the first experiences of a secure base.

The focus of participants on relationships with staff and the secure environment posed challenges as they approached discharge and were met with the reality of being discharged to a community which they had often become disconnected from. Entering into communities where others are unlikely to demonstrate the consistency and

predictability as experienced by inpatient staff was reflected upon as giving rise to challenges at the point of discharge. The idea of mental health services as a 'secure base' has previously been described (Goodwin, Holmes, Cochrane, & Mason, 2003) and discharge in this study thus represented the loss of the secure base. Individuals diagnosed with personality disorders have described the social world as a challenge in their recovery journey (Gillard, Turner, & Neffgen, 2015), and the need to manage discharge for individuals detained in secure environments has been described (Adshead, 2002). However, for this client group, there appeared to be the additional significance of the ending of the inpatient experience, which symbolised the loss of positive attachment experiences, resulting in increased anxiety around discharge, creating a potential for setbacks. Although findings from research into recovery in secure services outline the trepidation service-users experience upon discharge due to the loss of safety provided by the forensic institution (Mezey, Kavuma, Turton, Demetriou, & Wright, 2010), findings from this study represent the distinct addition of loss of safety in the interpersonal domain and locate this as a common source of setbacks and an area for consideration within the process of transition.

Participants described life-long difficulties which upon admission negatively influenced their views of recovery and contributed to a view of recovery as impossible, creating a sense of hopelessness for recovery. A study of hope among forensic mental health nurses identified the challenge of 'creating hope from scratch' for service-users who had little experience before admission that would create a belief of hope post-discharge (Niebieszczanski, Dent, & McGowan, 2016). It appeared that similar processes were described in this study whereby staff were seen as consistently reinforcing the idea of hope and working to instil a sense of worthiness in participants about their recovery.

The role of hope is considered central to personal recovery (Leamy et al., 2011). Studies of recovery in forensic services outline the complexity of maintaining hope in the secure environment (Mezey et al., 2010). Among these studies, however, the perspectives of individuals diagnosed with personality disorder are either absent or only moderately represented, with understandings of recovery and hope often obtained from a sample of individuals with experiences diagnosed as schizophrenia (e.g. Ferrito et al., 2012; Mezey et al., 2010; Shepherd et al., 2016). Alternative views of hope may be influenced by the way in which disorders are constructed and therefore treated. It is important to consider the significant and relatively recent reconceptualisation of BPD as a disorder that is responsive to treatment and how this may have influenced messages of recovery (Department of Health, 2003). Findings from studies of recovery for individuals diagnosed with BPD note the conflicting message of recovery held by staff, such as being told "*you won't get better after this*" (Gillard et al., 2015). Indeed, some staff still view recovery from personality disorder as a clinical task (Donald, Duff, Lawrence, Broadbear, & Rao, 2017) despite evidence that recovery for this client group involves a form of social recovery (Zanarini et al.,2011). Thus, for individuals diagnosed with BPD and detained in secure services the reduction of apparent 'clinical symptoms' forms just one aspect of recovery for service-users. Instead, service-user-defined recovery is, to an extent, socially located with focus placed upon meaningful connections with others and finding a place in the community. Thus, by constructing recovery as a clinical task, the recovery objectives of staff and service-users may become delineated, with goals and objectives competing for resonance and priority.

Participants reflected upon recovery as a process of improving one's own ability to cope., particularly with their emotional experience.[28] There was a dominant discourse

[28] See extended discussion section 4.3 for further information about coping

of little understanding or expectation of clinical recovery from personality disorder, with participants reflecting a belief that they would continue to have difficulties for the remainder of their lives. Central to their beliefs was that recovery instead became defined as an ability to self-manage, which offered a sense of hope for the future. This reflects the prevailing ethos of recovery literature, emergent from narrative accounts, and is also found in the literature surrounding recovery from personality disorder (e.g. Katsakou et al., 2012; Gillard et al., 2015). It appears that the process of recovery contains within it a process of gaining greater control over one's experiences with participants moving from an external locus of control to an internalised locus of control (Rotter, 1966), requiring less input from staff.

Participants described a recovery process within which they constructed and re-constructed their identity.[29] The nature of "identity-work" is a common challenge for individuals who have committed criminal offences, and the task of reconciling identity has been found in studies of recovery within forensic services (Ferrito, Vetere, Adshead & Moore (2012). The sample of participants in this study offered a unique perspective of recovery as a process of reconstructing identities of 'offenders' and 'mental health patients'. In the 'existing' stage most prominently, participants reflected on a self-concept that was dominated by views of the self as 'unworthy' and dominated by shame. For some participants, the sense of being unworthy translated into feeling unworthy of redemption, unworthy of life and unworthy of recovery. Findings from studies of forensic service-users identify self-worth as a recovery goal (Mezey et al., 2010). Whilst increased self-worth may be considered as an outcome within personal and clinical recovery, the idea of low self-worth impacting upon worthiness for recovery and therefore readiness for recovery, has not been described in either studies of

[29] See extended discussion section 4.2 for further information about identity.

recovery within the mainstream, or within forensic groups or among those receiving a BPD diagnosis. Processes of internalised self-stigma, managing guilt and shame associated with offending, and the potential for internalised blame following traumatic experiences may have contributed to this view.

Processes of self-discovery through relationships and therapeutic approaches appear to have influenced the development of self-worth, most notable within the 'turning point' and 'actively engaging' stages. Here, participants became distanced from totalised identities of 'offender' and 'mental health patient' and moved increasingly towards self-compassion and the understanding of the self who has acted badly, rather than is intrinsically 'bad'. Other research has suggested that 'self-discovery' may be a more appropriate term for service-users with BPD diagnoses, given the implied objective of returning to a past pre-illness stage. The concept of self-discovery has some salience in the model developed with women in this study.

Limitations

The primary limitation of this study relates to the inability to share the model with any further participants to determine the fit of the final model. Charmaz (2014) recognises the final stage of grounded theory as sharing the model to gain insights into its fit, although not all grounded theory studies achieve this. Recruitment encountered many challenges throughout the research process, and although several amendments were made to expand the project, the uptake was generally low, and few participants met criteria. Following unsuccessful attempts to invite further participants, the study concluded without reaching this final stage.

Another limitation is the under-representation of service-users considered 'risky' or 'in crisis'. During recruitment, on-site psychologists and RC's ultimately determined

which participants had the capacity to consent and/or should be approached to participate in the study. Several service-users were not approached as it was anticipated that the interview process might de-stabilise them. Thus, it is possible that the views of women experiencing 'crisis' have not been captured in this study. This may have provided further insights into the recovery experience at different stages.

A final limitation relates to the content of interviews whereby some participants' contributions exceeded the contributions of others. Two participants, in particular, struggled to engage in the interview as they appeared to be extremely tired. Therefore, the accounts of the remaining five participants typically offered more richness of data within the analysis stage. These more vocal participants were often further in their recovery, which enhanced insights into anxiety at the point of discharge and reflected upon early recovery stages. [30]

Implications and suggestions for future research

The study generated a grounded theory of the experience of recovery for women diagnosed with BPD in secure services. Findings had some similarities to recovery literature from forensic and personality disorder service-users, although findings from this study identified some idiosyncrasies which could be translated into clinical practice. This is the first staged-model of service-user defined recovery both within the forensic literature and within the personality disorder literature. It extends beyond available models of behaviour change commonly used within forensic interventions, such as the TTM. The emergent grounded theory model moves from the idea of motivation to change as in intra-personal endeavour and identifies the central role of relational factors

[30] See section 6 of extended paper for further discussion of limitations

in progressing participants through recovery, which could be used to harness motivation in the forensic service.

Participants described barriers within relationships as impeding recovery. The resultant recovery model identified distinct stages of recovery each with particular barriers to be overcome by the service-user. Through identifying these barriers, the model reveals opportunities which staff have to intervene and support recovery for service-users in times when they are encountering particular challenges. For example, the model outlines the overwhelming emotional distress in the early 'existing stage' during which time participants are likely to conceal their experience and resort to established strategies for regulation, including self-harm. Compounded by shame and guilt in such stages, there is a role for staff to intervene in providing support.

Similarly, the model outlines the challenges the women described as they approached discharge and how much of the transition signified a loss of the secure base and transition into the unknown. Within this model, transition anxiety is anticipated, outlining the need for careful planning and integration into life beyond discharge.

Staff working with service-users could use this model as a form of reflective tool to reflect upon the state of relationships with their service-users and consider the extent to which interpersonal processes may be playing out. Indeed, this study highlights the centrality of relationships which have the potential to both impede and foster recovery, thus rendering them an invaluable resource. Therefore, how staff construct their understanding of women who have attracted this diagnosis and how they, therefore, react and respond to behaviours is a fruitful area for reflection and attention among staff teams. This study has identified features of the recovery process which may be of particular importance to women who have a diagnosis of BPD and are in secure services. The study identified the fundamental role of relational security which staff can

harness to develop hope and contribute to turning points towards recovery for these individuals.

It is recognised that some participants in this study had previously been in high-security hospitals; however, there was no representation from women currently detained within conditions of high security. The developed model could be extended upon by considering the views of women with this diagnosis in high security, who typically face a lengthy transition to discharge through the routes described by participants in this study. Similarly, the study identified challenges which participants encountered as they faced discharge. At present, there is no literature available relating to how recovery is experienced beyond discharge for forensic service-users. Findings from this study may predict that women diagnosed with BPD may experience the transition with great anxiety contributing to de-stabilisation in recovery within secure services. It is likely that discharge and re-integration in the community may pose challenges to the ongoing recovery for this client group. Further research may seek to explore how recovery is experienced as participants transition into the community and continue with what they described as the ongoing process of recovery. This research may be strengthened by a longitudinal methodology tracking change in recovery progression over time.[31]

Conclusions

The grounded theory model provides a conceptual understanding of recovery as it was experienced by seven women who had attracted a diagnosis of BPD and were detained in secure and locked services. The model locates recovery within a relational paradigm,

[31] See extended paper sections 5 and 7 for further consideration of strengths, clinical implications and suggestions for future research

with safe relationships enabling the recovery process and an absence of enabling relationships constraining recovery and contributing to setbacks. Thus, how these women are experienced and interacted with by staff has great influence on the recovery experience which these women may encounter. This model offers both a rationale for recovery- and trauma-focused responding to expressions of distress typically understood as symptoms of BPD. The model further locates points for intervention whereby staff can intervene and maximise supporting recovery for service-users.

Central to recovery for these women were the constructs of coping and self-management, similar to recovery as described in mainstream principles (e.g., Anthony, 1993). However, for the women interviewed, finding relational security and constructing and re-constructing identity represented outcomes of recovery for this client group, locating recovery within both intra- and interpersonal contexts.

The model reflects the ongoing nature of recovery, with hypotheses for future challenges which women with this diagnosis may experience beyond discharge. Continuing research into community samples may identify further challenges and highlight opportunities for services to continue to support recovery at and beyond discharge.

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Extended Paper

1. Extended Introduction

1.1. Recovery

1.1.1. Origins of recovery.

Traditionally, within a biomedical model of understanding mental illness as a disease, recovery has been viewed as an observable reduction in clinical symptomology. Slade (2009) differentiated between clinical and personal recovery. Despite their conceptual distinctions, clinical and personal recovery are not mutually opposed. Personal recovery may, therefore, occur in the presence or absence of clinical recovery and vice versa. Since the emergence of the recovery movement, a widely embraced view of personal recovery has been established:

> *"a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness. Recovery from mental illness involves much more than recovery from the illness itself.' (Anthony, 1993,* p. 527).

Within the 1980s and 1990s emerging narrative accounts describing subjective recovery uncovered a disparity between clinically-defined recovery and the subjective account of personal transition (Deegan, 1993). Many of these accounts drew upon power imbalances within mental health services: disempowerment, limitations on autonomy and the subjugation of service-user views. Central to these writings were the roles of hope, identity, empowerment and independent living and how these factors were implicated in the process of recovery (Lester & Glasby, 2010). Service-user accounts began to transform the mental health field and force professionals to develop a critical approach to what had for so long been a medically-defined concept. Personal recovery in the context of mental health is intrinsically subjective (Bellack & Drapalski, 2012). Repper and Perkins describe that recovery is not about "getting rid" of problems but about seeing people beyond their problems, considering their abilities, relationships,

and social roles (Repper & Perkins, 2003), the result of which would require a significant shift in the values of mental health services (Slade, 2009).

1.1.2. Processes and stages of recovery.

Findings from a systematic review outlined key characteristics of recovery, key recovery processes and distinct recovery stages (Leamy, Bird, Boutillier, Williams, & Slade, 2011). Characteristics of recovery related to the active, non-linear, staged nature of recovery, which is individual to the person experiencing it (Leamy et al., 2011). Central to personal recovery was the notion of personal recovery as occurring without a clinical cure. The key processes of recovery are outlined in Table 6.

This model offers utility in gaining conceptual insights into recovery as experienced by the service-user and delivers a framework which is, therefore, high in ecological validity. A limitation of the CHIME framework, however, is the potential for underestimation of the wider social context of the individual, such as issues of discrimination, stigma, and social marginalisation. Stigmatised societal beliefs around mental health can impact adversely upon the individual through internalised self-stigma, with this shown to be elevated in psychiatric inpatients (Werner, Aviv, & Barak, 2008).

The CHIME model has been implemented into mainstream services' approaches to personal recovery. However, the applicability of the model to more specialist services has been questioned. One study (Turton et al., 2011) investigated recovery across three specialist services (dual diagnosis, eating disorders and forensic) and found that whilst there were commonalities between groups, differences also existed in how each group conceptualised their recovery, suggesting that perhaps mainstream principles may need to be adapted to facilitate the needs of specialist groups. However, a conceptual consensus of recovery amongst those working within healthcare is lacking (Le Boutillier et al., 2015), therefore questions remain as to how specialist providers can ensure that they are working within the recovery agenda to meet the needs of their service-users, and as to how service-users can make sense of a concept that is not clearly defined.

Table 6. *Processes of recovery (CHIME).*

Recovery process (categories)	Recovery process (sub-categories)
Connectedness	Peer support and support groups
	Relationships
	Support from others
	Being part of the community
Hope and optimism about the future	Belief in the possibility of recovery
	Motivation to change
	Hope-inspiring relationships
	Positive thinking and valuing success
	Having dreams and aspirations
Identity	Dimensions of identity
	Rebuilding/re-defining positive identity
	Overcoming stigma
Meaning in life	Meaning of mental illness experiences
	Spirituality
	Quality of life
	Meaningful life and social roles
	Meaningful life and social goals
	Rebuilding life
Empowerment	Personal responsibility
	Control over life
	Focusing upon strengths

1.1.3. Recovery in policy and practice.

Personal recovery is an inherently individual process, as the individual seeks to recover and rediscover within their own context and frame of reference. Just as definitions and experiences of recovery are considered individual, Slade argues that if mental health services are to promote recovery, they cannot rely upon a single service model of recovery (Slade, 2009). By developing services which address only the clinical domain of recovery, the key themes which became demonstrated through accounts of those in receipt of psychiatric services can become marginalised.

Recovery-orientated services require organisational changes in their delivery of services (Shepherd et al., 2010) but recovery is not merely an outcome-focused endeavour, rather a change in process, attitude and the nature of interactions (Rickwood, 2004). Staff and service-provider attitudes are considered to be a key determinant in the provision of recovery-oriented care (Repper & Perkins, 2003). Recovery-promoting interactions involve collaboration and an emotional connection or bond (Martin, Garske, & Davis, 2000). However, it is also recognised that some client groups create strong adverse counter-transferential responses in staff, such as those who are diagnosed with a personality disorder (Moore, 2012). Findings from reviews in which basic care has gone wrong have outlined the potentially harmful impact of culture, attitudes and beliefs within staff teams (e.g. Francis Report, 2003; Francis, 2013).

Service-providers offer interventions for which there is the most robust evidence. Evidence generated from large-scale randomised-controlled trials and meta-analyses of RCT's have a significant influence on the structure of mental health services through their incorporation into clinical guidelines, such as the National Institute for Health and Care Excellence (NICE) guidelines. Clinical guidelines have great influence over the structure of services, allocation of resources and interventions offered, all originating within the positivist ideal of knowledge and cure. However, it is acknowledged that even in the case of remission of what are understood as clinical symptoms, many service-users do not encounter personal recovery. Thus, the question for services becomes one of service ethics. Service-user led research identified disparities between objectives of clinical recovery held by the services with the perception of services overly-focused on risk and crisis management (Faulkner, 2000). Indeed, experiences of service-users completing treatment for Borderline Personality Disorder (BPD) reflect the disproportionate attention paid to behaviours such as self-harm, leaving service-users feeling that difficulties they experience, such as interpersonal difficulties, are not addressed by the intervention (Katsakou et al., 2012). Focusing on research and clinical practice which looks beyond what is constructed as illness and instead places itself within the subjective reality of the service-user is the premise of personal recovery research and practice.

In recent years, recovery principles have been adopted into many mainstream mental health services internationally. Mental health trusts within the National Health Service (NHS) have developed their own strategies for implementing recovery-

orientated care and national bodies for health service transformation, such as Implementing Recovery Through Organisational Change (ImROC), created by the Department of Health, have been established to facilitate recovery-oriented healthcare. The development of Recovery Colleges, increasing co-production and peer-working, and reducing restrictive practice are all forms of recovery-oriented practice seen within the UK mental health system today.

Despite its widespread implementation and developing evidence base (Slade, 2012), some have argued that the concept of recovery has been 'hijacked' by professionals (Mental Health 'Recovery' Study Working Group, 2009). Concern over the use of recovery as a new 'model' of service-delivery has been well-documented (Slade et al., 2014). Attempts to implement recovery approaches (e.g. My Shared Pathway) through commissioning targets such as Commissioning for Quality and Innovation (CQUIN) appear contradictory and create the illusion of recovery as another task for staff. This view has been reported by staff as a key concern of recovery approaches (Shepherd, Boardman & Burns, 2010). Whilst some studies have shown a translational gap between knowledge and implementation of recovery principles (Tansella & Thornicroft, 2009; Wensing, Wollersheim, & Grol, 2006) others have demonstrated the influence of competing priorities (Le Boutillier et al., 2015) and staff concerns over the risk of moving towards recovery-orientation (Tickle, Brown, & Hayward, 2014) as influencing their ability to work in a recovery-focused way.

The concept of recovery is a topic of much critical analysis (Stickley & Wright, 2011) with narrative experience and the priorities of evidence-based medicine appearing to be mutually opposed (Castillo, Ramon, & Morant, 2013). The use of the term 'recovery' has been criticised for its lack of conceptual clarity and therefore limited utility in mental health services (Ramon, Healy, & Renouf, 2007). Research indicates that a conceptual consensus of recovery amongst those working within healthcare has been lacking (Davidson, O'Connell, Tandora, Lawless & Evans, 2005) and whilst this is the case in mainstream mental health services, specialist providers have also demonstrated difficulty in subscribing to mainstream recovery concepts (Turton et al., 2011).

1.2. Women and Mental Health

Gender has significant explanatory power in the differential susceptibility to developing mental health issues (World Health Organization; WHO, 2013). Beyond susceptibility, gender is related to differences in diagnosis received, treatment and adjustment to mental health disorders (WHO, 2013). Epidemiological studies report significant gender differences in the prevalence of commonly diagnosed mental disorders, with women more likely to be diagnosed with depression, anxiety and social phobia and receive a diagnosis of borderline personality disorder than men (Kessler et al., 1994). In contrast, men are more likely to experience drug and alcohol dependence and receive a diagnosis of antisocial personality disorder (Kessler, McGonagle, Swartz, Blazer, & Nelson, 1993). Differences in help-seeking between genders have also been found whereby women are more likely to seek help from specialist mental health services than men, and men are less likely to disclose mental health problems. These findings locate part of the mental health conceptualisation within gender- and society-based expectations of behaviour and mental health. There have been calls to critically examine the nature of psychiatric diagnoses generally due to issues relating to the reliability and validity of diagnoses (Bentall, 2003). When considering variations in prevalence between genders, issues relating to help-seeking behaviour and gender stereotyping in diagnosis must be considered.

More recently there have been calls to consider the wider context of mental illness among women (Department of Health, 2002; WHO, 2013). The role of social disadvantage has been identified as a significant factor in the occurrence of common mental health problems. Such mental health problems are distributed along a social gradient with the poorer and more socially disadvantaged most affected (Fryers, Melzer, & Jenkins, 2003); women often occupy such societal roles. Research indicates that women's experiences of poverty (Rait, 1999), adverse life events (Harris, Brown, & Bifulco, 1986) and social isolation (Vandervoort, 2000) are significant risk factors in their susceptibility to developing mental health issues. Women are also three times more likely than men to report experiencing sexual abuse (Finkelhor, 1994; Pereda, Guilera, Forns, & Gómez-Benito, 2009) and it is estimated that up to one-third of women have been the victim of domestic violence (Cleaver, Unell, & Aldgate, 1999).

The high prevalence of such events in addition to women's experiences of sexual violence is considered to account for the increased prevalence of Post-Traumatic

Stress Disorder (PTSD) among women (WHO, 2013). Whilst men are more likely to complete suicide, distress among women is associated with increased levels of self-harm and attempts at suicide (Weissman et al., 1999) with gender-based violence associated with completed suicide among women (Stark, Evan, & Flitcraft, 1996). Therefore, understanding mental health difficulties and recovery among women requires attention to the many social factors which influence mental health among this population.

1.3. Borderline Personality Disorder

Borderline Personality Disorder (BPD) is a relatively new diagnosis, entering American diagnostic symptoms in the 1980s. The World Health Organisation (WHO) offers an alternative framework for conceptualisation, the International Classification of Diseases (ICD), which offers a conceptually similar diagnosis, Emotionally Unstable Personality Disorder (EUPD). Due to the widespread use of BPD in academic literature, the term BPD will be used in reference to both BPD and EUPD.

In diagnostic terms, personality disorders (PDs) are conceptualised as "impairments in personality functioning and the presence of pathological personality traits" (American Psychiatric Association; APA, 2013). Difficulties are considered to be persistent, enduring and pervasive. Some argue that BPD is a complex condition associated with a wide range of cognitive, emotional, behavioural, interpersonal and intrapersonal difficulties (Livesley, 2003). Diagnostic criteria identify self-harm and substance misuse as symptoms associated with having a borderline personality disorder.

BPD is diagnosed in approximately 1% in individuals in the UK (Coid, Yang, Tyrer, Roberts, & Ullrich, 2006), but is disproportionally attributed to women at a ratio of 3:1 in comparison to men (APA, 2013). The prevalence within clinical settings is higher given that individuals who display behaviours conceptualised as symptoms of BPD (e.g. self-harming) often seek help to manage their distress and are therefore more likely to attract the diagnosis (Zimmerman, Rothschild, & Chelminski, 2005). Presence at Accident and Emergency departments through the combination of managing distress through self-harming and a high rate of suicide attempts results in approximately half of attendees at A&E with such behaviours reaching these diagnostic criteria (Forman, Berk, Henriques, Brown, & Beck, 2004). In this sense, the circularity of personality

disorder symptoms has been argued, with the behaviours expressed by those with the diagnosis being considered the cause and the symptom of the disorder (Pilgrim, 2001).

Definitions of BPD/EUPD are subject to several shortcomings. Critics have commented on the lack of utility of the diagnosis, given the frequency in which people diagnosed with BPD receive diagnoses of other personality disorders (Oldham et al., 1992) and other diagnoses including depression, anxiety, substance use issues (Zanarini et al., 2011), raising questions about the validity of BPD as a diagnostic construct. The debate surrounding the disorder itself; its aetiology, diagnostic reliability and treatment of the construct has been widely reported (Alterman & Cacciola, 1991; Bateman & Fonagy, 1999). Guidelines offered by the National Institute for Health and Care Excellence (NICE) note the need for professionals to assure individuals with BPD diagnoses that recovery is possible and attainable, yet clarity over what recovery would constitute is absent. The inherent implication that the individual's personality is disordered represents a challenge to this traditional clinical approach.

1.3.1. Social constructionism and BPD.

As noted earlier, the concept of recovery can be delineated into clinical and personal components with potential for overlap. Each approach is underpinned by its own assumptions of the nature of knowledge, mental illness and cure. Positivism, with an assumption that the universe is objective and quantifiable, reduces experience to something which is measurable. By approaching mental illness from positivist positions, researchers and clinicians conform to a belief that diagnosis is true, rather than a hypothesis. Here, an alternative constructivist approach is described.

The ICD-10 definition of EUPD draws attention to the idea of experience within EUPD as differing from a cultural norm and thus, socially constructed; "they represent the extreme or significant deviations from the way the average individual in a given culture, perceives, thinks, feels, and particularly relates to others" (WHO, 1992). This is similarly summarised by the DSM-5's reference to "inner experience and behaviour that deviates markedly from the expectations of the individual's culture". Thus, the question of normality and societal expectations become the landscape upon which BPD is framed. Language is more than semantics (Linnet, 2004) and words such as 'disorder' have the power to construct and obstruct understanding of aetiology.

The medical conceptualisation of BPD has attracted much criticism from the feminist tradition, which argues that the diagnosis pathologises the experiences of individuals, mostly women, who fail to conform to "normal" expectations of behaviour (Shaw & Proctor, 2005). In this sense, feminist critique asserts that BPD is, in essence, a gendered disorder, given its comparatively higher rate of diagnosis among women. The authors draw similarities to past conceptualisations of 'socially deviant' behaviour among women such as 'hysteria', which has more recently been conceptualised as a response to powerlessness (Showalter, 1985).

Feminist authors (Shaw & Proctor, 2005) identify the use of BPD as the latest manifestation of historical attempts to explain strategies of managing and surviving oppression through the use of medicalisation. Showalter (1985) described the social act of situating women on the side of irrationality, giving rise to the silencing and disempowerment of women. It is argued that diagnosing BPD further serves to locate women against the norm of rationality, with diagnosing professionals judging responses such as fears of abandonment as inappropriate rather than appropriate given past experiences. Thus, the diagnosis minimises the social context of women and locates the problem as intrapsychic. The term 'double bind' (Chesler, 1972) has been applied to describe the processes by which women become pathologised for conforming to or failing to conform to societal expectations of female passivity. It asserts that women who fail to live up to their gender role as they express anger or aggression, or conversely, women who conform too strongly and internalise anger resulting in self-directed injury come to have this behaviour pathologised by the psychiatric system. Other authors (Warner & Wilkins, 2004) instead conceptualise these behaviours as attempts to exert some level of mastery, control and alliance with others in the face of trauma, helplessness and inner vulnerability.

The constructionist debate surrounding PD diagnosis refers to moralistic framings of the disorders in which culturally and socially defined moral orders are considered to be violated by the individual. Beck (1992) argues that personality disorder becomes used by a society which is over-concerned and over-identified with the concept of risk. The concept of morality within the diagnosis of BPD has been noted, with critics recognising the association between diagnostic symptoms such as inappropriate or intense anger and instability in relationships as suggestive of a moral deficit (Charland, 2006). As described by David Pilgrim, individuals with this diagnosis

are constructed in terms of morality: "*They are called 'patients', but they are assumed to have the same moral agency as non-patients. They are not pitied for their symptoms but for their moral failings*" (Pilgrim, 2001, p258). Indeed, Charland (2006) argued that treatment for personality disorder inherently involves a form of change in moral character.

The diagnosis of BPD has its origins in the psychoanalytic tradition, where it was considered that psychopathology exists along a continuum of neurotic to psychotic (Linehan, 1993). Individuals who did not fit in either dimension were considered to exist on the borderline (Stern, 1938). Due to the challenge of "fitting" into neither category and limited responsiveness to analytic methods available at that time, BPD as a result became a diagnosis afforded to "difficult patients" (Kernberg, Selzer, Koenisberg, Carr & Applebaum, 1989).

The use of language becomes important within this context as individuals allocated this diagnosis come faced with descriptions such as "emotional hypochondriacs", "help-rejecting, "treatment-resistant" and ultimately immoral. Disdain towards those with the diagnosis has long been noted, with those with the diagnosis being described as manipulative, attention-seeking and annoying (Lewis & Appleby, 1988). Such views are still held today whereby mental health providers often describe patients with BPD diagnoses as 'difficult' (Louis & Appleby, 2011) and clinical teams consider them a 'challenging' group (Markham & Trower, 2003). Tyrer (Tyrer, Casey, & Ferguson, 1991) reflected on the beliefs of staff that patients with diagnosed with PD were not viewed as falling into the role of psychiatry and the view that personality disorder did not constitute a 'real illness', recognising the implicit nature of such beliefs among staff. The reactions of professionals within services towards people with this diagnosis have been noted to impact the individual's motivation to engage with treatment (Adshead, 2001). Research has, however, indicated that attitudes are changing and becoming increasingly optimistic (Karaklic & Bungener, 2010).

1.3.2. Treatability of personality disorder.

Personality disorder as a condition requiring detention and treatment is a relatively new and controversial topic. The revision of the Mental Health Act in 2007 introduced significant changes to the way in which individuals with diagnosed mental illness,

particularly personality disorders could be treated. Prior to 2007, the 1983 Mental Health Act contained within it a 'treatability clause', stipulating that individuals could only be detained under the Mental Health Act in NHS settings if treatment was available which was likely to 'alleviate or prevent deterioration of his condition'. The Act allowed for the detention of individuals who had committed a criminal offence and were considered to suffer from a 'mental impairment' or 'psychopathic disorder' (considered an extreme personality disorder) with the legal justification of treatability. The nature of treatability gave rise to considerable clinical concern.

> *"The detention of offenders in the legal category of 'psychopathic disorder' in special hospitals for treatment raises a number of critical issues. There are doubts about the nature of the disorder; what constitutes treatment; who is 'treatable'; the effectiveness of the treatment; and whether evidence of psychological change implies reduced risk of reoffending". (Grounds, 1987; 474)*

The shift resulting in the possibility of detention of individuals with PD arguably has its origins in the social and political domains. Pickersgill (2013) outlines the clinical and legal debates which evolved as the amendment to the MHA developed, ultimately giving risk to construction of PD as a mental health disorder amenable to treatment.

The introduction of the term 'Dangerous and Severe Personality Disorder' (DSPD) by the Home Office was due in part to the offence committed by a mental health patient diagnosed with a personality disorder who was discharged as he was no longer considered eligible for detention under the MHA. Thus, public concern about the danger of individuals diagnosed with personality disorder began to broaden and influence policy. The government subsequently proposed 'legislative powers for the indeterminate, but reviewable detention of dangerously personality disordered individuals' (Straw, 1999, quoted in Gunn, 2000; 336). Such proposals were met with clinical concern for the use of psychiatry as both a therapeutic regime and source of public protection and concerns that risk management superseded clinical endeavour (Glover-Thomas, 2006).

The shift towards amending the 1983 Mental Health Act occurred within the context of concern about public protection and debate about the treatability criterion as it applied to individuals diagnosed with personality disorder. The discourse around personality disorder was divisive, with some advocating that there was 'no justification for global assertions that personality disorder is untreatable' (Adshead, 2001; 412). The debate about the DSPD category and development of services initiated much research on the topic of treating individuals diagnosed with personality disorders. Approaches such as Cognitive Analytic Therapy (CAT; Ryle, 1997) and Dialectical Behaviour Therapy (DBT; Linehan, 1993) gained supportive evidence largely within the BPD domain. Attempts to draw conclusions about potential transferrable efficacy for treatments designed for individuals with BPD onto those diagnosed with other PDs evidenced the perception of homogeneity among the client group (Crawford et al., 2007). Findings from studies concluded that psychological therapies were the most effective treatment, with medication also having an effect on the severity of what were considered 'symptoms' of personality disorder (Pidd & Feigenbaum, 2007), thus rendering personality disorders as responsive to treatment.

The Department of Health advocated that the removal of the treatability clause of the 1983 Act, would 'take away some unnecessary obstacles to practitioners' ability to use the Act where it is warranted by the needs of the patient and the degree of the risk' (Department of Health, 2006; 3). Instead of a treatability clause, the resultant amendment to the Mental Health Act included the clause of availability of 'appropriate treatment', though the construct of appropriateness was unclear, with the potential to be conflated with effectiveness. Guidance on quantifying effectiveness as it applied to those diagnosed with personality disorder was also absent.

Thus, through a complex social, legal and clinical debate taking place over two decades, with concerns about undesirable social behaviour, and the need for risk management and public protection, personality disorder became constructed as a disorder which warranted detention and treatment under the Mental Health Act.

1.3.4. Attachment theory and BPD.

The aetiology of what becomes conceptualised as BPD remains unclear, however, it has been associated with genetics (Torgersen et al., 2000), neurology (Rüsch et al., 2003) and traumatic events (Zanarini et al., 2000). Calls to reconceptualise BPD as a form of

complex trauma have arisen through the heightened prevalence of childhood maltreatment and neglect in individuals who later attract this diagnosis (Battle, Tracie Shea, Johnson, Zlotnick, & Zanarini, 2004). Disrupted attachment systems have also been implicated in the conceptualisation of difficulties associated with BPD (Lyons-Ruth, Yellin, Melnick, & Atwood, 2005).

Attachment theory (Bowlby, 1973; 1982; 1988) emphasises the significant role of early interactions between infant and caregiver. Early patterns of interaction are seen as core to the child's development in terms of developing an ability to regulate emotions, form an identity and interact successfully with others (Bowlby, 1973). Difficulties in these areas later form some of the primary diagnostic criteria or "symptoms of BPD" as conceptualised within medical models (e.g. as defined by the DSM-V; APA, 2013). Attachment theory proposes that cognitive representations of the self and others (internal working models; IWM's) are learned and organised on the basis of patterns of interaction between the infant and primary caregiver. IWM's provide structure in the form of anticipated responses from others on the basis of prior learning experiences. This allows the infant to predict responses from others and adapt behaviour to increase the likelihood of having their needs met or avoiding an adverse experience. Bowlby hypothesised that such models endure and are subject to updating throughout the lifespan, increasing in complexity and specificity over time.

In early infancy, the child seeks proximity to the caregiver to optimise their chances for survival through having their needs met, i.e., safety and protection. When responsive caregivers demonstrate attunement to such needs, this facilitates a secure relationship; that is, a secure base to which they may reliably retreat for support in threatening situations. The child learns to depend on the caregiver in times of physical and emotional distress and seeks this interaction. For securely attached children the IWM of others is positively represented, and the model of the self becomes complementarily positive; a self who is worthy of love, affection and care (Bowlby 1962, 1982). Secure attachments are associated with greater ability to emotionally regulate, reducing negative affect and the development of a healthy and coherent sense of self and others (Bateman & Fonagy, 1999).

When a caregiver is non-responsive to the infant's needs, either through rejection or inconsistency, the child may develop an insecure attachment; that is a lack of perceived reliability, consistency, safety and trust in the caregiver, resulting in

difficulty developing a robust emotion regulation system. Patterns of insecure attachment styles have been consistently found among those who become diagnosed with BPD (Argawal et al., 2004; Lyons-Ruth et al., 2005), although there was insufficient evidence supporting a link between any specific attachment style (Hazan & Shaver, 1987; Main & Solomon, 1990) and later diagnosis of BPD (Black, 2010). Research has suggested that rather than insecure attachment leading to the development of BPD, the experience of attachment insecurity leaves the individual vulnerable to difficulties in psychological development. It is the strategies later used to manage such vulnerabilities, which later become medicalised and conceptualised as "symptoms" of mental illness.

Bateman and Fonagy (2010) suggest that the ability to mentalise, that is, the reflective function of making sense of the self and others, in terms of subjective states and mental processes (Bateman & Fonagy, 2010), becomes compromised due to a failure of adequate development in infancy. These authors suggest a "loose coupling" of attachment and mentalisation (Fonagy & Bateman, 2006). Studies of mentalisation (Bateman & Fonagy, 1999) report increased deficits in mentalising abilities in adults who become diagnosed with BPD. Thus, insecure attachment may play a mediating role in the development of mentalisation, which may contribute to challenges in the development of stability in sense of self and relationships in adults who later become diagnosed with BPD (Bateman & Fonagy, 2010).

Insecure attachment styles have also been shown to be associated with difficulties in emotion regulation (Herman, Perry, & van der Kolk, 1989). Due to insecure attachment, it is argued that individuals experience difficulty in establishing safe relationships in which they can emotionally connect and be cared for. IWM's of others as unreliable may result in limited opportunities to receive support and based on an absence of learned abilities to gain emotional containment impede the development of skills in regulating emotion (Mosquera, Gonzalez, & Leeds, 2014). Fonagy (2000) argues that it is this limited development, due to insecure attachment, which contributes to ongoing emotion dysregulation (Fonagy, 2000). Expressions of difficulties in emotionally regulating through the use of strategies such as self-harming or misusing substances later become medicalised as symptoms of a 'borderline personality'.

For insecurely attached individuals, subsequent corrective experiences with others may alter IWM's, allowing for a healthier view of the self and others to form,

leading to more adaptive interpersonal relationships (Fraley, 2002). The development of IWM's influence both the tendency towards care-giving on behalf of others and care-eliciting for the self in times of threat (Solomon & George, 1996). The IWM's of insecurely attached individuals are often fragmented and are represented in disordered and incoherent narratives. Failure to develop coherent representations of the self and others may be due to impaired reflective functioning and mentalising. Challenges in conceptualising one's emotional states are thought to underpin identity disturbances, resulting in increased reliance on others to inform a sense of self.

1.3.5. Interventions for borderline personality disorder.

Interventions for those diagnosed with BPD have largely aligned themselves with the medical model, with a goal of reducing what, in medical terms, are considered the key clinical symptoms of BPD. Some treatments have demonstrated effectiveness in reducing these 'symptoms' including Mentalisation-Based Therapy (Bateman, Ryle, Fonagy, & Kerr, 2007), Cognitive Analytic Therapy (Ryle, 1990) and Dialectic Behaviour Therapy (Linehan, 1993). Inadequate outcome measures focus on reduced clinical symptomology as the objective for interventions for BPD but often fail to address the realities of the recovery process for individuals with this diagnosis (Andresen, Caputi, & Oades, 2010). For example, a reduction in what are considered core symptoms in diagnostic terms occurs more commonly than the longer-term recovery involving psychosocial recovery (Zanarini, Frankenburg, Reich, & Fitzmaurice, 2012). Indeed, the majority of people diagnosed with BPD maintain significant levels of distress and experience severe impairment in social functioning despite a reduction in 'symptoms'(Kongerslev, Chanen, & Simonsen, 2015).

In a review of treatments for BPD, the authors recognised the challenges in investigating the efficacy of particular treatments given the lack of common outcomes in studies of BPD (Bateman & Tyrer, 2004). Outcomes measured by studies focused on clinical symptoms, self-harming behaviour, recidivism, length of hospitalisation, change in personality status and global outcome scales. However, these factors may also be influenced by the presence of Axis II disorders and measures of behaviour rather than personality change (Bateman & Tyrer, 2004). Other outcomes related to quality of life and change in social function, although these factors were considered insensitive to

personality change and also had the potential to be influenced by comorbid presentations and wider sociocultural factors.

Psychotherapy intended for individuals with BPD diagnoses is typically highly focused on affect, involves an active therapist who pays particular attention to the therapeutic alliance and creates a supportive and validating atmosphere (Bateman, Gunderson, & Mulder, 2015; Clarkin, 2012; Livesley, 2012). The most common psychological therapies for BPD include Transference-Focused Therapy (TFP; Clarkin, 1999;Yeomans, 2015), Mentalisation-Based Treatment (MBT;(Bateman & Fonagy, 2004; Bateman & Fonagy, 2010), Dialectical Behaviour Therapy (DBT; Linehan, 1993; Linehan et al., 2015), Cognitive Analytic Therapy (CAT; Ryle, 1997; Chanen, McCutcheon, & Kerr, 2014) and Schema-Focused Therapy (Young, Klosko, & Weishaar, 2003; Arntz, Genderen, & Genderen, 2009). As mentioned, various approaches claim different mechanisms of action according to their model of disease causation (Livesley, Dimaggio, & Clarkin, 2016.). A Cochrane Review examining the effectiveness of psychological treatments for individuals diagnosed with BPD was cautious in concluding that although psychotherapy offers great utility in treating "symptoms" of BPD, the evidence base for each treatment was considered not to be robust and plagued by limitations in terms of quality (Stoffers-Winterling et al., 2012). Due to limitations in quality and quantity, only DBT was assessed against 'treatment as usual' conditions and reported moderate to large effect sizes for anger, para-suicidality and mental health, though such outcomes may too be associated with other mental health presentations. Due to the increasing research in the area of treatments for BPD, a further Cochrane Review is currently being completed (Storebø et al., 2018).

It is recognised that current interventions designed for those diagnosed with personality disorder are often long, difficult and arduous to complete (Pilgrim, 2001), and it has been suggested that unsuccessful interventions have the potential to reduce an individual's capacity to respond to future interventions (Jones, 2007). The founders of MBT, Bateman and Fonagy, have commented that past treatment for BPD has "impeded the borderline's ability to recover…and prevented them from harnessing advantageous changes in their social circumstances" (as cited in (Gunderson & Links, 2008), thus there is a potential that clinical interventions may be either misguided or limited in ecological validity. There is a risk that interventions may be unhelpful due to the selected intervention or influence of the therapist-client relationship (Kongerslev et

al., 2015). Iatrogenic effects of interventions for individuals with PD in forensic mental health services have been described (Jones, 2007) and it is recognised that engaging in particular therapeutic work has the potential to traumatise service-users (Jones, 2007). Suggestions have been made to increase emotion regulation skills before engaging in therapeutic work focussing on discussing past abuse, due to the potential for strong emotional reactions which could be managed through self-harm (Linehan, 1993). The pending Cochrane Review has recognised the potential for adverse effects for this client group and will seek to investigate iatrogenic effects using standardised psychometric rating scales (Storebo et al., 2018).

Inoculation Theory (McGuire, 1964) has been posited to account for future resistance to engagement following past unsuccessful attempts whereby interventions which have failed to change attitudes are likely to inoculate against attitude change in the future (Jones, 2002b). However, it has also been argued that there is a cumulative positive effect of therapeutic engagement by preparing participants to respond and engage more readily in future interventions.

1.4. Personality Disorder and Recovery

Following debate about the 'treatability' clause, clinicians were urged to forego the notion of a "fix all" for personality disorder and instead focus on the functional assessment of the condition (Davison, 2002). Despite this, treatments continued to be developed and evaluated on the basis of behaviours understood as clinical symptoms. Distinctions have been made between the nature of "recovery from" and "recovery in" mental disorders, the latter of which refers to the self-determination and inclusion in community life despite continuing to suffer from a diagnosed mental illness (Davidson & Roe, 2007). This may be salient for individuals diagnosed with BPD who experience residual psychosocial difficulties beyond a clinical recovery (Zanarini et al., 2012). Whilst research into personal recovery has increased exponentially in recent decades across a range of mental health conditions, research interest in recovery in the context of personality disorder has received little empirical interest until recent years. One possible explanation for the absence of recovery-based literature within this diagnosis may be the contestation of the disorder as a medical illness (Adshead, 2001; Pilgrim 2001) and the recognition of the impact of residual difficulties beyond clinical recovery (Zanarini et

al., 2012). However, it is for this reason that research in this area is increasingly valuable. The National Knowledge and Understanding Framework on personality disorder recognises these challenges and sets out to critically reflect on the concept of recovery for individuals with a personality disorder diagnosis (www.personalitydisorder.org.uk), as have numerous other authors (e.g. Nehls, 1999).

A 2015 meta-synthesis identified three qualitative studies examining recovery in relation to personality disorder (Shepherd, Sanders, Doyle, & Shaw, 2016). Findings from these studies identified that whilst the principles of recovery apply to individuals with this diagnosis, additional complications and idiosyncrasies were found. For example, some participants felt that recovery from a personality disorder was difficult to imagine. Participants noted that recovery implied a dichotomy of recovery positions and questioned what they would be reverting to, given their difficulties had been present for their lifetime. One participant reflected that for recovery to occur they would "*have to have a personality transplant*" (Katsakou et al., 2012, p5). Similar views have been reported elsewhere (Charland, 2006) and the notion of self-discovery rather than recovery has been argued to be more appropriate terminology for this client group (Gillard, Turner, & Neffgen, 2015).

The review also identified the discrepancy between service-defined goals for recovery such as reduction in suicidality and self-harm and self-defined recovery goals including improved interpersonal relationships (Katsakou et al., 2012). Thus, the concept of recovery in personality disorder is met with particular challenges for those who use mental health services. These studies (Castillo et al., 2013; Holm & Severinsson, 2011; Katsakou et al., 2012) sampled from community and specialist personality disorder services and primarily sampled participants with a borderline personality disorder diagnosis, thus, little is known about how women with a diagnosis of BPD perceive recovery within secure services.

Subsequent research from a community mental health service identified five conditions of change in recovery for individuals with a BPD diagnosis: support from others; accepting the need for change; working on trauma without blaming oneself; curiosity about oneself; and reflecting on one's own behaviour (Donald, Duff, Lawrence, Broadbear, & Rao, 2017). These findings highlighted the need for adaptation of working practices for professionals working towards recovery with service-users diagnosed with BPD.

A further systematic review identified views of both staff, family and carers in their conceptualisations of recovery in the context of BPD (Ng, Bourke, & Grenyer, 2016). Findings reflected the need for a degree of symptom alleviation (i.e. reductions in behaviours conceptualised as clinical symptoms, such as self-harm) to enable individuals diagnosed with BPD to engage in other aspects of recovery. Being able to regulate emotion without reliance upon self-harm, developing a sense of identity and strengthening interpersonal skills were all seen as promoting personal development and recovery. Slade has argued that clinical and personal recovery are not mutually exclusive, noting that clinical recovery may contribute to personal recovery (Slade, 2009). Ng and colleagues (2016) argued that when considering recovery in the context of BPD, there is a need to conceptualise this as a sub-syndromal experience, drawing attention to the difficulties which endure beneath clinical thresholds and in the absence of observed "symptoms".

1.5. Forensic Mental Health Services

Forensic psychiatric services offer treatment for individuals with offending histories and psychiatric diagnoses. Service-users are detained under legislation which mandates assessment and treatment, emphasising public protection (Sarkar, 2010). Treatment within these services is extremely costly, costing £1.2 billion per year and accounting for 1% of the NHS total budget and 18.9% of the adult mental health budget (Rutherford & Duggan, 2008). Forensic service-users comprise a heterogenous group in terms of diagnosis (Blackburn, Logan, Donnelly, & Renwick, 2003). They may be referred to secure services from other services which cannot manage their behaviours, such as prisons or other mental health services, and considered to present harm to themselves or others because of their mental health issue. Individuals in secure care are placed within a restrictive environment in which they receive treatment for their difficulties whilst risk is also managed through security provisions.

The three levels of secure care within the NHS (high, medium and low) comprise 7000-8000 beds in the UK. The cost of one year in medium secure care is estimated at £165,000 and £300,000 for a year spent in a high-secure service (Centre for Mental Health, 2011). It is estimated that up to two-thirds of service-users remain in these units for longer than required, causing an increased financial burden to service

providers (Reed, 1997). Developing a service which can provide effective care whilst meeting requirements set out by relevant stakeholders such as the Ministry of Justice has both financial advantages and advantages for service-users. The recovery approach has been reported to improve motivation and engagement in treatment within mainstream services (Dixon, Holoshitz, & Nossel, 2016) and forensic services (Livingston, Nijdam-Jones, Lapsley, Calderwood, & Brink, 2013), though this has yet to be assessed in terms of the impact on length of stay or longer-term outcomes.

Forensic services operate around a model of risk. Due to concerns about the danger that forensic service-users pose to the public, decisions are more likely to be made on the basis of the need to manage risk, rather than the wishes and desires of the service-user (Maden, 2007). Risk is assessed through structured clinical and actuarial tools (e.g. Historical and Clinical Risk-20; HCR-20). Such assessments are typically completed by psychologists within teams and repeated at regular intervals, such as 6-monthly Care Programme Approach (CPA) meetings or Mental Health Tribunals. Such models have historically been done "on" the service-user, in the absence of their contribution or collaboration, emphasising power imbalances and creating disempowerment, although recovery approaches encourage collaboration in the risk assessment process (Baker, 2012). The utility of risk assessment measures in predicting future risk is variable. Limited utility in risk prediction and assessment for suicide in clinical settings has been noted (Chan et al., 2016) and there have been concerns that methods used to assess risk, such as the HCR-20, fail to adequately formulate risk among women (de Vogel, de Vries Robbé, van Kalmthout, & Place, 2012).

Categorisation of individuals into risk clusters such as high and low may not only demonstrate little utility regarding prevention but impose excessive restriction upon the service-user and conflict with recovery-focused practice. In many cases, service-users do not share the view of risk outlined by the team and tension can develop over the issue of whose risk it is (Baker, 2012). It has been suggested that structured assessments may work predominantly to mitigate the anxiety experienced by clinicians and the organisation (Chan et al., 2016) rather than provide any robust finding in relation to risk likelihood.

1.5.1. Women and secure services.

Historically, the provision of secure health services for women has been inadequate. Until 2003, women in high-secure services in the UK (Ashworth, Rampton and Broadmoor hospitals) shared sites with men and were subject to the same physical and procedural security. Policy documents published by the Department of Health (DoH 2002, 2004) were developed to adapt service practices to the needs of women, with particular attention paid to their trauma histories (DoH 2002, 2003; Mezey, Hassell, & Bartlett, 2005). A key feature of this change was the shared emphasis on both physical and relational security (Somers & Bartlett, 2014). Relational security involves applying staff knowledge about their patients into enhanced care by using it to inform care plans, decision-making and interactions. However, the allocation of resources towards developing services addressing the needs of women has been met with some criticism, with some arguing that individuals in secure care often have similar traumatic histories and that by focussing on services for women only serves to discriminate against men, who have often experienced similar adverse life events (Adshead & Sarkar, 2005).

Women in secure care have high levels of learning disability (Bartlett et al., 2014), histories of trauma (Bland, Mezey, & Dolan, 1999; Ministry of Justice, 2012) and limited educational experience (Singleton, Meltzer, Gatward, Coid,& Deasy, 1998). Gender differences exist in the nature of crimes committed and, in comparison to men, women are more likely to have harmed their partner, children or family members (Karsten, de Vogel, & Lancel, 2016). The nature of violence by women has also been argued to be more reactive than instrumental, as seen more frequently in men (Verona & Carboney, 2000). Typically, women have been treated as a homogenous group within secure services where comparisons are drawn on the basis of gender alone. The experiences of those working closely with women in secure services reflect a need for gender-sensitive service-delivery, paying attention to relational security, attachment and the recovery model to address the complex needs of this client group (Bartlett & Somers, 2017). Treatment outcomes are more robust when gender-specific factors are conceptualised as responsivity factors (Ashley, Marsden, & Brady, 2003), and recommendations have been made to enhance gender-informed treatments for women in forensic psychiatric services including the need to complete gender-sensitive risk-assessments (de Vogel et al., 2012).

Many women in secure services are diagnosed with BPD (de Vogel, Stam, Bouman, Ter Horst, & Lancel, 2016), and many are diagnosed with other personality disorders and substance disorders (Warren et al., 2002). Women have also been shown to spend a longer time in higher levels of security than necessary, particularly given their low risk of absconsion and risk to the public (Coid, Kahtan, Gault, & Jarman, 2000). Studies have shown that women in secure services and diagnosed with BPD are more likely to have experienced multiple forms of abuse and more likely to self-harm than women who have not attracted this diagnosis (Karsten et al., 2016). The study also found that women diagnosed with BPD were rated higher on actuarial risk assessment tools than those without this diagnosis (HCR-20; Karsten et al., 2016). Women in secure services have been found to have experienced comparatively more severe histories of victimization than men (de Vogel et al., 2016) and experience episodes of restraint, seclusion or forced medication as staff's responses to incidents such as self-harming (Leontieva & Gregory, 2013), thus, creating further potential for re-traumatization through service approaches. Thus, having a BPD diagnosis appears to be associated with an increased perception of risk.

Whilst epidemiological studies and policy documents have made numerous recommendations regarding working with women in secure services, there are few studies of this population, reflecting not only their minority status within secure services but their underrepresentation in the evidence-base and marginalisation of their experience. Studies which involve women in secure services are typically orientated towards examining clinical recovery rather than seeking to explore their experiences. Such experiential literature is also lacking in the context of males diagnosed with PD, and it is possible that those who used PD services, described as 'difficult' and 'manipulative', are not considered attractive participants for services-based research. One qualitative study (Parry-Crooke, 2000) revealed that women in secure services felt they had to "toe the line" by taking medication and participating in therapy. Central to this research was the theme of women feeling that they occupied a subordinate role within such services and that they lacked autonomy in decision-making about their care.

1.5.2. Attachment and secure services.

Few individuals with mental health diagnoses detained in secure hospitals have been found to have had early attachment experiences which would promote secure

attachment (Coid, 1992). This study identified not only the absence of secure attachments but also traumatic experiences including extremes of abandonment, cruelty, humiliation and terrorization (Coid, 1992). The impact of such experiences has profound effects on the development of the ability to modulate distress (Schore, 2001). Adshead (2002) outlined the role of attachment dynamics in increasing the risk of violence.

Bowlby (1988b) described how threat to attachment through loss or separation could initiate intense feelings of anxiety and rage. Early insecure attachment experiences are therefore associated with difficulties not only in regulating the self, but an increased sensitivity to threat. The inpatient experience is likely to pose attachment-related challenges for individuals with disrupted attachment experiences through sudden loss or separation (Adshead, 2002). The secure environment is one in which endings and losses are common due to staff turnover and service-user transfers. The loss of a valued staff member may symbolise further loss for the service-user, particularly those with insecure attachment styles, with the potential to stimulate unresolved attachment feelings and create dysregulation. Managing endings, particularly in psychological therapies, is particularly important for individuals diagnosed with BPD as therapy can abruptly end due to staff turnover or care provided by trainees (Bostic et al., 1996).

Experiences in forensic services may not only challenge the individual through attachment-related loss but also, threat and fear within the institution itself. Threatening situations activate the attachment system, resulting in service-users seeking out attachment figures who fit with their internal representations. Such attachments may, however, be pathological (Adshead, 2001) and represent early attachment patterns which have been damaging. The ability of the clinical team supporting the service-user to detect and appropriately support attachment at such stages is essential, maintaining appropriate levels of clinical boundaries. The ability to promote reflective thinking and adaptation by staff in relation to such challenges has been recommended (Adshead, 2002).

The therapeutic relationship has been identified as having a key role in the delivery of both effective security and treatment (Hamilton, 2010). Patterns of enmeshed attachments have been found in individuals diagnosed with BPD (Fonagy, 2000) and relate to patterns of intense and volatile relationships. Such experiences can also occur with staff, resulting in a form of splitting whereby groups of staff view the

service-user in wholly positive or negative terms. Service-users who present with self-harming behaviours can challenge staff, who often respond with distress and anger (Adshead, 1997). Relational security involves using knowledge from therapeutic relationships to inform formulations for care progression (Hamilton, 2010). Therapeutic alliance is both fundamental and predictive of treatment outcomes (Horvath, 2000) and is associated with service-user satisfaction in secure services (Bressington, Stewart, Beer, & MacInnes, 2011). Having somebody who believes in you has been identified as positively influencing desistance from offending (Maruna, 2001).

In the early stages of admission, service-users may struggle to manage the meaning of their offence, particularly if it occurred in an attachment context and guilt. Post-traumatic stress disorders include symptoms of hyperarousal, increased sensitivity to threat and irritability (DSM-V; APA, 2013), and the commission of violent acts can too be conceptualised as a traumatic stressor (Ford, 1999). Within a trauma framework, discussing the offence may trigger traumatic memories, and there may be a strong urge for individuals to avoid thinking or discussing their offence, thus preventing offence-focused work to take place.

Service-users may also experience attachment to the institution itself (Goodwin, Holmes, Cochrane, & Mason, 2003. For many, the service represents the first opportunity to receive care and safety and may also represent the first enduring attachment of adult life. Thus, discharge has the potential to create conflict as the service-user leaves the 'secure base'. When approaching discharge some service-users' attachment systems have the potential to become activated, resulting in behaviours seen as 'self-sabotaging' but serving the function of reducing anxiety and increasing psychological security.

Adshead (2002) outlines some of the features necessary to make a forensic institution a secure base:

- Set and maintain therapeutic boundaries
- Support and supervision of staff in boundary practice
- Monitoring, naming and regulation of affects for both staff and patients
- Managed separation and losses: avoidance of abrupt terminations
- Facilitating effective mourning

- Understanding anger as the result of anxiety, lowered threat perception and failure to regulate arousal
- Damage limitation

Here, she draws upon the dual role of clinical staff as both therapists promoting inner security and an identity as a custodian of external security. Security occupies a double-speak in secure services; with aspects of forensic security such as relational, procedural and operational components addressed by the service (Department of Health, 2010) but also the concept of psychological security in the context of safe relationships with staff.

1.5.3. Recovery in secure services.

Clinical and personal recovery form two sides of the pursuit of well-being for individuals detained in secure services (Roberts, 2011), however, supporting recovery in forensic mental health services involves the balance of tensions between personal autonomy and the need to manage risk and recidivism (Pouncey & Lukens, 2010). In recent years there have been calls to consider if and how the personal recovery concept can become a reality in forensic settings (Dorkins & Adshead, 2011; Simpson & Penney, 2011).

Whilst one goal of forensic care is ensuring safety to the public, some treatment approaches such as the Good Lives Model (Ward, 2002) aim to address offending whilst also working towards the patient obtaining personal goals which may facilitate personal recovery. This model proposes that individuals offend as a means of obtaining primary goods or needs. Therefore, the focus of the Good Lives Model approach is the identification of alternative ways of obtaining such goals/goods, thus identifying the wider personal needs of the individual. This model adopts a unique approach to focussing not only on risk factors for offending but also dynamic social and psychological factors which form part of the person, recognising that those who offend need not simply lead less harmful lives but also the possibility of better lives (Willis & Ward, 2013). However, desistance research identifies the importance of community-based rehabilitation such as opportunities for employment and education in the facilitation of change (Laws & Ward, 2011), which may pose challenges to the

translation of traditional recovery approaches to forensic service-users. This is particularly evident post-discharge as the stigma of criminality is reinforced by employers who can express reluctance to employ individuals with offending histories (Albright & Denq, 1996), thereby creating challenges to social connectedness, and creating a positive identity, both considered central to recovery (Leamy et al., 2011).

The concept of recovery for this client group is, however, more complex than for other individuals diagnosed with mental health disorders. Recovery here is not just about 'feeling' better, but 'behaving' better, comprising both clinical and moral objectives (Adshead, 2000). The inherent contradiction in supporting autonomy and choice during involuntary detention based on past choices has been noted (Mezey & Eastman, 2009). Dorkins (2011) outlines four challenges of the recovery agenda in secure services: the values and identity of forensic service-users; social exclusion as a community response to trauma and violence; empowerment for those who misuse power and do not respect the choices of others and hopelessness and the offender identity.

Shepherd outlined the underlying imperative of recovery as occupying meaningful social roles within one's community (Shepherd, Boardman & Slade, 2008). Many forensic service users have been socially disadvantaged (Mezey & Eastman, 2009) and whether they will be accepted back into the community or at what personal cost poses some questions. Further, recovery models, such as that proposed by Slade (2009), assume that all service-users wish to be citizens. However, for some individuals in secure settings, this may not represent their desire nor fit with antisocial belief systems.

The recovery model emphasises personal responsibility for the management of mental illness; however, research has shown that many forensic service-users view their diagnosis as a distant object. The principles of hope, empowerment and individualism are likely impacted by sanctions, restrictions and indefinite detentions which some service-users are faced with (Turton et al., 2011). Hope within secure services has been found to be mutually influenced, with staff's views of hope for service-users both influencing and being influenced by the hope of the service-user (Niebieszczanski, Dent, & McGowan, 2016).

While ‘maximal choice’ is the goal for recovery for mainstream service-users, ‘optimal choice’ has been proposed as an alternative for forensic service-users, reflecting the limitations on choice in the secure environment (Roberts, Dorkins, Woolridge & Hewis, 2008). Positive risk-taking, trust and choice for service-users have been identified as factors for organisational change necessary for recovery orientation (Shepherd et al., 2009). However, the role of risk management underpins service-delivery in the forensic context and can thus limit the opportunity for organisational change if not approached differently (Drennan et al., 2014). Tension can also exist between the view of risk held by the service-user and that held by professionals and clinicians may be considered naïve for accepting service-user views of risk, limiting the potential for true collaboration, as advocated by the recovery agenda.

Forensic services have adopted recovery-based approaches such as the Wellness Recovery Action Plan (WRAP; Copeland, 1997), which focuses on self-management, support systems and ways of coping. Additional service-user accounts of the recovery process such as the Developing Recovery Enhancing Environments Measure (DREEM; Ridgeway, 2004) have been used in the U.S. and the My Shared Pathway approach in the U.K. Embedding recovery principles into practice has been demonstrated to increase treatment engagement significantly (Gudjonsson, Savona, Green, & Terry, 2011).

Experiences of forensic service-users have also been absent from much academic research until recent years. A systematic review and meta-synthesis of qualitative studies of personal recovery within secure settings (Shepherd et al., 2016) identified five studies. The review identified the necessity of safety and security as a base for the recovery process. The level of security was also viewed as a potential impeding factor for recovery due to fears of losing such sense of asylum. The review revealed a lack of clarity of routes out of secure care, with participants reporting a sense of feeling claustrophobic. Of key significance to this client group, was the central role of identity work involving three components: making sense of past experience, understanding the role of the disorder and constructing a sense of self. Here participants engaged in therapeutic work relating to past trauma and offence-focused work which was considered crucial to their recovery.

A further review outlined similar themes (Clarke, Lumbard, Sambrook, & Kerr, 2016), but extended beyond those cited by Shepherd and colleagues. This review gave particular credence to the role of relationships and the nature of connectedness,

recognising the opportunity for confrontational staff relationships to increase social isolation and contributing to passivity in relation to care (Ferrito, Vetere, Adshead, & Moore, 2012). Similar to Shepherd et al., this study revealed the potential enabling nature of valued relationships as facilitators of recovery.

1.6. Theories of change

1.6.1. The Transtheoretical Model of Change

The Transtheoretical Model of Change (TTM), or Stages of Change Model (Prochaska & DiClemente, 1982; 1983), was developed to understand the process of behaviour change in relation to smoking cessation. The model (see Figure 7) extended earlier research outlining ten change processes (Prochaska & DiClemente, 1982) and refined a model comprising six stages which must be navigated for change to occur and be maintained (Prochaska & DiClemente, 1983). The model describes a progression through a sequence of change stages, each characterised by changes in attitudes, beliefs and behaviour.



Figure 7. *Transtheoretical Model of Change*.

The Transtheoretical Model has been applied to a diverse spectrum of behaviour change including weight management (Prochaska, Norcross, Fowler, Follick, & Abrams, 1992), drug and alcohol use (Brown, Melchior, Panter, Slaughter, & Huba, 2000; Davidson, Rollnick, MacEwan, 1991). The model has attracted criticism for its over-simplistic nature, with criticism directed towards the multifaceted nature of human functioning which cannot be reduced to such discrete stages (Bandura, 1997), and the assumption that progression towards change occurs in such a linear fashion, which has attracted little empirical support (Davidson, 1992).

Stages of recovery can be considered to map onto the stages of change provided by the TTM (Leamy et al., 2011). A systematic review outlined how processes of recovery may be reduced and considered to occur in each of the stages outlined by the TTM. Models of offender rehabilitation also draw upon the TTM, and the model underpins numerous interventions for substance abuse, sexual offending and violent offending. However, the utility of the model as it is applied to the offending population has attracted some criticisms, with recognition of the differences in motivation towards change in offending behaviour, versus other behaviours for which the TTM has previously been applied (Casey, Day, & Howells, 2005). For example, motivation may not be internally located and may be located in the need to comply or complete mandated treatment for reward or discharge. Also, measuring behaviour change using this model with a detained population offers little insight into whether the behaviour truly has changed or whether the restrictive environment enforces desistance (McMurran, Tyler, Hogue, Cooper, Dunseath, & McDaid, 1998). As noted by Tierney and McCabe (2001), in the case of child sex offending, lack of access to this population may create the illusion of motivation to change, reinforced by verbal expressions of change, which may appear to locate the individual in maintenance or abstinence stages. Recommendations have been made to consider the needs of offending groups in each stage of the TTM, which may be more effective than a 'one-size-fits-all' model (Casey et al., 2001). For example, these authors argue that offenders within the pre-contemplation stage may benefit from techniques such as motivational interviewing rather than a cognitive behavioural approach which may be more effective in behaviour change at later changes where a level of knowledge and motivation is assumed.

1.6.2. Treatment readiness model for personality disorder.

The Treatment Readiness Model for Personality Disorder (TReMoPeD; Tetley, Jinks, Huband, Howells, & McMurran, 2012) extended the Multifactor Offender Readiness Model (MORM; Ward, Day, Howells, & Birgden, 2004) to provide a model of factors influencing engagement in treatment for those who offend and are diagnosed with personality disorder. The model outlines a series of internal and external factors influencing engagement for this client group.

Through the use of Delphi methodology, the authors identified motivational factors specific to groups diagnosed with personality disorder and with offending histories: trait factors, comorbidity factors, relating factors and physical factors (Tetley et al., 2012). The model provides guidance for areas to target to enhance treatment engagement suggesting that clinicians should work to enhance the therapeutic alliance and therapeutic environment to enhance engagement. However, there has been little empirical investigation of applications of the TreMoPed in practice or research.

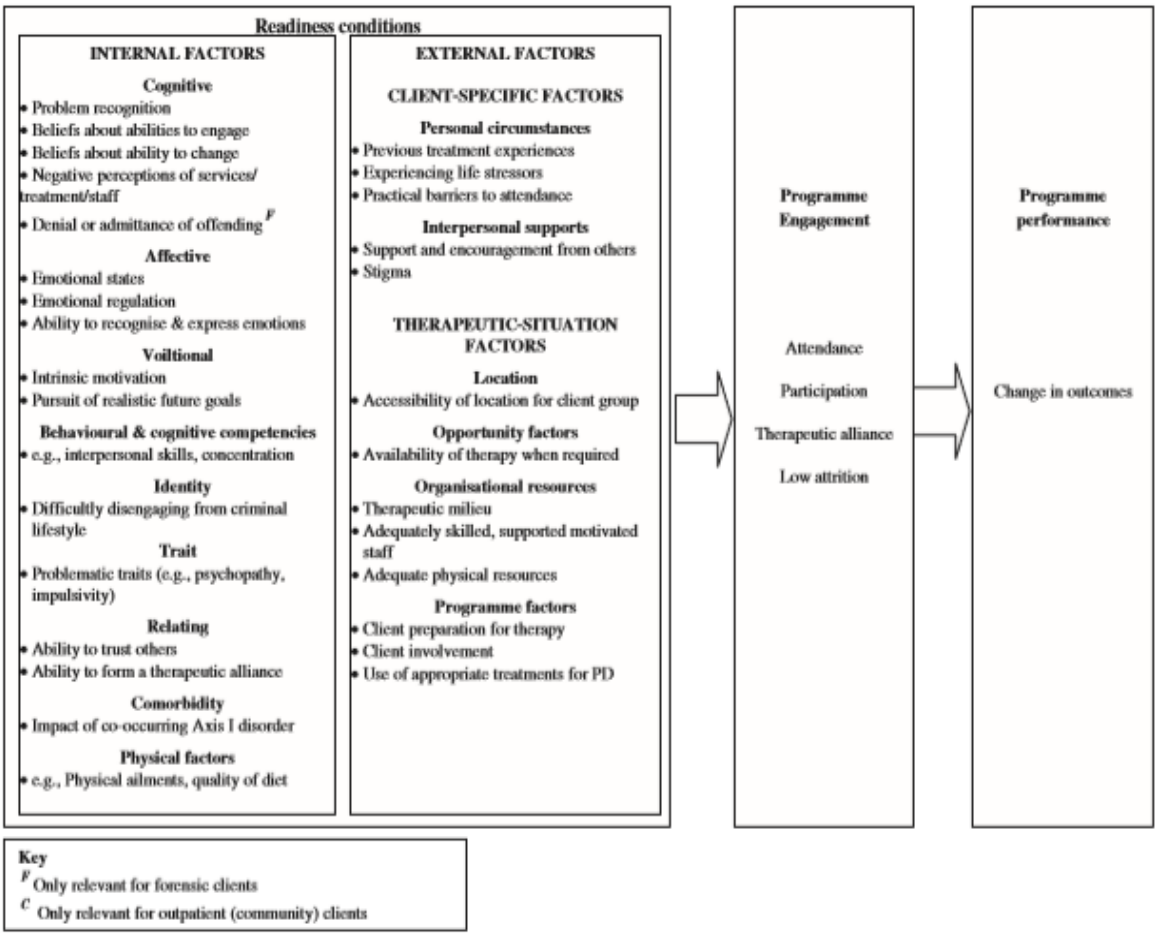


Figure 8. *Treatment Readiness Model for Personality Disorder (TReMoPeD).*

1.6.3. Theory of Human Motivation

Maslow's theory of human motivation (Maslow, 1943; (1970) posits that all humans are motivated to achieve certain basic needs. The theory identifies a hierarchical series of basic needs including needs for food and water, followed by safety, belonging and esteem. Self-actualisation is positioned at the top of the pyramid in which individuals can become "everything that one is capable of becoming" (Maslow, 1943). Maslow posits that individuals possess the capability to progress towards the top of the pyramid, although he acknowledges that life events or failure to meet lower needs may disrupt this.

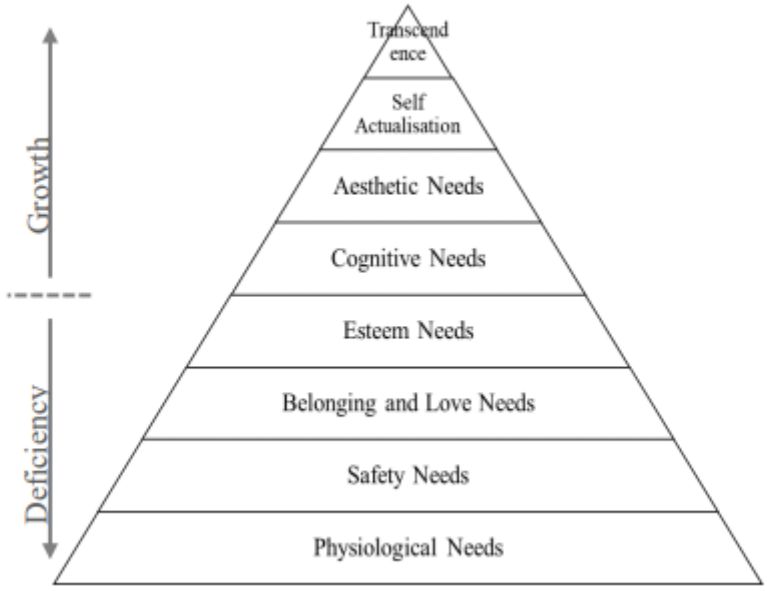


Figure 9. *Maslow's hierarchy of needs*.

Individuals are firstly motivated to have their basic needs met. It is only when the basic deficiency needs are satisfied that they may access capacity to engage in personal growth. Similarities between Maslow's hierarchy and recovery have been observed (Henwood, Byrne, & Scriber, 2015). Whilst recovery research in the context of mental illness has drawn upon Maslow's theory (e.g. Clarke et al., 2012), there has been little focus on how issues such as maternal deprivation, or basic needs such as housing affect personal recovery (Padgett, Stanhope, Henwood, & Stefancic, 2011). A systematic review of recovery in forensic services (Shepherd et al., 2015) outlined the need for safety in the recovery process. The authors considered this within Maslow's model, identifying how for recovery to take place, service-users were motivated to achieve safety and security in their environment before engaging in recovery.

2. Extended Methodology

2.1. Ontology and Epistemology

Ontology is the study of being (Crotty, 1998) and is concerned with the nature of reality. Epistemology is concerned with the nature and forms of knowledge (Cohen, Manion, & Morrison, 2007), generating assumptions of how knowledge can be created, understood and communicated. Guba and Lincoln (1994) propose that epistemology asks the question "what is the relationship of the would-be knower and what can be known?" In approaching research, researchers must consider their perception of what constitutes reality and take the relevant position.

Research paradigms and methodologies are built of ontological and epistemological foundations. Epistemology may be considered along a continuum with positivism and post-modern perspectives positioned as opposing extremes. Traditional medical and social research has orientated itself with positivist philosophical underpinnings. Positivism assumes that reality is universal, objective and quantifiable. Rather than seeking causality, post-modern interpretive approaches consider theoretical understanding as gained through the theorist's interpretations of studied phenomena. Interpretive approaches aim to understand meanings and actions and how the actor constructs these.

One such approach is social constructionism, which asserts that reality is constructed by and between the people experiencing it (Gergen, 1999). Social constructionists posit that worlds are constructed under historical and social conditions which shape individual views, actions and collective practices (Charmaz, 2008). Social constructionism recognises the existence of multiple realities, each of which is dependent on our unique understanding of it (Darlaston-Jones, 2007). It considers the questions what do people assume is real? And how do they construct their views of reality? In the research context, constructivist approaches assert that the researcher and the researched mutually construct the data, influenced by their positions and experiences (Charmaz, 2008).

Researchers are encouraged to select research paradigms which are consistent with their own beliefs about the nature of reality and truth (Mills, Bonner, & Francis, 2006). The paradigm which I have selected reflects my beliefs about the

intersubjectivity of knowledge and its construction through language. As such, this research has been approached through a social constructionist epistemological stance.

2.1.1. Researcher position.

Constructionist approaches recognise the intersubjectivity of reality and recognise how the views of both the researcher and participant may vary. On this basis, the emergent understanding is derived through multiple realities recognising the person's imagined understanding of the other person's role and response during the interaction (Mead & Copeland, 2000). To remain as transparent as possible, the following section describes personal experiences and views which may have influenced the research process. It is intended that this will allow the reader to consider the lens through which this research was conducted, rather than an effort on the part of the researcher to remain objective.

I became interested in recovery principles within my first-year clinical placement, during which time I was required to evidence my skills in evaluation among other clinical and professional competencies. In many cases, I had observed considerable change and heard qualitative accounts of improvements and re-engagement in life. Occasionally these were not reflected by clinical outcome measures, and this engaged my curiosity regarding how services and I were conceptualising change, recovery and the role of mental health services.

Prior to clinical training, I worked in secure services with service-users diagnosed with various mental health conditions including personality disorder. Within these roles, I heard accounts from service users who spoke of frustration over stagnation within the system. I observed a discourse around personality disorder and the challenges in treating this, noting increased attention towards risk and long-term management, with the absence of discourse around recovery. I witnessed discussions centred around manipulation, attention-seeking and splitting within limited consideration of what had happened to these service-users which could explain this behaviour.

In my personal life, I have a family member with a diagnosis of BPD and have noticed how this diagnosis has enabled them to gain some comfort that their difficulties are able to be understood by others. I recognise, however, that this family member is not within the forensic mental health system, nor do they live in the UK. Therefore, to an extent, their experience of the diagnosis may be protected from the stigma and

challenges which are often reported by service-users in the UK. I have also witnessed the challenges in this family member's recovery journey, with little discussion or consideration as to how BPD will present and how it can be managed and recovered from. As such, my views on the topics addressed by this research will be influenced either consciously or sub-consciously by past experiences and views.

2.2. Rationale for Qualitative Methodology

Quantitative methodologies have dominated the field of published social sciences research. However, there has been increased interest in utilising qualitative approaches in social research (Hayes, 1997). Quantitative methods seek to establish causes and explanations for phenomena through research, assuming that knowledge is objective and typically operationally defines concepts for hypothesis-testing through efforts to achieve accurate, replicable, empirical measurement. As such, quantitative research emphasizes parsimony and aims to maintain objectivity and impartiality through distancing personal values and beliefs from research. However, in social sciences, such research approaches can result in narrow explanations and simplistic theories which can marginalise emotional and cultural contexts.

Quality and texture of experience are central to qualitative approaches (Willig, 2001) and this research seeks to explore through investigative enquiry, the experiences of recovery for this client group. The recovery movement has its origins in qualitative accounts with narrative accounts of individual experience creating a new discourse around mental health difficulties, the psychiatric system and the experiences of those engaged with it. Qualitative approaches provide this space to empower those who have been marginalised to use their voice. For reasons previously described, women diagnosed with BPD and offending histories constitute groups whose perspectives and discourses have been marginalised with most published research investigating treatment outcomes. This research is an exploratory investigation, aiming to generate an understanding of how participants make sense of and experience recovery in the context of BPD diagnoses and forensic services. As such, qualitative methodology was considered most appropriate for this study.

Individual experience may be considered to be socially organised, the naming of disease too may be conceptualised as a social process. As a diagnosis, many assert that

personality disorder is to a degree a socially constructed concept (e.g. Pickersgill, 2013). Within mental health services, recovery as a clinical concept is socially constructed such that its created reality exists through consensus alone. Recovery, as defined in this context, is a process centred on social values. Individuals will construct definitions and markers of their recovery in the context of social and cultural norms. The language used gives rise to reality, and this study aims to identify the subjective realities of recovery in personality disorder. As such, utilising a qualitative methodology which acknowledges both objective and subjective realities appear most appropriate.

2.3. Grounded Theory

Kidder and Fine (1987) distinguish between 'big Q' and 'small Q' in qualitative research. 'Small q' research refers to the incorporation of non-numerical data collection techniques into hypothetico-deductive designs such as an open-text response option in a questionnaire. 'Small q' approaches do not seek to engage with the data and gain new insights. 'Big Q' methodology refers to open-ended, inductive research methodologies with the objective of creating new theory and exploring new meaning. This study aims to explore service-users' experiences of recovery in secure services and will, therefore, utilise 'big Q' methodology.

Grounded theory represents one form of 'big Q' methodology (alternative approaches are described below). Grounded theory offers a set of systematic yet flexible guidelines for collecting and analysing data to construct theories from the data themselves. It was developed by Glaser and Strauss (1967) as a post-positivist response to the dominant methods of inquiry at the time, proposing that qualitative analysis could construct abstract theoretical explanations of social processes recognising the limitations of quantitative research in developing new information in this area.

Glaser and Strauss (1967; Glaser, 1978; Strauss, 1987) defined the key components of grounded theory, which have been adapted over time giving rise to diversity within the grounded theory paradigm (Mills et al., 2006). The original version of grounded theory, as proposed by Glaser and Strauss, posited that the researcher discovers theory from the data. Subsequent approaches vary in the extent to which stages are prescribed such as specific coding parameters and whether data is considered to be constructed or uncovered (Annells, 1996). Pigeon and Henwood (1997) identified

four ways in which knowledge is produced in qualitative research: the understanding of the participants, the interpretations made by the researcher, the cultural systems of meaning for both researcher and participant and the acts of judging particular interpretations as valid by the scientific community.

Constructivist grounded theory attempts to acknowledge this and examines the researcher's perspectives, position, research situation, reflexivity, and depictions of social constructions in the studied world. Attention is paid to language used, recognising that the world is known through language, which reflects values and views (Charmaz, 2006) and that the researcher's interpretation of language contributes to the meaning afforded to it in the development of theory. Thus, the emergent theory is formed from the co-construction of meaning between the participant and researcher. Constructivist researchers are attentive to theorising the interpretative work which participants engage in constructing their reality, but also are cognisant that the resulting theory is an interpretation (Bryant, 2002). In this sense, it is recognised that the emergent theory cannot exist without the existence of researcher views throughout the research process.

Researchers remain reflexive in their approach towards the processes and products of the research, drawing attention to *how* theory evolves. It is recognised that research provides a context for the emergence of understanding, and constructivist approaches position the research process itself as an important condition interacting upon the emergent theory. In this view, research processes and products become constructed, and these constructions occur under structural conditions, arising in emergent situations. Processes and products become influenced by the researcher's perspectives, positions, interactions and locations (Charmaz, 2014).

A completed grounded theory is characterised by a close fit with the data, usefulness, conceptual density, durability over time, modifiability, and explanatory power (Glaser, 1978, 1992; Glaser and Strauss, 1967). A key feature of grounded theory is constant comparative analysis (Glaser and Strauss, 1967) whereby momentum in coding is maintained through moving back and forth between the identification of similarities and differences between emerging categories. It involves not only the building up of categories but the breaking down of subcategories to capture variation within a category (Willig, 2013). The search for negative cases, i.e. those that do not fit with emerging categories, is another core feature of grounded theory accounting for

complexity and depth within the data. As coding develops, the researcher is alerted to the need to follow up particular lines of enquiry through revision of the interview schedule. This allows for the development of a broader theoretical understanding to account for complexity within the data.

It is recognised that the interview process is dynamic, and more information is collected within the process than is observable from an interview transcript. Analytic ideas brought about by researcher interpretations of the setting, in addition to observations of non-verbal behaviour are captured within the memo-writing process and are later integrated into the analysis.

The completion of the literature review is an example of the distinction between grounded theory research and other qualitative research. Whilst it is argued that completing the literature review following the analysis stage enables the researcher to develop a theory which is truly grounded in the data, the extent to which the researcher enters into the research process with some knowledge, including the preparation of a research proposal, poses some challenges to this. This argument has particular relevance in the clinical psychology domain whereby the product must offer some value to the clinical psychology field, offering something beyond what is currently available.

2.3.1. Critique of grounded theory.

Despite the proliferation of studies utilising grounded theory, particularly in social sciences research, grounded theory has also been subject to well-documented criticism (Haig, 1995; Layder, 1993; Thomas and James, 2006).

Common criticisms relate to the epistemological roots of grounded theory. It has been argued that through prescriptive methods (such as those outlined by Corbin and Strauss), the methodology adopts a positivist methodology. The original intention behind grounded theory was to work by induction to allow new theories to emerge from data, thus liberating the researcher from hypothetico-deductive research. Critiques of positivist research have, however, identified that what emerges from data is standpoint specific (Dey, 1999). Thus, grounded theory has been criticised for failing to address issues of reflexivity sufficiently. Subsequent derivations of grounded theory, including the constructivist methodology (Charmaz, 2006; 2014) employed in this study, have sought to overcome such challenges, recognising the co-construction of categories

between researcher and participant, rather than the discovery of data as advocated by earlier grounded theorists.

Originally, grounded theory was designed to study social processes from the "bottom up", allowing researchers to trace how actions had consequences and how patterns of interaction give rise to particular social processes. As such, grounded theory was developed to examine sociological issues and has since been applied to psychological research. The focal shift from examining social processes to examining psychological experience has attracted criticisms relating to the suitability of grounded theory for such processes. It has been argued that through the conceptual mapping of emergent categories, grounded theory serves only to develop a descriptive account rather than a theory per se and some have suggested that grounded theory may be better suited to social psychological processes (Willig, 2001). Others have argued that a theory is an explanatory scheme comprising a set of concepts related to each other through logical patterns of connectivity (Birks & Mills, 2011).

2.4. Alternative qualitative approaches

It is important to acknowledge the alternative methodologies available and consider why alternative approaches may be less fitting to the research question in this study.

2.4.1. Thematic analysis.

Thematic analysis is a method used to identify, analyse and report themes within data. Alternative versions of thematic analysis exist: inductive and deductive. Inductive thematic analysis employs a bottom-up approach, staying close to the data but not drawing upon the researcher's theoretical interests. Deductive thematic analysis offers a top-down approach, with a focus on a particular theoretical aspect of interest. Thematic analysis has been critiqued for the principles upon which it rests which are commonly found in other qualitative methodologies (Boyatzis, 1998), thus minimising the approach as a methodology in its own right. Braun and Clarke (2006) provide guidance on the use of the principles in a flexible but theoretically and methodologically sound way, emphasising its justification as an approach in its own right.

The criticism outlined by Boyatzis (1998) does, however, relate to the strength of thematic analysis as a malleable approach, suitable for use in studies based on varying epistemological stances. The limitations of thematic analysis in comparison to grounded theory approaches are most prevalent in the process of analysis. Whilst thematic analysis develops initial codes before searching for themes; grounded theory seeks to develop an overarching theory which considers the relationship between various themes. Thematic analysis may be considered vulnerable to a conflation between frequency and importance. In grounded theory research, the value of the data in contributing towards a theoretical understanding is not measured by frequency, rather explanatory power in conceptualising experience. The attendance of grounded theory to investigating negative cases and constant comparative analysis is a comparable strength. Further, theoretical sampling and amendment of interview schedules allow for constant development and movement toward theory construction, with the researcher retaining focus on the direction of the emergent data thus contributing to a more flexible and responsive approach. Thematic analysis is primarily a descriptive approach and does not seek to generate new theory and is therefore limited in its suitability for this study due to the understudied phenomena.

2.4.2. Interpretive Phenomenological Analysis (IPA).

Interpretive phenomenological analysis (IPA) is an exploratory and inductive analysis, specifically focusing on lived experience or the interpretation of the participant. Interest is directed at the individual in their own context, and each interview is analysed in detail before moving on to another participant. Following analysis, convergence and divergence between cases are explored. Whilst IPA aims to develop an understanding of the lived experience of the individual; grounded theory aims to explore the social process as it occurs within the environment of interest; in this case how recovery occurs for women diagnosed with BPD in secure services.

IPA and grounded theory share many features. Both methods begin with individual cases and seek, through the development of categorisation, to arrive at an understanding of individual experience. IPA, however, does not seek to make connections between emerging categories nor does it seek to generate a coherent theory. Like thematic analysis, IPA is limited in the flexibility of its application. It does not

allow for amendment of interview schedules in response to emergent data, nor is it active in the process of constant comparison, thus limiting scope and responsivity.

Like grounded theory, IPA is inductive in its nature, aiming to explore the meanings individuals ascribe to their experiences with no pre-existing hypothesis. IPA adopts a critical realist epistemological stance which conflicts with my own stance.

2.5. Sampling and participants

2.5.1. Theoretical saturation and sufficiency.

Charmaz asserts that processes of theoretical sampling and analysis take place until theoretical saturation takes place (Charmaz, 2014). This indicates a point at which no further themes or concepts are contributed to the theory through the addition of new data and is the objective for many grounded theory studies. Glaser and Strauss (1967) identify the potential for new perspectives of data to emerge at any point in the research process, suggesting that "the published word is not the final one, but only a pause in the never-ending process of generating theory" (cited in Dey, 1999: 117).

It has been suggested that achieving theoretical saturation is impossible for a small-scale study (Pidgeon & Henwood, 1997). An alternative concept of theoretical sufficiency (Dey, 1999) has been employed for this study. Theoretical sufficiency can be used in small-scale studies when achieving theoretical saturation is unlikely. Theoretical sufficiency is achieved when themes are robust to the addition of new data without requiring modification (Dey, 1999).

2.5.2. Sample size.

Grounded theory adopts a unique approach to sampling. The sample size for studies employing grounded theory methodology cannot be pre-determined as it is reliant on the emergence of theory (Cutcliffe, 2000). The iterative processes of data collection and analysis continue until the point of theoretical sufficiency is achieved (Dey, 1999). Mason (2010) contends that sample size and saturation need to take account of the research question and quality of the data, recognising that a skilled interviewer conducting 10 interviews may produce a more sophisticated analysis than a novice

completing 50 interviews. Sample sizes in published studies employing grounded theory methodology are widely variable, ranging from seven to 245 participants (Adamson & Braham, 2011; Mottram, 2011).

2.5.3. Eligibility criteria.

Purposive sampling was used to identify participants for whom the research topic was most relevant. A number of inclusion and exclusion criteria were applied to the study. Participants were eligible to take part in the study if they were:

- Female
- Between the ages of 18 and 65 years
- Diagnosed with Borderline Personality Disorder (or Emotionally Unstable Personality Disorder)
- Able to provide informed consent.
- Able to speak and understand English.
- Detained in forensic mental health services under the Mental Health Act (1983) as amended in 2007.

Participants were not eligible to participate in the study if they:

- Were currently experiencing active, positive symptoms of psychosis impacting on functioning.
- Were unable to provide informed consent.
- Had a diagnosed learning disability.
- Were subject to transferred prisoner sections of the Mental Health Act 1983, as amended in 2007.

The research question sought to develop a theoretical understanding of the process of recovery for women in medium- and low secure services. Theoretical sampling was implemented and directed the researcher to pursue new data relating to the recovery goals of transferring out of secure services and into locked rehabilitation services. This was identified by many participants as a "stepping stone" towards recovery and discharge into the community. As such, theoretical sampling extended the sample to participants within a locked rehabilitation service to test developing hypotheses.

2.6. Participant Recruitment

2.6.1. Procedure.

Participants were recruited from one medium secure service, two low-secure services and one locked rehabilitation service across four counties in the Midlands. The services comprised three NHS sites and one private provider.

On-site psychologists acted as field supervisors and were the main point of contact for the researcher. The researcher circulated specified inclusion and exclusion criteria to field supervisors, who identified potential participants from within their service. Field supervisors considered issues of capacity to consent to the research through discussion with potential participants' Responsible Clinician (RC). No formal capacity assessments were undertaken, but potential participants were only approached if their RC and the field psychologist had no reason to doubt their capacity to consent, as capacity is assumed under the Mental Capacity Act (2005). The field supervisor was considered the most appropriate person to make the initial approach to participants to protect confidentiality. The field supervisors, acting as gatekeepers for the research carried with it some benefits and drawbacks. Whilst it allowed participants to be approached by professionals with whom they were familiar, the relationship of the field supervisor to the participant contains within it an inherent power imbalance which it is possible may have influenced participant motivation to engage.

During the initial approach, the field supervisor provided participants with the information sheet (Appendix i) and sought consent for the researcher to approach. It was acknowledged that participation in the study was entirely voluntary and that the choice to be involved was solely theirs. The researcher later approached participants at a time agreed with field supervisors and participants, and written consent was obtained (Appendix ii). The researcher discussed the project with participants and a date and time were scheduled for the interview. Interviews were scheduled for within four weeks of providing consent. Two interviews were later re-scheduled at the request of participants. The researcher remained attentive to the issue of capacity throughout the research project. There were no concerns that participants did not have the capacity to consent or engage in the research process.

2.6.2. Participant withdrawal.

Participants were assured that their participation was voluntary and would not influence their care. Confidentiality and its limitations were discussed. Participants were informed of their right to withdraw their consent up to one week after the interview, at which point their data would be included in analyses. This information was detailed in the information sheet, discussed during the consenting process and within the interview process. One participant withdrew consent before completing the interview.

2.7. Ethical Considerations

Approval was sought from the University of Nottingham as a sponsor for the research. Once approval was granted, approval was sought and gained from the North West-Greater Manchester West NHS Research Ethics Committee (Appendix iii). Local approval was gained from Nottinghamshire Healthcare NHS Foundation Trusts' Research and Development department to approve the research for sites within the NHS. Further local approval from on-site clinical teams was gained following a presentation of the research project to the clinical/academic teams of the two sites in Nottinghamshire Healthcare.

Due to difficulties in recruitment, a non-substantial minor amendment (Appendix iv) was submitted and approved allowing recruitment from a private provider, St. Andrew's Healthcare, and a further non-substantial amendment was approved to recruit from another private provider, Partnerships in Care/ The Priory. Local approval was gained from the Research and Development Department at St. Andrew's Healthcare, however, Partnerships in Care/The Priory withdrew support for the project before recruitment could take place. A further substantial amendment was submitted to extend the date of recruitment and also to recruit from a locked rehabilitation service within Lincolnshire Partnership NHS Foundation Trust, which was granted (Appendix v).

Each site considered the ethical, practical and research implications involved in supporting this research. This was evident through various procedures, which the researcher became involved such as liaison with clinical directors, presentations to academic panels within services and ongoing discussion with field supervisors, each of which added to the demands placed upon time. Encouragingly, services were open to

the research process and each site purported to align themselves with the values of recovery-based approaches, with some sites having on-site recovery colleges or close links with local recovery colleges. The potential burden for participants was identified at one site who recognised that their client group was frequently invited to engage in research, though male participants appeared to be the target population for most projects.

The issue of capacity and consent was reflected upon heavily by the researcher and field supervisors throughout the research process. Consent was taken to be a non-static entity such that for many reasons participants may choose to withdraw their consent at any point. Although all participants who were approached were assumed by their RC's to have the capacity to consent to the process, clinicians often considered the wider implications for participants. Clinical risk issues were considered by field supervisors and impacted upon decisions about how and when to approach participants. For example, one field supervisor identified a participant who met criteria and who had the capacity to consent. However, due to recent self-harming behaviours, it was considered more appropriate to approach this participant at a later stage in the research process. To this end, field supervisors drew upon their clinical opinion of the difficulties which could arise for the participant should they engage in the interview. A potential limitation of such processes, however, is that it is possible that the sample recruited for interview represent a subset of the intended population, and that the voices of women experiencing overt mental health crises may have been marginalised. It is possible that the clinical decision to restrict autonomy and deny the invitation to engage in the interview represents some of the organisational and professional challenges of forensic services (this is further discussed in the Limitations section).

2.8. Data Collection

2.8.1. Socio-demographic data.

It was decided that reviewing the files of participants was not in keeping with the epistemological position of the research. Through arming myself with knowledge of the mental health and offending histories of the participants I was mindful that this might influence my chosen avenues of questioning and potentially move the research from a bottom-up position. It was also considered that participants may have multiple

diagnoses and/or offending histories but may identify themselves with a particular diagnosis or offence. Similarly, the recovery model advocates empowerment and equality, and it was felt that using my position to access information which could be alternatively provided may disempower the participant. Therefore, it was considered more authentic to the research position to obtain demographic information from the participant. Socio-demographic information (Appendix vi) was obtained following the receipt of written consent from participants and prior to the interview.

The majority of participants had received many diagnoses, commonly Antisocial Personality Disorder (ASPD) and additional diagnoses including schizoaffective disorder, obsessive-compulsive disorder (OCD) bipolar disorder and post-traumatic stress disorder (PTSD). Offences included violent offences (actual and grievous bodily harm), aggravated robbery, child neglect and making threats to kill. One participant had no offence history. Participants were detained under various Mental Health Act (MHA) Sections including 3, 37 and 37/41.

Although participants described a length of current stay up to 8.5 years, some participants described longstanding involvement with forensic psychiatric services. Charlie had been an inpatient in her current unit for 2 years and 8 months but described a longstanding history with secure services including a past 6-year admission in a low-secure service. Katrina had been an inpatient for four years at the time of interview. However, she described having been "in and out" of services for 37 years.

2.8.2. Semi-structured interviews.

Grounded theory, similar to other qualitative methodologies, can use data from interviews, text or observations (Corbin & Strauss, 1008). Intensive interviewing focuses the topic while providing the interactive space and time to enable the participant's views and insights to emerge (Charmaz, 2014). There is a good fit between grounded theory and intensive interviewing as both are open-ended yet directed, shaped and emergent and paced yet unrestricted, enabling the researcher to pursue ideas and issues immediately as they emerge. This was considered appropriate as it allowed in-depth discussion and exploration of participants' experiences. The interview aimed to explore how participants conceptualised recovery in the context of their lived experience.

Face-to-face interviews are considered the gold standard as they provide additional contextual and nonverbal cues, such as body language (Novick, 2008; Rahman, 2015). Interviews were completed face-to-face on the wards of each participant. Interviews were generally completed on a 1:1 format, although one participant requested to have a member of staff support her through the interview, which was facilitated.

2.8.3. Interview schedule.

The general themes for the interview schedule were developed based on the aims of the research. A representative of the Service User and Carer Advisory Panel (SUCAP) at the University of Nottingham with a diagnosis of BPD volunteered to be involved in the refinement of the interview schedule through a mock interview and discussion and reflection. Through this process, the interview schedule for the first interview with forensic service-users was constructed (Appendix vii).

The initial interview schedule sought to cover three key areas; participant understandings of their diagnosis; recovery and; their experience of recovery in the secure context. Interview questions were open-ended, enabling greater exploration and avoiding biased questioning. Participants were encouraged to expand upon particular comments they made through prompts. Participants were encouraged to reflect upon their recovery journeys and future goals for recovery.

Each interview was audio recorded, transcribed and analysed before the next interview to aid constant comparative analysis. In line with grounded theory approaches, the interview schedule was reviewed after two interviews were transcribed and coded. This is in line with the principles of theoretical sampling. Throughout the research, the cyclical process of data collection and analysis resulted in two revisions of the interview schedule. The development of interview schedules is contained in appendix vii.

2.9. Analysis

Intensive interviewing forms the first stage of analysis (Charmaz, 2014). Interviews were audio recorded and transcribed verbatim by the researcher. The first stage of

coding, initial coding was completed following transcription. Coding is developed through the construction of meaning by the researcher, recognising the questions being raised by the data as they emerge. Thus, the resultant codes do not develop as a result of the application of an extant coding frame, as is the case with alternative grounded theory approaches (e.g. Strauss and Corbin).

During initial coding, the goal is to remain possible to all theoretical possibilities. However, it is acknowledged that the researcher cannot remain a tabula rasa (Glaser & Strauss, 1967) as their own experiences, viewpoints and knowledge may shape how sense is made of the experience of others. For example, my experience working in secure services and the process of preparing the research proposal enabled a level of familiarity beneficial to contextualise the research process. I also acknowledge that the resultant theory will not constitute an empirical reality, rather, my interpretation of how participants interpret their own reality, and the language used to arrive at such interpretation.

Once interviews were transcribed, coding was completed at both line-by-line and the incident-level. It was important to remain as close to the data as possible in this stage, ascribing descriptions of coded units which remained close to the language used by participants. Descriptive labels provided the first insight into meaning within the data which later formed the link with emergent theory (Charmaz, 2014). Initial codes are subject to revision and reinterpretation. As the research process progressed and the researcher became familiar with data and emergent concepts, initial codes were re-visited and revised, where appropriate. An example of the coding process can be seen in Appendix viii.

Following initial coding, the next stage of focused coding was completed. Focused coding is directed, selective and conceptual (Glaser, 1978) and allows for larger segments of data to be synthesised into theoretical entities. During this process, earlier initial codes were identified which either occurred frequently or offered some explanatory power in understanding the experience of recovery for the women interviewed. Here, the descriptive codes were extended to develop higher level categories which were more analytic than descriptive. In this stage, consideration was paid to which initial codes offered the most insight in enriching the researcher's understanding of the experience of recovery for the women who were interviewed. Therefore, initial codes which extended understanding of the experience were

developed into focused codes, and those who did not contribute to greater understanding of the recovery experience were set aside. Appendix viii contains examples of the development from initial to focused codes.

Grounded theory outlines that to construct a theory which is grounded in the data it is necessary for the researcher to engage with the data and pursue lines of inquiry from the bottom up. As coding developed, emerging themes and concepts were identified which required further exploration. In order to pursue these, the interview schedule was revised to include questions or prompts to explore these themes further. In some cases, this allowed for what was appearing in the data to be expanded upon in interviews with future participants. On other occasions, lines of questioning did not yield new insights; however, some resulted in divergent experiences being captured.

Similar to some other qualitative methodologies, grounded theory utilises constant comparative analysis (Glaser and Strauss, 1967): the process of moving back and forth between the emerging categories in search of similarities and differences. Incidents from the same body of data and data obtained from another participant were compared. Therefore, diversity within categories became apparent which later formed subcategories and allowed for a more expansive category to be developed. Developing experience was then further explored by re-visiting past codes to identify those who did not fit with what is emerging, i.e. a negative case analysis. In these cases, the experience of these participants was explored further to consider the context of this experience and how it differed to the experience of other participants.

Alternative methods of grounded theory, such as that proposed by Strauss and Corbin (1990) advocate a further stage of axial coding. Although axial coding may enable researchers to explore their data to an extent, it encourages a form of analytic frame to be applied, thus constricting the emergent and constructive elements of my chosen methodology. Instead, and in line with Charmaz' methodology (2014), theoretical coding was applied as the final coding stage.

Theoretical coding is concerned with how focused codes may relate to one another as hypotheses to be integrated into a theory, thus "weaving the story back together "(Glaser, 1978: 72). As such, focused codes were considered in relation to one another and to what extent they described various aspects of the studied experience. The process aims to ascertain how, and to what extent the studied experience is

embedded in larger positions, networks, situations and relationships (Charmaz, 2006). See Appendix viii for examples of the development of codes.

In line with grounded theory methodology, a literature review was completed within this final stage of analysis. Glaser (2004) asserts that completing the literature review before analysis violates the inductive assumptions of grounded theory methodology. Instead, it is seen as an additional data source to be integrated into theoretical coding. As such, in this final stage, emergent concepts were considered in terms of how they related to one another. Finally, this was extended upon by referring to existing bodies of knowledge and theory to extend the theoretical understanding of the recovery experience.

2.10. Quality Assurance Methods

2.10.1. Constant comparative analysis.

The progression through coding stages is not necessarily linear. Constant comparative methods (Glaser and Strauss, 1967) are used to establish analytic distinctions and thus make analytic comparisons within the analysis process. Comparisons are made between data emerging within an interview and between interviews. For example, as themes became identified in later interviews, these were then compared with codes from earlier interviews. On some occasions a concept which emerged in later interviews was compared with codes from earlier interviews and it was found that although the same concept was not explicitly coded, implicit relations between descriptive codes enabled a more analytic experience to be captured Such experiences may have gone undetected in the absence of the concept becoming detected in later interviews. The process of constant comparative analysis enabled the experience of earlier participants to remain connected to the experience of subsequent participants, either in the similarity of experience or alternative experiences of similar phenomena (e.g. shame or pride in offending).

2.10.2. Reflexivity.

Theoretical sensitivity is the ability to understand and define phenomena in abstract terms and to demonstrate abstract relationships between studied phenomena (Charmaz, 2014). Generating theory from data means most hypotheses come not only from the data but are systematically worked out in relation to the data during the research (Glaser, 2004). Glaser outlines that the first step in theoretical sensitivity is to enter into research with as few preconceptions as possible (Glaser, 2004).

In relation to my own theoretical sensitivity, aspects of my experience will have potentially influenced my construction of data. Recognition of the perspectives of the researcher and the potential for bias underpins one of the criticisms of alternative forms of grounded theory. Within constructivist theory this concept of reflexivity is considered an added level of explanation for how theory emerges, increasing the robustness of findings through identification of the researcher position (Engward & Davis, 2015). Charmaz (2014) recommends keeping a methodological journal, outlining methodological dilemmas, directions and decisions. I began a journal at the beginning of the research process, documenting changes in the direction of the project including theoretical sampling, ethical considerations and challenges at various recruitment stages.

To maintain the indicative nature of grounded theory, I was mindful not to conduct a literature review before engaging in the data collection and analysis processes. However, it is recognised that researchers approach research with some degree of background knowledge (Strauss and Corbin, 1990). Though I did not immerse myself in extant literature in the areas of investigation, my clinical experiences of working in forensic services and with individuals diagnosed with BPD, in addition to personal experiences will have influenced my approach to the research. Additionally, as a clinical psychology trainee, a degree of understanding was required in the preparation of research proposals and also to understand the processes and language used by participants in interviews. Processes of memo-writing, reflexive journal-keeping and supervision were utilised to develop a form of audit trail of such influences.

2.10.3. Memo-writing.

Memo-writing is a distinguishing characteristic of grounded theory (Glaser and Strauss, 1967), bringing awareness to the shaping of findings through the researcher's own interpretations of and interactions with the data. Memo-writing focusses the researcher on their justifications of labels or categories and allows for the tracing of emerging relationships, thus enabling transparency. Through the research process, I utilised audio-recorded memo-taking following interviews, recounting my initial reflections on the process of the interview. This provided directions for future ideas which later formed part of the analysis. I later developed memos as I asked questions of the data. This enabled me to move from lists of categories, to explore the relationships between them, thus, creating a theory with explanatory links.

As a researcher, one's own interpretations of the data and their interaction with it ultimately shapes findings. Memo-writing focusses the researcher on their justifications of labels or categories and allows for the tracing of emerging relationships as data is abstracted to the theoretical level. Examples of memos in this study are contained within Appendix ix.

2.10.4. Supervision.

I accessed supervision from each of my academic supervisors throughout the research process. This enabled me to challenge my decision making and was particularly valuable when considering directions for theoretical sampling. Though it is recognised that a need for consensus is not an objective within constructivist grounded theory projects, supervision afforded supportive dialogue when constructing focused and theoretical codes and supporting me to consider relevant existing literature which could offer insights to the developing model. Similarly, research supervisors encouraged me to reflect upon my developing model and consider how I may seek to refine this.

2.10.5. Evaluation.

In order to ensure the quality of constructivist grounded theory as a substantial form of qualitative analysis, Charmaz (2014) outlines four criteria (Appendix x) from which to establish the quality of constructivist grounded theory studies. Qualities of credibility, originality, resonance and usefulness of studies were considered throughout the research

process. This was reflected upon in supervision throughout the research process, and a summary is provided in Table 7.

Table 7. *Evaluation of study against Charmaz (2014) criteria.*

Criterion	Evaluation (strengths and limitations)
Credibility	Rich data were gathered in the chosen topic. Claims made are reasonable given the small sample size and theoretical saturation is not claimed. The study is limited by having exhausted recruitment opportunities before achieving theoretical sufficiency, and this is recognised as a limitation. Themes cover a wide range of empirical observations and are expansive. Supportive quotes illustrating themes have been provided, in addition to transparency in coding processes.
Originality	The themes developed offer new insights into the experience of women with BPD diagnoses detained in secure and locked settings. The developed model offers the first service-user-derived account of recovery for this client group, thus providing an insight which can be connected to existing literature. Findings extend upon published research into recovery in the context of individuals diagnosed with personality disorders and those detained in secure settings by drawing upon similar themes, such as safety, but considering the impact of relational safety for women in such settings as part of the recovery process. The model adds weight to the concepts of relational security, attachment principles and trauma-focused practice for women in secure settings. It extends beyond intra-psychic models of change and outlines both inter- and intra-psychic processes contributing to the recovery process. The model has some resonance with existing recovery models and principles but offers insights into challenges and barriers to achieving this for this client group, i.e. overcoming the offender identity, losing the secure base.

Resonance	Themes portray the studied experience. Experience was drawn from individual participants and connected to the experience of other participants. Analytic processes such as negative case analysis and constant comparative analysis identified unique or common experiences. Resonance was unable to be investigated with further participants which is a shortcoming of the study. Whilst themes were derived and shaped by participants and constant comparative analysis contributed to the robustness of the study; recruitment difficulties resulted in the final step of sharing the model to determine resonance was not possible. This is a limitation of the findings.
Usefulness	The model offers some useful contributions to both academic and clinical fields. The findings revealed an apparently staged process of recovery with some points in which recovery could be supported by clinical staff. As such, the model offers clinical utility and directions for staff in terms of considering the model within reflective practice. In addition, the model identifies sources of barriers and setbacks which could be planned for within the clinical setting. The model extends upon extant research but also provides directions for future research, such as the study of recovery post-discharge. The model proposes challenges in this transition and therefore understanding the experience of recovery beyond secure environments may enable planning for successful transitions.

3. Extended Results

3.1. Time

Many participants reflected the idea that time took on a new form in secure services such that expectations for recovery were often measured against the time spent struggling with emotions and time spent in services:

"cos I'm coming up to discharge soon so I think next year, sounds far away too but for me, that's pretty close cos I've been here for like half a decade."

- Michelle

Participants reflected unique relationships with time, describing a sense of time passing by them in secure services, and also time being paused in their community lives. Thus, a sense of being suspended in time was described. The sense of community life as paused was reinforced by a process of participants detaching themselves from the community world which no longer felt tangible to them. A small number of participants reflected a loss of meaning of time-specific events such as birthdays. Instead, time became measured by mental health processes such as ward rounds, CPA's and tribunals all external indicators of recovery:

"I put everything into focusing on my tribunal, and then it didn't happen, and now I'm putting everything into focusing on my tribunal in January. It's a far-fetched thing to focus on, but you don't look forward to Christmases. Cos they are a thing of the past. You don't look forward to birthdays cos there's nothing to celebrate…you just look forward to little things"- Michelle

It appeared that recovery could not be separated from the processes of the secure world, which ultimately provided reinforcement of recovery or identified that participants were not progressing towards recovery and reduced risk. Time-specific processes such as those described by Michelle became opportunities for external views of recovery to be gained.

One participant who experienced a discharge and later re-admission reflected that this had occurred as she felt she was transitioned too quickly without feeling adequately recovered or prepared. Participants reflected that they were often required to balance their felt sense of capability with a need for steadiness in their transitions. Allowing time to pass and waiting for particular processes to take place, such as CPA's

and tribunals, however, represented a great source of frustration and restlessness as it was experienced as limiting opportunities for progression towards recovery:

> *"so, I'm waiting on my transfer to locked from the Ministry of Justice. I just sit and wait for the Ministry now, that's what I do. I wait. I wait and wait and wait and wait"*- Michelle

Whilst community lives were on hold participants became immersed in the secure world, while holding in mind the key figures from their community lives. However, existing within the secure world created many challenges as participants reflected a sense of being 'in limbo'.

3.2. Relationships

3.2.1. Trust.

The development of trusting relationships with staff was seen as both a facilitator and indicator of recovery. During the early stages of the recovery process, the nature of trust represented a significant barrier for participants. It was often reflected that past experiences which had violated participant trust (in professional or personal domains) impacted on their sense of confidence to place trust in others. In light of these experiences, the nature of trust taking time was reflected upon by many and was described by Kelly:

> *"I've always struggled to put trust in people because growing up… I just didn't trust anybody, not my parents, not my sister; I used to keep everything to myself, I wouldn't talk to anybody...I got into services here, and I just didn't feel like I could trust anybody. I've always struggled to trust people, and it takes ages for me to trust someone"*- Kelly

Challenges in trust gave rise to a sense of caution in relationships. Participants described a sense of vulnerability in their peer relationships, recognising that relationships with other service-users represented a potential source of de-stabilisation, increasing the likelihood of dysregulation and becoming violent. Participants reflected that becoming dysregulated and aggressive could be interpreted as poor coping and increased risk, resulting in a setback in terms of security or restrictions, thus distancing them from their goals. As a result, some considered the potential of interpersonal conflict too great a risk to their recovery and withdrew from other service-users as a strategy intended for self-preservation:

> *"So, I try to. I'm not an argumentative person. I say I'm violent. When I get going I am violent, but I keep myself to myself cos I don't like that side of me, so I don't let that side of me show. I know what I'm about, I know what I'm capable of, but I don't. I don't bother anyone, so no one bothers me…I keep myself to myself"*- Michelle

Other participants reflected caution in terms of emotional safety with peers, choosing to engage in topics which were considered safe. In this sense, participants described feeling they had to guard what they said to their peers due to lack of trust. Peer relationships were characterised by superficiality, described as distant and lacking in meaningful connection. A consequence of this was an experience of unsaid inner experience and a sense of disconnect in relationships:

> *"but when I'm sitting there with them patients and that, none of them know me. They know my name, some of them know where I come from, none of them know what I'm in for. I wouldn't tell anyone about me because fucking news travels like the plague and it's dangerous. It's a dangerous environment to be in this is"- Michelle*

Superficiality in peer relationships appeared to be maintained by the expectation of developing positive peer relationships. Thus, participants often described reluctance in engaging in peer relationships:

> *"Cos there's not one of them patients that if I met in the community, I'd associate with… They are just people that I have to be nice to, and I have to live with…so that's, that's difficult as well, you know having to be nice to people and having to, you know when people are horrible sometimes. It's hard to be nice"*- Amy

The women described a sense of isolation in their daily experiences on the wards. Despite residing on wards with many other service-users, the sense of loneliness was apparent, raising questions for some participants about their identity:

> *"I just sit in a room full of people and just think, how can I be around so many misfits and not fit in. I'm the biggest misfit myself"*- Michelle

The transitory nature of inpatient relationships was reflected upon by participants. It was recognised that service-users are detained under various mental health sections, resulting in discharge or relocation to other services or wards:

> *"She's never there when I need her and always there when I don't. I have [patient] who just picks and chooses when she wants to be there or not"*- Michelle

In this sense, overcoming the challenges to establish positive peer relationships was accompanied by recognition of the inevitable loss of these relationships.

Caution was also described in participants' relationships with staff. Participants described presenting a "false self" to staff as they were concerned that sharing their true

thoughts and feelings had the potential for adverse consequences. Caution in how their views would be interpreted by the team was apparent, resulting in participants feeling silenced due to caution:

> *"hard to say what you want, exactly what you want to say in here because it just gets treated like a piece of shit to be fair…written down…completely wrong. That's the worst thing about it cos you can say something, and it's meant the complete opposite but now it doesn't matter because now you've said it the way they've put it around makes it even more shit"*- Sammy

Participants described isolation in their emotional experience. Due to the barrier of trust, many participants carried distressing thoughts and feelings without feeling able to access support. For Sammy, this was reflective of past experiences in relationships:

> *"It's picked up in the wrong way completely..almost all the time..so sometimes you're better off not saying anything at all. But then…I've known that all my life. It's just that now it's got worse for me now"*- Sammy

Participants reflected on the nature of trust as a constructive process in which both actors [service-user and member(s) of the clinical team] contribute. The expectation of placing trust in their clinical team was described as increasing participants' vulnerability in their recovery process by creating a loss of control. Participants reflected that they experienced many clinical teams and psychiatrists along their journey and that placing trust in their team has taken time. In many cases trust was facilitated through the participant having a validating experience with their team in which their wishes were heard and respected:

"I didn't think I was able to cope on my own at all…I didn't have any confidence in myself and my coping skills especially because I didn't trust anyone at the time and it was really difficult, but I learnt to trust the staff as they took me off 1:1 cos I realised that they weren't going to rush things and they were going to take things slowly and they were listening to what I was saying and mm I learnt to trust the staff through coming off 1:1"- Kelly

Once trust became established it appeared that participants felt more confident to have faith in that staff member. Thus, trust also became facilitative of engagement:

"I take her word as gospel. That's what it is. I take her word, and I run with it. I trust her 100%"- Michelle

3.2.2. As a source of de-stabilisation.

The nature of relationships participants were engaged in was often complex and presented a potential for destabilisation of the participant's coping. Some participants reflected on the enduring nature of their interpersonal difficulties and how pervasive these difficulties are:

"I've had very, I have shit relationships with people, but then when I have good relationships with people, I'm very intense, and very in-depth relationships with people. So, they're either shit, or they are very in-depth…There's not really a happy medium, but that's just me"- Michelle

The challenge of maintaining multiple relationships with many members of staff and peers was reflected upon. Within these relationships, participants reflected a demand they felt whereby they were required to be flexible and tolerant. Some participants reflected feeling that they had to regularly adapt to accommodate other

service-users or approaches of new team members, which they experienced as frustrating. In addition, participants reflected upon the challenges of managing distress created by the inpatient environment and the impact of managing other service-users' distress:

> *"and people have to understand that we have to live here so other people's stress is our stress too, cos they display it in such a way that we all have to see it or hear it or deal with it, so it feels like you're not only dealing with your own issues, you're having to put up with everybody else's"*- Amy

Some participants reflected the experience of living with other women who had the potential to cause them harm, resulting in a lack of felt safety.

> *"I think some of the patients, they shouldn't be in here, they should be in low secure…like * name * was going to dash boiling water and sugar over someone she doesn't like here…we feel unsafe"*- Nicola

.

Relationships with staff such as nurses and support staff offered many sources of potential de-stabilisation. The impact of disagreements with staff members was described as having a negative emotional consequence for many participants, with the potential to contribute to setbacks.

> *"it's like I was doing really well at one point and this member of staff that I don't particularly get on with and then we'd had this argument, and she treated me like crap, and I went from feeling like shit to really downhill because I wasn't getting on with this member of staff*- Amy

Participants reflected a felt sense of lack of understanding from staff in relation to their experience in services:

> *"and staff say oh just ignore it… until someone's at your door kicking and screaming you can't ignore it. And I think a lot of the time a lot of the staff don't really put themselves in our shoes"* -Amy

This had the potential to become exacerbated by staff not only showing a lack of understanding of participant experience but creating frustration for some participants through creating reminders of difference between staff and service-user life, and the associated losses of inpatient life:

> *"Some of the staff can be ignorant and rude and say that they are gonna go home and lay on the sofa and put the fire on and have a glass of wine, you know, and I think don't say that in front of us cos we're not going home. I get a bit agitated when they say that"*- Nicola

Participants described being particularly aware of negative attitudes or judgements they felt that staff had towards them, reflecting the potential impact this could have on their mood.

> *"… you can tell the staff that don't see the true potential in you that don't want to help you and those that go out of their way to put barriers and blocks in your way and the ones that judge you. I know that I've done bad things but I'm not a bad person…you can tell by the way staff look at you that…you're the one who deserves to be here and I think I'm not; I'm not…I need help… You shouldn't have judgements like that in the workforce, especially ones like that on a patient. It made me really sad actually…It cut me deep in a way"*- Michelle

In times where they experienced a setback or behaved in a way in which they anticipated a negative response from the team, many reported fearing that they would experience some form of emotional, interpersonal punishment. Within this, there appeared to be a feeling of letting the team down and being punished in terms of rejection from staff and feeling uncared for.

> *"Well if you don't do things yeah then you get put to the bottom of the shelf. It's hard to say things cos shit happens if something happens no one gives a shit and even though they say they do they don't"*- Sammy

Participants often described wishing to remain present in the world which they were physically absent from. Managing the physical absence of relationships, particularly for participants who were placed farther from their hometown or those who had been detained for a longer period, represented significant challenges in their recovery. Some reflected the emotional challenge of the physical distance to their valued relationships in the community while living in secure services:

> *"I feel a bit lost without my family because they live just outside [rural area], so they find it difficult to get here and I miss them a lot so I'm trying to get to move to [closest city] to move closer to my family so… mmm I'm trying"*- Charlie

Some recognised the need to balance their desire to return to the outside world with the need to equip oneself by remaining in the secure world, resulting in a sense of exasperation which ultimately required adjustment from participants through acceptance:

> *"Yeah it's just frustrating like being so far away from home and stuff, I miss my family..but at the end of the day I know that I'm not ready to*

leave here yet and I know that there's still a lot of work to be done"- Kelly

Though physically absent from their external world, participants reflected that their external life impacted significantly on their experiences in secure services and in their recovery. Participants recognised that they had the potential to become distressed by events occurring in their external world and also by memories of their experiences before admission. In this sense, both the internalised experiences from past lives in the community and the occurrence of events in the present time had the potential to de-stabilise participants and contribute to setbacks. Memories and experiences from the external world continued to distress participants as did the occurrence of issues outside of hospital while participants were detained. Many described events on the outside world as a source of de-stabilisation:

"I worry more now cos I worry about me family and things. Yeah, me daughter died last year, she committed suicide"- Katrina

For some participants, the presence and impact of the external world was a positive influence and source of support. Some described the positive external relationships they had maintained which influenced their motivation to recover and re-engage in this world:

"Some days I wake up, and I'm fucking distraught. I wake up, and I call my mum, and I'm like mum, like, what gets me through"- Michelle

Others described that being in secure services offered them protection from their external world and situations which they would no longer wish to be in:

"I want to be as far away from my mates as I can. As much as I love them I just can't; I can't be into the same shit as I was into before"- Michelle

3.2.3. As a secure base.

Participants reflected the positive impact which relationships with staff had on their recovery. Caring relationships had profound effects on many participants. Feeling cared for in times of need was an experience deeply valued by participants, reinforcing beliefs of worthiness. Nicola asked a nurse to support her in the interview and reflected upon the value of this relationship within the interview:

"I was really upset the other week wasn't I [to nurse in the room] and eh….she finished work, but she stayed with me until I stopped crying. She had given up her time to be with me. Not many would do that; I'll tell you that now"-Nicola

Many participants reflected the value of staff members maintaining hope for their recovery in times when they could not envisage it. Feeling consistently cared for as staff held hope sustained participants until they could grasp it for themselves:

"In medium secure, there were 3 staff that, one in particular that always went the extra mile for me. You know, I couldn't fault her, she was just always there. She was the light switch to the light in my tunnel"- Michelle

As relationships with staff developed through the experiences of kindness and care alongside transparent and trustworthy relationships, a sense of safety became established in relationships. This safety enabled participants to explore sensitive topics such as offending, engage in reflection and progress them along their recovery journey.

Safety in relationships appeared to allow participants the space to make mistakes with anticipation of acceptance and support by those whom they felt safe and secure with:

> *"[psychologist] knows everything about me, there's not one thing I wouldn't feel confident saying to [psychologist]. Even the most stupidest thing or the most horrific thing or even the most randomest thing, I tell [name] and yeah we have a really good relationship because I know that there's..I tell her more things than I tell my mum, I tell my mum everything, but I tell [psychologist] the rawest things because if I need help, she's the one I go to because she helps me with even the slightest little thing"*- Michelle

3.3. Stages of recovery

3.3.1. Existing.

Participants described the process of recovery as initiating from a place of non-recovery, where a sense of existing was described, e.g.:

> *"I just want to lay in bed all day and not have to look at 'em [staff and patients]...I'm just existing in this place, we've all got a number"*- Nicola

3.3.1.1. Self-concept.

Participants reflected on the way in which they viewed themselves early in their recovery journey. Receiving their diagnosis had profound impacts on the way in which they viewed themselves. Most participants had received their diagnosis at the point of admission, although Nicola had received hers in her teenage years. Some participants reflected the sense that the diagnosis implied something fundamentally flawed in their being and way of life and struggled to accept the diagnosis as they believed it constituted an attack on their identity:

"…they were like we think you've got a personality disorder and my first thought was like oh there's something wrong with my personality and then like I was gutted. I thought there was something wrong with who I was... I thought I was really messed up, and it messed my head up quite a bit when I first got the diagnosis to be honest thinking there was something wrong with me"- Kelly

Some participants reflected a belief that the diagnosis was a moral diagnosis, imposed upon them due to their behaviours. For participants who had committed an offence, the diagnosis was seen as a direct response to the offence:

"…why are people telling me I've got this disorder when all I did was do something really wrong. You know, my index offence was very wrong but why does it need a label? And even now I struggle to think where this label comes from when all I've done is something wrong"- Amy

The sense of the diagnosis reflecting a flaw in one's inherent morality was also experienced by the one participant who had not committed an offence:

"Like I thought my morals were wrong really"- Kelly

Though not all participants accepted their diagnosis, there was a consensus among them that it did offer some utility in terms of offering a direction for treatment. Thus, participants reflected a view of the diagnosis being used by clinical staff. Amongst this group, some also commented that the diagnosis resulted in all behaviour being reduced to a symptom of the diagnosis. Despite these views, a minority of participants spoke of the normalising impact of receiving a diagnosis and feeling as though they were not alone in their struggle:

"it's a relief, to be diagnosed. It's a relief to know that, you know, I'm not a fucking imbecile, I'm not a freak of nature, I'm not a weirdo. I do fit into this world just in a unique minority of the world with mental health issues"- Michelle

Those who struggled to accept the diagnosis still, however, reported some resonance of the diagnosis affording a sense of closure in the quest for understanding their experiences, offering relief, reassurance and hope:

"I just wanted some clarification, cos I knew there was something wrong with me, well like something not quite right and mm...I just wanted to find out why I was feeling the way I was feeling cos it took like...I'd been under mental health services since I was 11 and I didn't get a diagnosis until I was 17 so…all those years I was stuck, not knowing what was wrong with me, I just felt like I was a lost cause, to be honest"- Kelly

3.3.1.2. Coping.

Participants reflected that in the existing stage they struggled to cope with the intensity of their emotional experience. The experience of difficulty in managing one's own emotional experience represents one of the core challenges of recovery across all stages. However, during the existing stage participants reflected that they had little knowledge, skills or internal resources to enable them to manage the intensity of their emotional experience:

"When I first came into hospital I didn't cope too well. But I didn't know what I was sitting with"- Michelle

Participants described the difficulty in accessing internal resources to regulate emotion, recognising that past strategies were often reliant on external resources such as

self-harm or the use of drugs and/or alcohol. In the early stages, with the absence of internal resources, participants drew upon what was available to them: the use of self-harm and the secure environment. Those who self-harmed reflected that in the existing stage, this was their most accessed source of coping. Participants described self-harming for two functions: to regulate emotions generally or to punish themselves for the painful emotions created due to the impact of their offence:

> *"…because I did something very wrong…I started punishing myself and feeling really guilty and really bad and really horrible and that's how things escalated…there was a stage where I went through blood-letting to die. There's a stage where I went through it just to punish myself, there's a stage where I went through it, and it was to make me feel physically ill, like [the victim] felt"*- Amy

One participant spoke of becoming trapped in a cycle of using self-harm to manage emotions, then feeling guilty for the burden placed on family, resulting in further self-harm to manage these emotions and punish herself:

> *"…it was so terrible, and it was awful for me and my family like what I put my family through. It wasn't fair, and I felt really bad about it. Mmm… but I think like part of it was like punishing myself for what had happened…like I felt like I deserved to be in hospital again and that I deserved to be hurt because of what I put my family through"*- Kelly

Some participants reflected that restricted access to commonly used objects for self-harm (e.g. knives) resulted in participants experimenting with new and harmful methods of self-harm:

> *"I started that last year. I think it was because there wasn't anything else available for me to self-harm with and I panicked, and I ended up*

swallowing a battery to start off with and emm…and then I went onto wires and then last year I ended up really poorly for swallowing a wire"- Kelly

Kelly reflected a sense of powerlessness, resulting in drawing upon self-harm as a strategy to communicate needs and wishes which she either felt unable to verbalise or were unheard:

"When it came to choosing placements I was really like nah I don't want to go there, so I self-harmed and then they would be like why did you self-harm and it's like cos I didn't want to be there and they would listen to me because they would be like oh we won't send you there because we can see you really don't want to go and you don't want to engage with them"- Kelly

Many participants described being the recipient of the safety provisions afforded by the secure environment. While for some participants the secure environment withdrew usual ways of coping and created further challenges, others reflected on the containment afforded by restrictions, staffing measures and medication:

"I haven't got access to sharps and uhh…like if it's thought that I really am a risk they might take stuff out of my room or anything out of my room or…they might increase my observations if like I was spending a long time in bed and if they weren't able to assess how I or I was or that kind of thing"- Katrina

While, for some participants, being in receipt of security measures was a passive process, others reflected that actively externalising control afforded a sense of safety in a time when participants felt they lacked the ability and responsibility to manage alone:

"It provided a safety blanket. So, like, I could put responsibility for my actions on somebody else in a way, that's what I felt like. Whereas now I know I need to be responsible for my own actions, but I felt like I could use it as a way to put responsibility for my actions in someone else's hands and it was just an easier way of coping like. I don't know, I hated it because I hated the restrictions it had on me, but at the same time I kind of liked it"- Kelly

Some acknowledged the safety in being restricted and how this had the potential to keep them within services due to lack of sense of safety in the community:

"at the time it was quite comforting…mm…cos being in hospital can be quite safe, you know what I mean, but it's not like a life…" - Kelly

"I find it very helpful cos… I feel safe now I'm inside but when I go out I feel all anxious and things like that, so you know eh…I just feel safe in the surroundings and people and the nurses and that helping and that and I just don't feel safe when I go out very much"- Charlie

Here, Kelly and Charlie reflected upon the containment provided by the secure environment. Kelly reflected from her current position of approaching discharge, recognising the benefits and limitations of relying upon the secure environment in earlier stages of recovery. On the one hand she describes feeling safe, but at later stages in recovery, came to feel limited by restrictions and sought more autonomy. Charlie too acknowledges the limitations of becoming dependent upon the secure environment. Here, she reflects upon the imbalance of safety experienced in secure services in comparison to the vulnerability described in the community.

3.3.1.3. Readiness.

"I just kind of thought like fuck it, I'll spend the rest of my life in hospital and mmm.. I couldn't see a life for myself outside hospital; I thought I would be in hospital for the rest of my life"- Kelly

Participants described how past experiences of attempting to recover impacted upon their current expectations of recovery. Hopleseeness for recovery negatively impacted upon motivation and engagement. Those participants who transferred from prison described considerable difficulty in adapting to life in secure services and the associated shift in expectations placed upon them. Those who transferred from prison recognised that before admission to secure services; they had not considered the prospect of recovery:

"I wasn't anywhere in my recovery. I was just on a cocktail of drugs. I was in a very dark place... I was just trying to piece myself back together after everything that just happened. I didn't even know what recovery meant. Didn't want to know. Didn't want to hear the word recovery. I was happy in my own little fucking bubble"- Michelle

Participants described a sense of dependence in this stage in terms of external resources from staff and the environment. The sense of feeling ready to be independent was not something which was described in this period. Participants described limited volition in terms of moving towards recovery. Instead, they were were in receipt of restrictions and care which either guided them towards recovery or prevented movement. In this stage, participants reflected that they were not engaged in active recovery processes but were being directed to and encouraged to attend interventions and activities. As a result, many participants described a process of attending groups to comply with demands but not being engaged or seeking much from their attendance. For some, this was seen as a necessary but unwanted step:

"that's what they want me to do then that's what I have to do. I can't stop myself from doing things they want me to do"- Sammy

whereas others reflected on attending group programmes to achieve alternative needs. Thus, it appeared that within the existing stage participants were "going through the motions" with limited desire for any gains from attendance:

"I knew I needed to do DBT again, cos I've done it before, but I didn't take it in. I was too young at the time and to be honest I just saw it as a social group, and I just used to mess about with my friends and eat chocolate. I didn't used to; I wasn't committed at all"- Kelly

In this sense, this stage was characterised by limited volition in the way of engagement. Participants recognised a required cognitive shift towards engagement and recovery, necessary for progression. Amy reflected on this as the difference between listening and hearing, recognising the need to be in the right cognitive space for recovery:

"Cos you could sit here and listen all day and listen, or you can sit here all day and listen and hear the things that you can learn from. It depends where you are in in you know your pathway…10 years ago I wasn't interested"- Amy

One participant described the sense of feeling moved towards recovery prematurely, when she did not feel in the cognitive place to engage with the challenges of recovery:

"Like I trust my team now but when I first came here, and they took me off 1:1 I didn't…I just felt like I didn't trust any of them cos I didn't

think that any of them understood and felt like they were all rushing me and felt battered into doing better than I was ready for" -Kelly

The safety, security and comfort provided by the secure environment were reflected upon as impeding readiness to move towards recovery:

"you know you've got some people who have nobody, so it doesn't make a difference because this is their family this is their home..they're getting fed and all that and it's something. I find that very sad…but..a lot of people just don't want it. They're happy where they are"

3.3.2. Being stuck in the system.

3.3.2.1. Feeling restricted and seeking independence.

In this stage, the restrictions which participants previously described as containing and a positive impact on their felt sense of safety came to be experienced as a source of imposition. Through sufficient containment and the felt sense of capability afforded by containment and restriction, participants described an increasing motivation to move forward in their recovery journey. This was particularly frustrating for participants when restrictions were imposed on a ward- rather than individual-level:

"I can only be as independent as I can be here because of other people's restrictions and that's difficult to work with, very difficult to work with. They talk about like the least restrictive practice – it doesn't work… It shouldn't be a ward based on what other people do."- Amy

In this stage, participants reflected a sense of becoming frustrated with the lack of access they had to restricted belongings and the limited freedom of movement they were subject to. The process of asking for restricted belongings impacted upon participants' sense of autonomy:

"You know I'd like to get up and open the toilet door myself. I'd like to say hey, I'm going for a piss now instead of excuse me, can you open the toilet for me"- Michelle

Loss of freedom and autonomy was described as being reinforced through the policies and procedures of ward life. For some participants, the subordinate role they occupied in terms of having to ask for belongings was at odds with their previous identities and symbolised the further loss of perceived social power. The sense of worth created through this disempowerment had a negative impact upon self-efficacy:

"Sometimes you just feel like everything's taken away from you cos you, you know, you.'re not with your family and you might not have your job or your house, everything's taken away from you and then ..for somebody to tell you that you can't go in the kitchen or you can't, can't just use your deodorant, it's a bit degrading…you know it makes you feel really like worthless and proper like well, am I ever gonna get better cos I can't do this because I can't do that"- Amy

Feeling restricted was described as impacting upon participants' mood and sense of autonomy, creating a sense of feeling stuck and different:

"Well, it makes me feel a bit trapped and a bit…a bit…em…I dunno, just a bit trapped and a bit…abnormal"- Katrina

Participants were motivated towards having their restrictions reduced, which they described as being contingent upon evidencing improved coping and therefore reduced risk, as viewed by their clinical team. They described becoming locked in a conflict with their team on this matter whereby improved coping was considered both necessary for restrictions to be reduced and also a product of restrictions being reduced.

Participants struggled to equate the coping inferred by actions and how this resulted in restrictions:

> *"You know, if I act this way for 3 weeks, it doesn't mean you can't cope with that. You might have cried solid for three weeks, but it doesn't mean that you're incapable of having a television in your room"*- Amy

In this sense, the majority of participants reflected upon views of risk as the clinical team's view of recovery, which was often at odds with their own view of their recovery and own view of the level of risk they posed.

Participants who experienced setbacks often described returning to this stage, as they continued to seek increased autonomy. Staff response to significant events, such as returning to increased levels of restriction and loss of previous privileges defined setbacks for participants. In these instances, participants described moving up security levels following significant incidents:

> *"I got to low secure many many years ago. I went to [ward] over in the main building but I stabbed another patient, and I had to go back to medium-secure…and I was meant to progress here last year, but I severely beat up another patient"-Michelle*

The extent to which participants believed recovery took place in secure services was varied. Many participants believed that they could not fully achieve their recovery goals within the confines of secure services. Instead, participants reflected the social dimension of recovery, which they felt unable to engage with whilst living in a restricted environment.

3.3.2.2. Powerlessness.

Participants reflected a sense of powerlessness within this stage. Many participants described that being restricted by the decisions of the clinical team and the secure environment resulted in them feeling powerless to progress and constraining their sense of control:

> *"I hate it. I like being in control. Not that I like to control people, just that I like to have control in my life. I just like to have control on things cos I've never had control over things...not in this environment you know people control you"*- Michelle

Participants reflected a felt sense of absence from the decisions being made by the clinical teams, further reinforcing feelings of disempowerment:

> *"I just kept going round to ward round; I didn't even know what ward round was. I was just invited into a room every week …I just didn't know what was going on…they were just talking about me, not to me"*- Michelle

The process of ward round was commonly reflected upon as a process in which participants felt particularly limited in their ability to assert control over their progress. Participants reflected that in this stage, they felt as though the process appeared tokenistic, such that the team had often arrived at clinical decisions before they entered the ward round, leaving them little opportunity to present their case for reduced restrictions or increased autonomy:

> *"It's like, and they discuss that before you come in, so they already know what you're asking for and already know what answer they are giving"*- Amy

Powerlessness was described in terms of the subjectivity of clinician opinions. Participants reflected the perceived control clinicians have in determining their future. Participants described not only feeling powerless by the power differential between them and their clinical team, but also a sense of vulnerability in placing trust in different clinicians due to changes within clinical teams:

> *"I find it scary that these people are controlling our lives. It shouldn't depend on what doctor you've got. Your treatment and your recovery should not depend on what doctor you've got "*- Amy

3.3.2.3. Relationships as fragile.

Although participants were experiencing intrapersonal struggles, much of this became concealed, contributing to isolation. Isolation from the clinical team was reinforced through the disempowerment and detachment experienced within ward rounds:

> *"It's like the ward rounds and the MDT, and you come in, and you sit there, and there's loads of people at the table, and I look, and I think out of, there's usually about 7/8, 7 or 8 people and I look round the table and I think you know what out of the 7 or 8 people there's 1 of you that's spoke to me"*- Amy

This concealment was also present in the relationships participants described with other service-users whom they viewed as a potential source of conflict. Participants were focused on wishing to progress closer to discharge or further in their recovery, and many described distancing themselves from peers due to this interpersonal vulnerability. I have considered this to be reflective of a lack of confidence in coping skills, perpetuated by lack of opportunity to gain confidence due to restrictions.

The majority of participants did, however, reflect that the need for restriction was a necessary component of their recovery. These participants reflected the need for recovery to take place slowly. It also required a sense of trust in their clinical team that the level of restriction was, in essence, for their benefit given the challenges they faced

in coping during this stage. However, at this point in recovery, participants described an absence of faith in clinical teams, reinforced by feeling disempowered and detached from clinical decision-making, resulting in increased frustration and a sense of stagnation.

3.3.3. Turning point.

The role of risk and restrictions occupied much of the discourse about how participants measure their recovery. For some participants, recovery was measured in terms of the teams' view of a reduction in the level of risk participants posed to others. Often, participants described holding their own views of their risk, typically lower than their clinical teams, and waiting for external validation of this by the team, evidenced through reduced restrictions. By having restrictions reduced, Michelle suggested that this implied an external indicator that she was more able to regulate her emotions and less likely to cause harm to members of the public:

> *"Well, that means I'm more stable in my mental health and my recovery. It means that my risk level has come down and that I'm not as violent and I'm not as risky towards the public and that my risk isn't as out there to the public as it was before, so it means that I'm more, less volatile and more friendly and approachable to the public"*- Michelle

Gaining access to leave or transitioning to services or wards with lower levels of security represented significant indicators of recovery to participants. In contrast to necessarily indicating recovery, many participants spoke about being granted reduced restrictions or leave as an incentive for attending or engaging in suggested programmes. Participants often came to measure recovery through the reduction of restrictions, which appeared contingent upon attendance or engagement in prescribed activity. Thus, attending prescribed treatments could facilitate reduced restrictions without the participants necessarily feeling a personal change towards recovery. Although, as many participants described, reduced restrictions also allowed opportunities for skills to develop, thus, facilitating their recovery.

3.3.3.1. Deciding.

All participants described making a decision to move towards recovery. For some participants, being supported towards connecting with recovery goals provided a source of motivation to engage in this process:

> *"at one point, I just thought I'll stay here forever, I don't need to ..I don't need to leave hospital, it's safe here, I'm looked after, I'm fed, I'm warm and.. I never thought I could do it but when I came here we started to do a lot of goal work and I looked at like what I wanted to get from my life"*- Kelly

Some participants recognised that there were always many pros and cons of working towards recovery and at times the cons maintained the status quo. Kelly described the shift which took place whereby she came to consider her cons as no longer productive in enabling her recovery:

> *"I think wilfulness, like you, don't want to do it cos you're not arsed, or you're never going to get better or cos I don't know, cos, you feel safer in hospital or whatever, there's always reasons behind it, but none are productive ones"*- Kelly

For some participants, the work required to recover conflicted with what had been expected of them in prison, reflecting that the recovery process is a far more demanding and uncertain process than detention in prison. Michelle described the many setbacks which could be experienced throughout the mental health system:

> *"In jail...so like you go to court, you go to jail, you sit in a cell, and you get released. You go to jail, you go to hospital, you go to admissions, you go from admissions to medium, you go from medium to low, you go from low, you go to locked, you go from locked you go to, I don't know*

a halfway house. You go from a halfway house you go to a flat, you go from a flat you go to another place you go from there, you maybe come off your section, and you go to another flat, and there's so many stepping stones, and then on each one of them stepping stones, there's a little ripple that gets in the way that maybe takes you back a step- Michelle

Many participants reflected upon developing an increased sense of responsibility for their own recovery, facilitating them towards engagement:

"I was my own worst enemy... I suppose if you asked anyone on this ward, who stops you from getting well, well you can't say the police, my mum, my dad; you stop yourself from recovering. It's your choice"- Michelle

Participants reflected upon the responsibility placed upon them in maintaining progress towards their recovery. While in previous stages participants reflected upon feeling disempowered by ward round processes, here participants described a sense of autonomy over the process by demonstrating behaviour and coping which their team would deem acceptable. Thus, the ability to negotiate with the process of ward round appears to shift participants towards empowerment:

"I suppose what I mean my role is what happens in between those three weeks. You know do I still to the agreement, do I go off the wall, do I go on leave once a week for two weeks like they said I can and get it right or do I get it wrong or mess it up on purpose or.. you know my role is what happens in those three weeks"- Amy

Other participants reflected decision-making as making a conscious choice to comply with the service and various processes to progress towards discharge. Many of

those participants who did wish to engage in a recovery process acknowledged that compliance was a necessary compromise they had to make to facilitate them towards discharge and recovery.

3.3.3.2. Positive risks.

Participants reflected that the process of being stuck shifted when teams afforded increased autonomy to them. The nature of positive risk-taking was something which was reflected upon by many participants. Participants did not appear sure what motivated teams to reduce restrictions and agree to take positive risks. Some reflected that this was a lottery whereby some clinicians tended to afford positive risks to participants whereas others were more risk averse which, as described, had the potential to progress or impede progress:

> *"but different doctors work differently because the doctor I had before the one I've got now was very much, we won't give it to you in case you get it wrong whereas the doctor I've got now is like we will give it to you, but if you get it wrong we will deal with it. So that has a big impact"*- Amy

Participants reflected that the approach of the psychiatrist was of key importance in this stage. Many acknowledged the benefit of having a psychiatrist who was willing to "work with" them. This often implied affording positive risks but also working with participants through openness and transparency:

> *"[Psychiatrist] Is willing to take positive risks. She's also willing to see negatives, to see the positives and negative consequences. And she's just willing, she's willing, she's willing to work with you"*- Michelle

3.3.3.3. Acceptance and compliance.

Participants reflected on being involved in a struggle for control in the earlier stage of being stuck in the system. One of the key processes involved in becoming un-stuck was a disengagement from this struggle. This appeared to occur either through acceptance or compliance. Some participants described coming to terms with the forensic mental health system and the sense of disempowerment it imposes:

> *"I think it's a bit annoying how they rule how long you're going to be here, and they rule like what treatment you do, and it feels like you've got not much control over anything, mm you just have to sort of accept it and sort of carry on getting better"*- Kelly

Rather than accepting the process and continuing to work towards recovery, other participants spoke in terms of compliance. Complying with the clinical team, in the expert position they occupy, was reflected upon as feeling necessary but wrong for Sammy:

> *"And if you tell them that you don't want to take it [medication], that it's not the right medication for you then it's like why isn't it? Why? You kind of know bits but in the end, the doctor is the doctor, and you've got to just fucking agree with them…in the end. And I think that's wrong as well"*- Sammy

Acceptance was often described as occurring with some resignation. In this sense, acceptance was described by many as a requirement, though not necessarily in line with the wishes or beliefs of the participant. This was reflected by Charlie as she spoke about her diagnosis:

> *"I just have to accept it cos I don't know how long I'm gonna be labelled with it for do I"*- Charlie

While some participants spoke of acceptance in the context of enabling them to move forward for recovery, other participants reflected that the struggle for control had afforded them little success and described how relinquishing the struggle allowed them to disengage emotionally and instead, "play the game". This was described in terms of compliance often to achieve the primary objective for these participants- discharge rather than recovery. A degree of compliance was reflected by all participants, even those motivated towards recovery:

> *"You have to play the game…and I don't mean play the game where you just tick a box because I genuinely do like DBT, but out there [indicating the ward], out there is one big game"- Michelle*

Some spoke of this in terms of delineating own recovery goals from the recovery goals of the team. Within this, participants spoke about stepping back and allowing the team to continue to use the diagnosis as a tool for planning and directing treatment, while the participant directed themselves towards their own objectives, which at times were different:

> *"Yeah well you can't like cos I'm on a section, you don't get too much say in what happens, you sort of have to go along with it and hope for the best"*- Kelly

When reflecting on their diagnosis, participants reflected that they did not believe that they would ever be free of their personality disorder. Participants clearly explained that this did not mean they would not recover. Instead, a view was reflected of recovery which takes took place in spite of their diagnosis:

"I think… a PD is something that stays with you forever, but it doesn't mean you can't recover from it, you can still get better, and you can still learn to live everyday life and cope with everyday life"- Kelly

Many acknowledged that their definition of recovery was personally held and somewhat detached from the idea of recovery the clinical team appeared to work towards. Some reflected that they were unsure of what the team expected when they said 'recovery'. For some participants, recovery was not a personal or clinical concept that they could engage with. In this sense, many participants spoke about detaching themselves from the diagnosis and working towards their own view of their difficulties:

"I've had this label for like 10 years. I've not really, I've not really thought about it too much. I've kind of thought about what I'm going through rather than what is a personality disorder and where do I fit into that. I'm just working round what my problems are and how I deal with that, and that's more important to me than finding out what a personality disorder is and seeing if I fit …I see where I'm at as my problem"- Amy

3.3.3.4. Relationships as a resource.

Participants described the length of time taken to trust various professionals and that opportunities to build and develop trust provided faith for participants in others:

"I've gotten a lot of nurture from many members of staff. I suppose I look at [psychiatrist] like that. You know, we have our arguments, she takes a lot of shit off me. I take a lot of shit off her. Only the other day, she was talking, I was crying…but then we have that rapport where we can do that. I've known [psychiatrist] for 5 years; you know you don't just let someone in. Five years, five fucking years"- Michelle

Positive experiences with staff members appeared to increase motivation toward recovery. This was most pertinent in times when participants expressed wishes or needs which staff members responded to. This was not simply a case of having needs met through having requests granted by staff. Instead, being denied requests but having the decision-making explained constituted a positive experience in which participants described feeling valued. Being afforded choice and being treated respectfully enabled participants to move from perceived subordinate roles and enact a sense of agency towards recovery:

> *"You know [psychiatrist] has never told me you will go on this medication, you will go on this, she has always said to me, spoken with me and she's never done what the other doctors have done; sat me down and told me what I have to go on like I was a guinea pig. You know she always had that respect for me and made me feel like a human being, not a human doing and yeah she's always shared my diagnosis and been open and honest with me"*- Michelle

In this stage, the behaviours and intentions of staff which may have been present throughout come to be recognised and valued by participants. Within this stage, participants described the impact of staff who demonstrated compassionate qualities, in addition to going the extra mile, which enabled participants to feel cared for:

> *"She was just, she was just so brutally honest, yet so compassionate, you could just tell that she just cared so much"*- Michelle

The value placed on these relationships for participants contributed to the development of true connection with staff members. One participant reflected upon the challenge in maintaining the boundary. The relationships described with certain staff members were considered fundamental in moving towards change:

"I class her as a friend. I shouldn't class staff as friends, but if I could have friends, them two would be my friends. And you know when you wake up one day, and you have an epiphany, and you think you know what people care, I'm going to change. They were the reasons why I changed"- Michelle

3.3.4. Actively engaging.

Definitions of recovery were varied, but a prominent theme as participants became engaged in their recovery was the desire to live a "normal" life. Participants described a belief that their personality disorder would be an enduring part of their lives, but that successful management of the difficulties associated with their diagnosis represented a more tangible objective for recovery than a form of 'symptom eradication'. Recovery, therefore, contained the constructs of coping and self-management:

"I think I'll always have it [BPD], but I think the nature and the degree of it will be a lot less. So, the way that I feel, like my feelings will still be there, but they will be easier to cope with.,."- Kelly

Participants who used self-harm described a reduction in self-harm as an indicator of recovery, reflecting increased ability to manage emotions without this resource. Achieving this was described as impacting positively on self-confidence for Kelly:

"it's been a couple of months since I've kind of [self-harmed] and em.. I feel a lot better for it, like a weight has been taken off my shoulders and that I am coping better and feeling more confident in myself, so I do feel better for stopping. Long may it continue"-Kelly

As described, recovery was measured for many participants in terms of coping with and tolerating difficult emotions. Ability to move from avoidance of difficult

emotions and past experiences towards accepting and compassionately managing such emotions was described by Michelle as indicative of recovery:

> *"I talk about things…. I remember things from my adolescent years, and I can talk you through anger, and it doesn't bother me. I might cry but that's an emotion, that's a feeling that's warranted. I don't block things out anymore"- Michelle*

Through the processes described above, many participants recognised that they were facilitated towards engaging in processes which progressed them along their personal recovery pathway. Some participants, however, reflected they did not wish to engage with treatments offered for any form of personal development or change in behaviour. Instead, they wished to continue to attend programmes to be discharged. One participant expressed this and explained that she was not motivated to do anything other than "play the game". In terms of the model, this participant may still be considered as being within the early stages as she sought increasing independence but was not motivated to engage in personal change. The journey for this participant would not be explained through the remaining processes.

Through the changes and processes within this turning stage, participants reported feeling safe and supported in their relationships with a reasonable degree of self-efficacy to progress towards a stage of engagement.

3.3.4.1. Learning.

Many participants reflected on the learning process which occurred as they worked towards their recovery. Many remarked that learning occupied the most central role in recovery. Although learning was ongoing for many participants, this period reflected a process of intentional learning through engagement, with a shift towards increased personal responsibility for recovery. Many learning experiences occurred in the relationship between participant and psychologist:

"I really struggle sitting with shame, guilt, acknowledgement. But my, my…my therapist makes me sit with a lot of these. It's hard because I've never sat with them before. And I feel a lot of guilt for things that have happened in my life; I feel a lot of shame for things that have happened in my life"- Michelle

Through experiencing supportive relationships, many participants reflected the ability to move on from old coping behaviours:

"since being in hospital I've learnt different ways of doing things so instead of indirectly going around the houses asking help in a not a great way, I've learned that I can talk about things and discuss things with people and be open and honest about what I'm thinking and feeling works a lot better for me now than bottling things up or going and getting drunk or going to hospital or something"- Amy

Every participant mentioned psychological therapy as something which facilitated their learning in some way. Many participants reflected that learning took place in terms of increased understanding of themselves, their behaviour and exploring and understanding their offence. In many cases, this involved coming to terms with past experiences:

"I've suffered quite a lot, and mm..very traumatic things happened in my life that I never dealt with historically, but I'm dealing with them now"- Michelle

DBT was described by participants in positive and powerful terms, offering profound insights, experiences and learning for participants:

"DBT, things just started clicking into place when I did that. DBT made me see how easy it was or is to just be open and honest with the right people and how easy it is to actually put things to one side and say no you are worth something…you know that, I think that was a big turning point"- Amy

Participants reflected upon the skills which they developed within this stage of engagement. Many identified DBT as the main influential factor contributing to the development of emotional awareness and management through the development of coping skills. Michelle described the sense of putting knowledge into practice:

"when I feel shame and embarrassment and guilt and that lot it brings the emotions on….that's where you have to use your skills and each skill interlinks with one of the other skills from each group, so you have to be fully prepared to use each and every skill"- Michelle

Many participants reflected on the learning which they had engaged in throughout their time in services and noted the value of this. For many, the sense of hindsight became apparent:

"…round about the time when I had kids so about 18/19..and if I'd learnt then to do what I do now, you know, I wouldn't have spent all this time, you know, a third of my life locked away… because I didn't know how to do it"- Amy

3.3.4.2. Flexible coping.

Participants reflected that through learning, they increased their ability to tolerate the difficult emotions which depleted their coping resources in earlier stages. Participants described a shift in their ability to cope which became largely internally regulated. Managing difficult emotions and challenging interpersonal situations independently

became an indicator of recovery. Asking for support represented a new skill for many participants who, in earlier stages, felt blocked by caution and lack of trust with the team to seek support:

> *"I've learned to get help sooner, so I don't get myself in situations like that again"*- Amy

Many spoke about the need for flexibility whereby in times of crisis, they felt supported to be able to ask for help from the team or utilise medication as an external resource to support coping. A decreased reliance on staff represented a significant change. Rather than feeling restricted by external measures, here, participants drew upon more helpful resources than those which they drew upon in earlier stages (e.g. self-harming) representing a shift in learning, coping and skills:

> *"My meds give me a happy medium, but I shouldn't have to take meds to find a happy medium I should be able to do it naturally, but I can't so at the minute it's medication"*- Michelle

3.3.4.3. Constructing and re-constructing identity.

Participants reflected a shift in their self-concept, occurring through multiple contexts. A significant shift for many participants was in relation to their concept of self-worth. Increasing self-worth appeared to be an evolving process for participants who reflected on the journey from worthlessness to feeling worthy. This was often mediated by staff members who reinforced worth and communicated positive reflections towards participants. The development of self-worth and processes of learning were interdependent such that self-worth increased motivation for learning and learning also increased self-worth.

Acceptance in terms of past behaviour was described not only in terms of offending but in the context of self-harming too. Kelly, who had no offence history,

described the shift in her identity, whereby acceptance of difficulties and past coping behaviours facilitated her sense of worthiness for life without struggling:

> *"I think it goes away when you start feeling better about yourself, so when you stop self-harming, and you learn that there are better ways to cope and that your life is worth more than self-harming…I think when you learn that, you learn that you don't need to punish yourself for, for your illness cos you like, what's happened has happened, and you can't change it you just have to move on from it and make the future better"* - Kelly

Some participants reflected that when looking back at themselves before admission, they now recognised aspects of themselves they no longer wished to engage with. For some participants, the identification of old behaviours or ways of coping was motivating while for others it was a source of shame.

Many participants reflected that they recognised that they were the same person as when they were admitted but acknowledged that they had changed in many profound ways:

> *"Cos I'm still the person I was, I just do things differently, but I'm still the same person, I just deal with things a lot better, and that's what I've learned through being at hospital"*- Amy

Other participants described feeling that through the change they experienced, the identity they constructed through their time in services was entirely new:

> *"Only cos I can look back and see myself then as a different person to what I am now"- Michelle*

3.3.5. Transitioning to discharge.

Many participants spoke of recovery in terms of living a 'normal life', with many recognising that their goals for recovery reflected commonly held aspirations such as having a job, having a flat, partner or pet:

> *"Just seeing myself doing what everybody else is doing. You know you get up, go to work or..if you've not quite got a job yet you know you get up, chilling out, doing the washing the ironing, you know..normal things without freaking out…If I can get up every day and be happy and go to bed happy then I'd be doing something right"*-Amy

Michelle described her goals or recovery and considered at what point in her recovery she would achieve these milestones:

> *" So, at 50% I'd be discharged, settling into my own flat, prowling the gay clubs, now and then, looking for, *inaudible*, 75% would be, would have found a partner, would have found a buggy, found a little cot and then 90% would be the full shebang"*- Michelle

Katrina had experienced many admissions and spent much of her life in secure services. The function of time spent in services was described as limiting her sense of ability to cope in the outside world, such that for her, personal recovery may take place in secure services alone:

> *"recovery for me might now be…after all these years…it might not actually be…um being discharged into the community fully… I'm not really thinking that as goals of my recovery. I'm thinking of my recovery as more of at the moment moving on from here to somewhere like a low…like a locked rehab. So that's where recovery will start as opposed to like living in the community. It's been so many years you*

know in a hospital environment… in a way because being in hospital so long I never really thought it would get this far so even the initial step, although it might be small…to me its recovery"- Katrina

3.3.5.1. Ambivalence.

Participants described the idea of leaving secure care as one which provided many opportunities but also many challenges. For these participants, there was a recognition that the community presented them with many challenges which they had been protected from in secure services, including access to substances and the reality of managing finances and employment:

"I've never lived on my own, you know, I've lived with my mum or my aunty or my sister… So, I think to go out and live on my own, to pay bills, it's going to be a big challenge to me"- Michelle

One participant who had previously been discharged and re-admitted to secure services reflected the challenges of adjusting to changes in the community. Charlie reflected the sense of vulnerability present in the community where people are not aware of her difficulties in comparison to the inpatient experience.

"if you go out of hospital and into society, and things like that people don't realise what's wrong with you and …you could start getting very very inpatient, and things like that and people don't know you're not very well, so you know having a label, you don't have it on your forehead and people don't understand"- Charlie

Although participants often spoke about feelings of isolation in their secure experiences with peers, there was a sense of fear of further isolation upon discharge. Many participants recognised that the transition from living with many people to living alone was a worrying issue:

"to be on your own living with a PD could be quite difficult but if you've got help and people helping you and things like that, with your day to day living. I think that would be helpful"- Charlie

Some participants reflected upon setbacks which were experienced due to feeling unprepared when having restrictions reduced or being discharged without feeling prepared. One participant described previously being discharged before feeling ready, resulting in feeling overwhelmed and unsupported in the community. This led to later re-admission and was conceptualised as a significant setback in recovery:

"I was released into a hostel which wasn't the ideal thing for me to be doing kind of thing cos it was like one day I was here with lots of restrictions on sharps and that and then the next day I was in a hospital- eh..in a hostel with access to knives and you could just go out when you wanted to so it wasn't really suitable"- Katrina

3.3.5.2. Moving forward.

Participants reflected that moving forward occurred at points where they felt better able to manage their symptoms and had a good degree of self-efficacy to manage transitions. Participants described that the development of newly established coping skills could be challenged by the availability of old coping strategies in the community such as alcohol or substances:

"Well, I think you will always be recovering from being with alcohol, it's not a recovery with alcohol… It's gonna be in supermarkets, shops, it will be wherever you go so you know it's not a thing that...you know it's gonna be hard you know to be fully recovered"- Charlie

Some participants acknowledged a paradox between the level of access they currently had on the ward and the level of independence they would have in the community. In this sense there were aspects of community experience which could not be translated into the inpatient experience:

"*…it gets really frustrating, and it gets really hard, and it's like I'm independent enough to be discharged in two weeks- time but little things like I can't do my washing when I want and I have to ask for cutlery to eat my dinner, and I've got to this, I've got to do that, but it's like I'm this close to discharge, why have I got to eat my dinner with a rubber spork*"- *Amy*

Having been supported in secure services by many people, participants described some anxieties about how they may adjust to managing independently. Many reflected the desire to have further support in the community to enable them to manage. Participants spoke about wishing to involve loved ones in their care and to have professional input after the discharge:

> *"My partner will know my triggers and my early warning signs…cos I'll be able to sit down and explain to them everything. And I'll be able to have an honest and open conversation and say you know what babe when I get like this, and I get like this you need to look out for this, this and this"* – Michelle

The women considered their life in the community and how they would continue to be managed and supported. Many described the use of diagnosis at this point as a label which hung over them, allowing professionals to reduce them to this label to be managed and directed in the future should this be necessary:

> *"but if something is slightly different ..then they are not going to look at that straight away…instead of saying well she had a personality*

disorder, but the behaviour she's displaying now is nothing to do with that..it's this.I think it's just like a bit of a cop out..bit of a oh it's cos she's got a PD, so they don't go exploring what this new problem might be. Put a label on it, give 'em the meds, put 'em in hospital or not…and we will say that's what it is"- Amy

For some participants, discharge reflected the point at which recovery could begin, reflecting the limitations of the secure environment in attaining their definitions of recovery. This was common among those participants who did not choose to engage in recovery processes in services and instead described patterns of attendance, compliance and withdrawal.

3.3.5.3. Coping as fragile.

Participants recognised that discharge from services did not constitute an endpoint in recovery:

"discharge doesn't mean like you're better and that's it forever"- Amy

Instead, participants reflected that coping would be an ongoing issue requiring constant work and attention. When considering how they may cope in the future, participants acknowledged the potential for old coping resources such as self-harm to re-occur:

"with me, there's always going to be an issue of self-harm you know I haven't done it for a long time, but it was a big part of my life"- Amy

Participants recognised that their ability to cope felt fragile. Many reflected a degree of fear in relation to the potential for future events to de-stabilise them. In this sense the element of coping was a challenge which was viewed as a constant struggle, giving rise to minimal likelihood of becoming "recovered":

"…if I'm having trouble getting a job and because I'm having trouble getting a job I can't pay my bills then I'll get really stressed out then it's a possibility that I will revert back to self-harm, not sleeping properly, maybe drinking cos of being back in the community that's something I can do"- Amy

"Everything is going to be a risk for me. Walking to the shop is going to be a risk"- Michelle

4. Extended Discussion

4.1. Attachment

4.1.1Attachment as empowering.

The role of relationships was reflected on by participants as contributing to key changes in identity, motivation and experiences and expectations of interpersonal relationships. Recovery appeared both facilitated and characterised by a change in the nature of relationships. Drawing from attachment theory, the process of recovery may be mapped onto to the concept of attachment security, whereby participants appeared to move from insecure attachments, manifested through relationships with staff, towards relationships characterised by greater attachment security (Mikulincer & Shaver, 2007). Changes in attachment orientation over time have been found in studies of psychotherapy outcomes. Such findings have been reported in studies of participants receiving TFP for BPD (Diamond, Stovall-McClough, Clarkin, & Levy, 2003), inpatient treatments for post-traumatic stress disorder (Muller & Rosenkranz, 2009) and inpatients receiving psychodynamically orientated psychotherapy (Fonagy et al., 1996). Evidence identifies that many therapist-client dyads who finish therapy meeting the definitional criteria for an attachment bond do not commence therapy from this position, drawing attention to the role of time in developing attachments.

In the ‘existing’ and ‘being stuck in the system’ stages, participants described relationships characterised by caution and mistrust, resulting in strategies of interpersonal withdrawal for self-preservation. Here, participants anticipated that staff would either not be able to tolerate or would respond punitively to their true feelings. Such mistrust of the ability of others to respond appropriately in a time of need is common among individuals with insecure attachment styles (Mikulincer & Shaver, 2007). In the absence of a secure base, participants did not appear to explore new ways of being, instead existing within a ‘fight, flight, freeze’ orientation whereby they adhered to old strategies for coping. They described drawing upon the secure environment either passively or actively, as a source of containment.

Cassidy and Kobak (1988) distinguish between hyperactivating and hypo-activating attachment strategies which insecurely attached individuals draw upon to cope with threats, frustrations or losses. It is likely that the women who participated in the study, through their own experiences had come to anticipate rejection or disregard from others, based on internal working models they have developed. Hypo-activating strategies minimise the needs of the attachment system, avoiding proximity and interdependence and denying vulnerabilities as a strategy for self-preservation based upon the expectation of rejection or being let down. Participants described engaging in similar behaviours in early stages of recovery whereby they did not communicate their needs due to fears of being punished, or through an expectation that they would not be heard. Conversely, some participants also drew upon hyperactivating strategies in earlier stages. The goal of hyperactivating strategies is to elicit care and protection (Cassidy et al., 1988). In this sense, some spoke about eliciting care through self-harm. Participants often reflected that the lack of trust they had with their clinical team meant that they could not express their wishes or communicate their needs for support, thus maintaining their emotional difficulties and IWM’s of others. Thus, participants appeared to describe a sense of relational disempowerment whereby the sense of insecurity they held within relationships disempowered them from progressing towards recovery.

The disempowerment described in this study appeared influenced by two factors: contextual disempowerment (described in the ‘being stuck in the system’ stage), and relational disempowerment. Becoming empowered is one of the core components of recovery (Leamy et al., 2011) but is also recognised as one of the challenges of

recovery within the secure environment (Dorkins & Adshead, 2011). Previous research into recovery in secure services describes disempowerment in terms of limited choice for forensic service-users and the impact of paternalist services on personal agency (Roberts, Dorkins, Wooldridge, & Hewis, 2008). Other studies outline the challenges of empowerment among individuals who are motivated by antisocial and violent behaviour (Dorkins & Adshead, 2011). Constraining empowerment is often considered a consequence of prioritising risk management and managing staff anxieties about risk (Baker, 2012). However, management of risk in secure services does not have to be mutually opposed to the empowerment and agency principles of recovery (Drennan et al., 2014). It appeared that risk was a concept held and managed by staff, with little reflection by participants of recovery as associated with risk. Rather, participants spoke of recovering from their past risk and the impact of their actions. In this study, contextual disempowerment became minimised through developing trust with staff, acceptance of the secure system and a shift towards positive risk-taking.

Despite the recognition of the potential for disempowerment in secure services, there has been little consideration of how disempowerment in recovery can occur within a relational context. Women in this study reflected that disempowerment manifested in their expectations within relationships in which there was an anticipation of rejection or ill-treatment. Due to their internal representations of relationships, participants described a sense of being disabled from placing trust in staff, engaging in transparent dialogue and feeling secure in therapeutic alliances to re-visit offending and past traumas, all later reflected upon as facilitating recovery. The term 'chronic disempowerment' (Chu, 2011) has been used to describe the challenges which individuals who have experienced complex trauma such as extensive childhood abuse face in their abilities to assert control and autonomy in relationships. This finding appears to extend beyond the concept of safety and the role of relationships as described in previous forensic recovery studies (e.g. Shepherd et al., 2016), though the studies reviewed by Shepherd and colleagues contained little representation of service-users diagnosed with BPD. Similar themes are, however, described in the literature relating to recovery among individuals diagnosed with a personality disorder (Gillard et al., 2015). Thus, for service-users who become diagnosed with BPD, the nature of relational disempowerment presents a challenge to their ability to progress beyond 'stuckness' and

move towards recovery due to the necessity of secure relationships for progression towards recovery.

Bowlby (1988) posited that in spite of inadequate early attachment experiences, subsequent positive experiences could alter a person's sense of attachment security. The role of subsequent key attachment figures, such as partners, has been shown to have long-term influences on attachment security and mental health (Shaver & Mikulincer, 2008). Bowlby identified the possibility of context-specific attachment figures (Bowlby, 1982), which in this case may represent staff in secure services. By acting as a secure base, staff members have the opportunity to demonstrate attunement, support affective processing and facilitate self-exploration with the client (Holmes, 2004). The development of a secure base enables the exploration of painful emotional experiences and recognition of maladaptive defences is recognised as a pre-condition for the therapeutic process (Bowlby, 1988). Indeed, for some staff, the use of self was recognised as the most significant intervention when working with forensic service-users (Niebieszczanski et al., 2016).

In the 'turning point' and 'actively engaging' stages, security in relationships enabled interpersonal learning and facilitated engagement in therapeutic interventions. Thus, as participants moved closer towards relationship security, this, in turn, empowered them towards recovery as the conditions necessary for self-reflection, self-discovery and completing offence-focused work evolved. The principles of DBT aim to develop the skills which are considered lacking in interpersonal relationships (Linehan, 1993). While becoming empowered through relationships, participants additionally benefitted through the learning afforded by DBT. It is recognised that many interventions for women with offending histories aim to address the interpersonal context through enhancing self-esteem, improving assertiveness and intersubjectivity (Salisbury, Van Voorhis, & Spiropoulos, 2009). Thus, empowerment through attachment enabled participants to engage in learning processes which provided further opportunities for empowerment through increased self-awareness and skills acquisition, enabling responsibility, agency and self-management.

4.1.2. Attachment and connectedness.

In addition to staff being experienced as a secure base by participants, the way in which secure services were described was also indicative of the service and environment becoming a secure base. Previous studies have outlined the secure qualities of mental health services (Goodwin et al., 2003). Participants in this study reflected a recovery process in which the contexts of attachments shifted, with increasing emphasis placed upon attachments within inpatient relationships and increasing detachment from community relationships over time. A number of factors may contribute to this.

Firstly, participants in secure services are often placed in services far from their hometown, making access to family through visitation increasingly difficult. This may be exacerbated for women for whom there is a lower provision of forensic mental health care services, often resulting in being placed out of area (Harty, Somers, & Bartlett, 2012). This was reflected by three participants in this study, who felt that their inpatient stay created physical distance from their families. Secondly, this created prolonged and enforced separation from their communities. Participants in this study spoke about attempting to balance both the secure and community world which, over time, increased in its challenges. As two participants reflected, visits became less frequent as the length of stay increased. Thus, the experience of the secure environment itself presented a barrier to connectedness. Similar findings have been reported in other studies of forensic recovery (e.g. Barsky & West, 2007). In addition, participants reflected a sense of blame for this separation; that discharge was contingent upon recovery, which was a lengthy process. Insights into the frustration of the length of time working towards recovery and setbacks, particularly, appeared to result in participants feeling a sense responsibility and powerlessness for their current disconnectedness.

Connectedness is identified as a key component of recovery (Leamy et al., 2011). Relationships with staff as a form of connectedness is a commonly reported theme among forensic service-users (e.g. Nijdam-Jones, Livingston, Verdun-Jones, & Brink, 2015), however, for participants in the current study connectedness with staff in the secure world appeared to occur at the expense of connectedness with the community world. The women described alternative views of their community relationships; the challenge in maintaining connectedness with desired relationships, and the desire to distance the self from damaging relationships. It is recognised that recovery contains within it the concept of social recovery (Tew et al., 2011). In this review, Tew and

colleagues outlined the need to develop new personal relationships, recognising the common occurrence of social isolation for individuals with mental health difficulties (MacDonald, Shildrick, Webster, & Simpson, 2005). The absence of opportunities in the transition toward discharge thus renders participants increasingly vulnerable as they lose their current connections.

Participants reflected the challenges they faced at the point of discharge as they became confronted with the loss of established supportive relationships and concern over their ability to re-integrate into their communities. This may be conceptualised as attachment-related anxiety occurring at the prospect of separation and loss (Adshead, 2002). The recovery framework assumes that individuals wish to be valued members of society and will be received in such a way. However, for individuals who have often spent much of their lives in secure services, re-engagement with society may not only not be realistic or desirable but may represent distinct threats to the individual. Participants in the present study described a distinct fear at the prospect of social isolation, resulting in increased anxiety as they approached discharge. The attachment-anxiety which arises can often result in setbacks for service-users and is often conceptualised as a form of self-sabotage. Managing the loss of relationships not only creates a challenge upon discharge (Coffey, 2012) but also a challenge for connectedness within recovery as participants re-enter communities which they have become disconnected from over time. The challenge of feeling accepted by the community for forensic service-users has been found in previous studies (Clarke et al., 2016), however, engaging in vocational opportunities and having community day leave can help in overcoming these barriers (McQueen & Turner, 2012). Participants in the present study frequently spoke of wishing to return to employment or voluntary roles. For forensic service-users, additional challenges such as obtaining pro-social and affirmative employment remains a challenge post-discharge (Drennan & Wooldridge, 2014) and participants in this study recognised the challenges they may face in obtaining their goal of employment due to their forensic histories. Thus, throughout recovery participants become increasingly connected to their immediate relationships, rendering discharge a point of relational uncertainty with an increased likelihood for disconnectedness. It may be anticipated that this may create challenges in participants' ongoing recovery. However, there is little research to demonstrate how forensic service-users continue to recover post-discharge.

4.2.1. Identity

Recovery involved the process of constructing or reconstructing identity. The concept of identity, as viewed within the constructionist paradigm, is not one of personality variables and no single or stable position. Instead, identity is the emerging and ongoing process whereby the human experience is embedded within the social world and in the context of relationships. Most participants described the development of identity as having its roots within the relationships provided by the social context of the secure environment.

Establishing a positive identity is central to the principles of personal recovery (Leamy et al., 2011). Drennan and Alred (2012) outline the unique recovery task of 'offender recovery', in the context of making sense of and discussing past offending behaviour. The term 'secure recovery' has been applied to the process of recovery for forensic service-users as they work towards the reality of risk reduction in combination with the features of personal recovery (Drennan & Alred, 2012). Participants in the present study described a shift in identity as they moved from totalised descriptions of the self as "bad" due to their offence to more reconciled and balanced identities. Previous research has described the sense of feeling blamed and criticised, which service-users with a BPD diagnosis describe in their relationships with staff (Aviram, Brodsky, & Stanley, 2006; Lohman, Whiteman, Yeomans, Cherico, & Christ, 2017). For some participants in this study, the view of the self as bad was reinforced by staff who were experienced as judgemental and punitive.

Constructing a positive identity was an additional challenge for participants who had transferred from prison. The process of social role organisation refers to the process of responding to the way in which you are organised and therefore treated in society. Two prevailing narratives exist around individuals who commit offences: the nature of madness and the nature of badness (Greig, 2002). For women who were previously managed in prisons, it is likely that that the nature of the prison environment engendered a sense of badness, carried through to services in the prevailing sense of negative self-concepts and shame. Prisoners diagnosed with personality disorder have identified the challenges of being supported by prison officers who were challenged by the complexity of their presentation (Shepherd et al., 2017).

Additionally, participants who attract BPD diagnoses often hold internal working models of the self which are negative and self-blaming and the narrative of badness within prison services may confound this. The narrative of 'madness' however, implies alternative treatment approaches and conceptualisations of offending behaviour. As such, the language and construction of offending behaviour becomes uniquely organised within the forensic system, which may challenge the beliefs held by prison-transferred women as they then move forward to reconcile this new approach to the self and behaviour.

Transition towards a more reconciled identity appeared to occur through two primary pathways: regular and consistent reinforcement of worth by staff and enhancing self-understanding through psychological therapy. Maruna (2001) outlines the importance of individuals with offending histories being able to identify their 'core decency'. Through the development of 'core decency', in addition to having staff who maintain faith in the service-user, Maruna argued that the individual becomes better able to develop a redemption script, enabling desistance from offending. A similar process was described in this study through the role of affirming relationships with key staff members who offered corrective attachment experiences, reinforcing self-worth. In the present study, participants engaged in the process of looking back to past identities and integrating past identity with their current and future desired identities. It is suggested that the construct of a 'working self' (Paternoster & Bushway, 2009) deals with the self in the here and now. Drennan and colleagues posit that it is through the 'working self' that forensic service-users come to either disentangle or incorporate their identity as an offender (Drennan & Alred, 2012).

Participants described a process of acceptance through which they accepted their offence and created distance from the offence as defining their identity. Engaging in therapeutic work where they discussed their offence was recognised as increasing understanding and acceptance. Retrospective acceptance of the offence such as that which participants described through offence-focused work has been linked with the creation of insight and greater capacity to obtain emotional closure (Cox, 1974). It is possible that the felt sense of guilt and shame which participants described in 'existing' stages, compounded by lack of safety in relationships created a cognitive barrier towards discussing offending. As participants developed security in relationships, it appeared that the potential benefits outweighed the fears associated with discussing

offending. This thereby enabled the exploration of their identity as somebody who has offended which, in 'existing' stages appeared too risky a process. The idea of looking to the future and considering the desired or undesirable self has been described within the context of avoiding a 'feared self' (Paternoster et al., 2009). In this sense, as participants progressed towards learning and discharge, they began to re-appraise their recovery ideals and spoke of their desires to lead 'normal' lives free from offending and recall.

4.2.2. Identity and self-discovery.

While making meaning of their experiences, participants appeared to increase their self-awareness. In earlier stages of recovery, however, participants appeared unable or unwilling to engage with this level of self-reflection. Past research has found that individuals diagnosed with BPD have questioned the intervention target, considering the implied objective of clinical recovery as returning to a form of past-state, thus, requiring individuals with this diagnosis to consider what they would be returning to given their longstanding difficulties (Katsakou et al., 2012). Interventions in secure services for individuals diagnosed with personality disorders often aim to address a range of features of individual personality. Duggan (2004) identified concerns among participants that the necessity for compliance and the nature of interventions had the potential to reduce their sense of individuality. In this sense, engaging in treatment may offer a real sense of threat; whilst on the one hand, engaging in this work is likely to satisfy those responsible for their care, on the other hand, service-users face an uncertain task in which they may become further from their known self. Such a process may be considered in the 'existing' and 'being stuck in the system' stages whereby participants describe being encouraged towards engaging in treatments which they have little interest or perceive little value from, reflecting a lack of readiness. It is possible that participants with little perceived control over their experience sought to maintain control through compliance and attendance alongside the need to retain the sense of self they entered services with; to lose identity may increase perceived vulnerability and exacerbate lost control. Throughout the recovery process, however, there is a shift towards seeking self-discovery and enhancing self-awareness. Through processes of making sense of past experiences, diagnosis and offence, participants come to recognise unhelpful ways of managing emotion and behaving and perhaps through the

development of internalised control and enhanced security in relationships, feel better able to consider the self within a containing environment.

4.3. Coping and control

The process of recovery appeared to represent a transition from an inability to regulate emotions through to increased capacity to self-manage. Within the 'existing' stage, participants reflected a sense of being overwhelmed by dominating negative self-concepts. This was compounded by a sense of hopelessness for recovery and associated challenges in motivating towards recovery. The experience of 'being stuck in the system' represented a challenging time whereby participants felt they had to conceal their true emotions with difficulty in feeling able to communicate their true thoughts and feelings.

The experience of trauma or threat activates the central nervous system, creating hyperarousal and hypoarousal in the sympathetic and parasympathetic nervous system, resulting in activation of survival systems such as 'fight, flight, submission and freeze' responses (LeDoux, 2002; Ogden et al., 2006; Van Der Kolk, 1996). A threat may exist in many forms such as physical, cognitive and emotional, with the recognition that emotions such as shame, guilt and disgust can also contribute to the disruption of the emotion regulation system (Gilbert, 2009). Participants described that within the 'existing' stage, they experienced intense negative cognitive and emotional experiences, likely to impact upon the autonomic nervous system, creating dysregulation. Research has demonstrated that patients struggle to tolerate emotional and physiological responses when their regulation system is either hyper- or hypo-aroused, resulting in feeling emotionally overwhelmed (Ogden et al., 2006; Van Der Kolk, 1996a). With a lack of skills to manage dysregulation and absence of safety in relationships in 'existing' and 'being stuck in the system' stages, many participants drew upon previously successful ways of regulating their physiological arousal, through self-harming.

Siegel's Window of Tolerance model (WOT; Siegel, 1999) proposes that between the extremes of being hyper-aroused and hypo-aroused lies a window within which an individual is within an optimal state of arousal. Within this optimal state of arousal, it is posited that individuals have the capacity to tolerate intense emotion

without becoming overly dysregulated. Individuals who have experienced significant trauma, particularly childhood abuse, may experience lifelong difficulties in regulating their physiology (Ogden et al., 2006; Schore, 2003). It may be considered that within the 'existing' stage, participants largely existed within the hyperaroused state, with heightened levels of intrusive thoughts, intense emotions and harmful attempts to self-regulate. Also, participants appear to have experienced shifts from a dominant hyperaroused state, to a hypoaroused state, characterised by depression, hopelessness and apathy about life. Barriers to accessing the WOT often had their origins in the attachment domain whereby through relational disempowerment, participants could not draw upon resources for containment and continued to experience relationships as a source of threat.

The Window of Tolerance model provides a useful therapeutic framework, with an objective of moving the client towards their window of optimal arousal where they have increased capacity to think and feel (Fisher & Ogden, 2009). It appears that a central task of recovery for participants was to increase their window of tolerance, reflecting the increased capacity to cope. Increasing capacity to cope was reflected upon by participants as a key component of their recovery, which bears similarity to Slade's concept of personal recovery as having the potential to contain within it a sense of clinical recovery (Slade, 2009). The demands of the task of coping appeared to reduce over time as participants developed increased internal resources through learning and also the development of positive relationships which also appeared to have the effect of guiding participants into their optimal arousal level, thus improving their capacity to cope.

When out of their window of tolerance in early stages of recovery, participants reflected little ability to regulate their distress through internal means, instead, drawing upon the secure environment to offer protection. The construct of locus of control (LOC; Rotter, 1966) represents a person's beliefs about their ability to control outcomes in life through their own actions. Individuals with higher levels of internal locus of control believe that outcomes in their life are contingent upon their behaviour whereas individuals with greater external LOC view outcomes as out of the control of their behaviour and due to external factors (e.g. chance, the actions of others). Previous research has established links between higher levels of external LOC and the occurrence of mental health disorders (Lefcourt, 1982; Twenge, Zhang, & Im, 2004). In the current

study, participants described a sense of moving from an external LOC towards a more internal LOC. As participants progressed through recovery, particularly in the 'actively engaging' stage, a sense of internalised control was described. Here, participants reflected a reduction in the need to draw upon external objects for control, instead recognising that they possessed the necessary skills to cope alone. Their sense of internalised control was, however, recognised to be flexible but also vulnerable. As participants progressed towards the point of discharge with their perceived improved LOC, they acknowledged the potential for post-discharge events to challenge their ability to cope. Here they spoke about balancing internal control with newly acquired skills of communicating needs, through seeking support and accessing medication. Further, participants acknowledged that their control was, to an extent limited and recognised that old methods of coping, such as self-harm, may return in the instance of extreme stressors.

Rogers (1957) asserted the significance of the therapeutic conditions of congruence, unconditional positive regard, and empathic understanding as contributing to change, including the movement from external to internal representations of control. The most prominent psychological interventions for individuals diagnosed with BPD (e.g. DBT, MBT, IPT) also outline similar approaches to therapeutic relationships. Quinn (2011) asserts that increasing internalised control in therapy with individuals diagnosed with BPD is a key mechanism of change, through enhancing awareness and mastery over one's experience. In doing so, he recognises that this "*emerges slowly over time*". Thus, within the process of recovery, participants appear to slowly develop a greater internalised LOC, likely underpinned by the centrality of learning and establishment of secure attachments. Indeed, many treatments for women in secure services aim to increase empowerment through increasing self-esteem and moving women towards internalised control (Salisbury et al., 2009). Increased internal LOC was reflected upon by participants in their reduced need to self-harm, tolerate distressing emotions (such as those raised in therapy sessions).

As they progressed through recovery stages, participants gained increased mastery over their experience, increasing their capability to manage emotion and cope over time, thus moving increasingly towards their WOT. Dialectical Behaviour Therapy asserts that among other things, emotional dysregulation occurs due to a deficit in skills (Linehan, 1993). Critics of the diagnostic construct of BPD argue that it is little more

than a disorder placed upon those who, through adverse experiences, fail to develop these skills and the nature of skills acquisition provides further support for this view. Skills-deficits are recoverable through learning and participants in this study reflected an increased sense of mastery over their own experience, associated with internalised LOC. Whilst improved coping may be viewed as a form of clinical recovery, it may be better conceptualised in this context as an increased capacity to self-manage. The concept of self-management is central to personal recovery, recognising the ability to manage and cope with symptoms which may persist. The development of skills to self-manage is considered essential to enable individuals to function effectively and develop more personally meaningful lives (i.e., "recover")' (Salyers, Godfrey, Mueser, & Labriola, 2007, p.467). Participants in the present study recognised that they might experience challenges in the future and in this sense, the nature of coping was conceptualised as fragile. The concept of self-management within this study contained within it the idea of balanced autonomy, such that where necessary participants recognised a desire to seek out relationships or medication to support self-management. Similar findings were noted in previous research in forensic services (e.g. Ferrito et al., 2012; Mezey et al., 2010) although these studies had little representation of service-users diagnosed with PD.

5. Strengths

The study aimed to generate a theory to describe how women with a diagnosis of BPD experience recovery in secure services. A strength of the study is the inclusion of participants at various stages in the recovery process. Through theoretical sampling, participants were invited into the study where it was thought they might extend the emerging theory. The inclusion of women at various stages in recovery, with varying, or no offence histories and various lengths of time in services enabled the exploration of negative cases, allowing the development of a flexible model in accounting for diversity in experiences.

As identified in the journal paper, the model extends beyond existing change models, which are limited in explanations of factors influencing transition. The model in this study identifies the key facilitative influences and barriers towards recovery

within an attachment-based recovery framework, drawing particular attention to the therapeutic relationship.

Throughout the research process, I remained as close to the data as possible. This allowed me to pursue emerging avenues through the amendment of an interview schedule to gain a deeper understanding into emerging themes. Similarly, by remaining close to the data I remained reflective to my interpretations of the data, making memos throughout the research process which provided explicit scaffolding to the development of the theory. In addition, I was mindful of the quality criteria outlined by Charmaz (2014; Appendix x), which guided me at each stage of analysis and write-up.

6. Limitations

A number of limitations were outlined in the journal paper. Although participants were invited into the study if they reached specified criteria, the choice to participate remained with them. Field supervisors were requested to keep a record of those who were approached but declined to participate, but these numbers were not consistently recorded. Therefore, the opt-in rate relative to the rate of invitation is not available. It is recognised that the development of a grounded theory is dependent upon the content and quality of the data obtained. Whilst the uptake rate of the study is unclear, the extent to which the emergent theory may represent the views of women who are further into their recovery remains a primary concern. Though it is not possible to ascertain, it is possible that participants who did not choose to participate may not have wished to engage in a study asking about their recovery, particularly if they did not feel that they were in recovery or motivated to recover. This coupled with the clinical decisions not to invite participants who were considered ‘in crisis’ or ‘at risk’ may have resulted in reflections on stages such as ‘being stuck in the system’ which may have changed in their conceptualisation through learning. Thus, there was little data from participants currently in the ‘existing’ stage. The research may have been strengthened through the inclusion of these participants, either during the interview stages or in the final stage of determining the fit of the model. However, as described in the journal paper this was not possible.

7. Clinical implications and recommendations for future research

This research outlines the relational challenges which women who are diagnosed with BPD face as they recover in forensic services. While recommendations have been made to ensure that services for women remain alert to the prevalence of interpersonal trauma within this client group, this research draws additional attention to the interpersonal context as a key source of de-stabilisation and key facilitative factor in the recovery process. The centrality of the nature of relational disempowerment gives further support to the need for mental health services to work towards creating empowerment within recovery. The study proposes that engaging in offence-focused work or therapeutic work may be blocked by an absence of trusting relationships, creating a sense of 'stuckness'. Based on these findings, staff within forensic services working with this client may benefit from considering the potential for disempowerment to occur within a relationship which is already, by its nature power-imbalanced. Recommendations have been made elsewhere for reflective practice to support staff in managing their relationships with this client group who may themselves, fear the power of the service-users.

This study utilised theoretical sampling to obtain a sample for whom the topic was relevant. The emergent model identified concerns which participants had about their ability to continue in recovery in the community. At present, there is no research focusing on how forensic service-users continue to recover post-discharge. Though beyond the scope of this study, a longitudinal study may provide rich insights into how recovery is experienced from admission through to management in the community. It is recognised that the present study relied on an interpretation of concepts such as coping and locus of control. A longitudinal may be enriched by paying attention to changes in these constructs over time.

8. Reflections- learning from the process

8.1. Reflecting on epistemology.

This research offered many learning points throughout. The most frequent issues I grappled with were those around clinical ethics and the role of the psychiatric system. Approaching this research from a social constructionist perspective felt true to my beliefs about diagnosis, particularly BPD. The more I met with the women, the more I

came to question what was being labelled as symptomatic and where the line between "normal" and "disordered" truly lay. I entered the process aware of the dearth of women's accounts in forensic services and perhaps had anticipated that gender would have played a role in how these women were constructed by others and how they saw their issues. This, however, was not the case. Since then I have considered the nature of only knowing from our own realities. Therefore the extent to which the women reflected on their difficulties as a unique experience for women was reliant upon their own beliefs and reflections of being a woman. I wondered how much I viewed my life experiences as associated with my gender and how potentially my own beliefs primed me for searching for data which never arose. I do, however, wonder about the experiences women described: those of abuse, sexual violence and motherhood and how it could be argued that these are gendered phenomena. The extent to which women viewed these events as linked to recovery was only apparent as they spoke about coming to terms with the past.

8.2. Reflecting on the process.

Recruitment and time formed the two biggest challenges of the research process. Before commencing the project, I anticipated that my greatest challenge would be in gaining interest from participants. However, in the case of this research gaining support from services represented a great challenge. This required communicating with services to discuss the project, making presentations to clinical teams and in some cases, completing additional training on research sites in methods of 'Breakaway', all of which were time-consuming in addition to commuting across the Midlands and transcribing interviews. The biggest challenge, however, lay in the decisions of clinicians whether to approach particular service-users. Though more people met criteria than were invited to the study, this was largely due to clinician concern over their capacity to cope with the interview. Usually, this was following a recent 'incident' or 'decline. However, I have wondered about the autonomy and choice of service-users and how this had been removed from them. This differed across services, and I recall one interview with a participant who had recently been involved in an 'incident'. The result was an interview which was extremely rich in helping me to understand the struggle with restrictions. I wondered whether I was missing valuable insights from women who were struggling to manage and how an interview may have been facilitated, as with one participant, with the support of a trusted staff member.

8.3. Reflections on the interview process.

The interview process presented a unique experience for me. Before completing this research, I had not completed face-to-face interviews for research. As a clinical psychology trainee, however, I engage with service-users on a regular basis. I have reflected upon the role in which I was acting as an external researcher. As this research has illustrated, experiences in secure services are largely relational, and the development of trust is a necessary component of open discussion and recovery. I have since wondered about the benefits and limitations of acting as an external researcher. While on the one hand, I am independent to the clinical team, and a degree of confidentiality is assured, on the other hand, I am a stranger whom they may anticipate adverse reactions in the disclosures of offending. I became aware of caution of participants in terms of what they could say to me, often checking the conditions of confidentiality. This has led me to believe that perhaps acting as an external researcher may reduce the degree of threat in being open in an interview process when compared to having a team member act as a researcher.

8.3. Reflections on analysis.

The analysis process was a demanding process in terms of time and the procedure itself. Services would not approve of the use of transcription services due to confidentiality, therefore, I transcribed these myself. Though initially frustrating, I found this task increased my closeness to the data and encouraging me to reflect as I listened to the interviews again. I became aware of silences which I interrupted in early interviews which enabled me to identify ways to improve future interviews and similar styles of questioning which did not elicit much from participants. In future research, I would wish to transcribe again as it benefitted me greatly.

In developing codes and categories, I found it useful to keep a reflective log. In doing so, I was able to ascertain whether my conceptualisations of the data were true to the data or whether I was importing some of my expectations onto the data. The volume of data was, however, somewhat overwhelming at times. I found myself seeking supervision to support me in organising my thoughts and disentangling various categories from one another.

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Appendices

Appendix i. Participant information sheet for secure and locked services

The University of Nottingham
UNITED KINGDOM · CHINA · MALAYSIA

Nottinghamshire Healthcare NHS
NHS Foundation Trust

Participant Information Sheet

(Final Version 2.1, 17/01/2018)

IRAS Project ID: 218917

Title of Study: How do women with borderline personality disorder, receiving treatment in medium- and low- secure, and locked rehabilitation services perceive recovery? A grounded theory study.

Name of Researcher(s): Louise Canacott

You are being invited to take part in this research. Before you decide you should understand why the research is being done and what taking part will involve. We will go through the information sheet with you and answer any questions you have. Talk to others about the study if you wish. Please ask if there is anything that is not clear.

What is the study about?

This study will find out what women in medium- and low-secure or locked rehabilitation settings think about recovery. Up to 15 women will be interviewed. The research is part of a Doctorate in Clinical Psychology thesis at the University of Nottingham.

Why have I been invited?

You have been invited as you have a diagnosis of borderline personality disorder and are receiving treatment for this in this hospital. We are interested in hearing your views about recovery. We will interview up to 15 more people.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. This would not affect your legal rights or treatment.

What will happen to me if I take part?

If you are interested in taking part, firstly a researcher will come and meet with you and answer any questions you may have that are not answered in this information sheet. If you are happy with this and would like to take part, we will ask you to sign a consent form and will collect some demographic information from you. We will then arrange a good time to meet again for a more in-depth individual interview. The interview may last from between 30 mins to 120 mins, depending on how much you want to say. If it feels like a long time, we may take some breaks. We should not need to contact you again after the interview.

Expenses and payments

You will not be paid to participate in the study.

What are the possible disadvantages and risks of taking part?

Firstly, you will be giving up some of your time. The interview should not be more than 120 minutes long but it may be longer or shorter depending on how much you would like to discuss. Secondly, thinking about some of your experiences may be upsetting for you. The interview is not intended to be distressing and you do not have to discuss anything you do not want to, the interview is designed to focus on what you have to say. If participating in the research has been upsetting for you, a member of the clinical team will support you.

What are the possible benefits of taking part?

It is not expected that this study will benefit you directly. At present, little is known about how women in secure or locked services with personality disorder feel about recovery. This study allows you to contribute to a greater understanding of the experiences of women with personality disorder in such settings. It is an opportunity to share your experiences with somebody outside your care team. It could help to develop future services.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. Please instruct a member of your care team to contact the researcher. If you remain unhappy and wish to complain formally, you can do this by contacting

Phone: 01777 247396

Email: PALS@nottshc.nhs.uk

Write to:

Patient Advice and Liaison Service
Rampton Hospital
Retford
Nottinghamshire
DN22 0PD

Will my taking part in the study be kept confidential?

We will follow ethical and legal practice and all information about you will be kept confidential.

If you join the study, the data collected will be looked at by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty.

All information which is collected about you during the course of the research will be kept **strictly confidential**, stored in a secure and locked office, and on a password protected database. Any information about you which leaves the hospital will have your name and personal information removed (anonymised) and a unique code will be used so that you cannot be recognised from it. All research data will be kept securely for 7 years. After this time your data will be disposed of securely. All precautions will be taken by all those involved to maintain your confidentiality, only members of the research team will have access to your personal data.

Although what you say in the interview is confidential, should you disclose anything to us which we feel puts you or anyone else at any risk, we may feel it necessary to report this to the appropriate persons (e.g. nursing staff).

What will happen if I don't want to carry on with the study?

You can withdraw from the study at any point and there will be no negative consequences for you and your care will not be effected in any way. If you withdraw later than one week after the interview, the data you have provided will still be used in the study. Please tell a member of staff or the researcher if you decide to withdraw.

What will happen to the results of the research study?

The results of the study will be submitted as part of the Trent Doctorate in Clinical Psychology at the University of Nottingham. The findings may also be shared at conferences and submitted for publication in a peer-reviewed journal. You will not be identified in any publication. We can provide a copy of results at your request.

Who is organising and funding the research?

This research is being organised by the University of Nottingham and is being funded by Nottinghamshire Healthcare NHS Foundation Trust.

Who has reviewed the study?

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

Appendix ii. Consent forms for medium- and low- and locked services

The University of Nottingham
UNITED KINGDOM · CHINA · MALAYSIA

Nottinghamshire Healthcare NHS
NHS Foundation Trust

Title of Study: How do women with borderline personality disorder receiving treatment in medium- and low-secure services perceive recovery? A grounded theory study.

Final Version 1.1, dated 15/05/2017

Name of Researcher: Louise Canacott **IRAS ID:**218917

Name of Participant: **Please initial box**

1. I confirm that I have read and understand the information sheet (Final Version 1.1, dated 15/05/2017) for the above study and have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without my medical care or legal rights being affected. I understand that should I wish to withdraw more than one week after the interview, then the information collected so far cannot be erased and that this information may still be used in the project analysis. ☐

3. I understand that data collected in the study may be looked at by authorised individuals from the University of Nottingham, the research group and regulatory authorities where it is relevant to my taking part in this study. I give permission for these individuals to have access to such data and to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential. ☐

4. I understand that the interview will be recorded and that anonymous direct quotes from the interview/focus group may be used in the study reports. ☐

5. I agree to take part in the above study. ☐

_____	_____	_____
Name of Participant	**Date**	**Signature**
_____	_____	_____
Name of Person taking consent	Date	Signature

The University of Nottingham
UNITED KINGDOM · CHINA · MALAYSIA

Nottinghamshire Healthcare NHS
NHS Foundation Trust

Title of Study: How do women with borderline personality disorder, receiving treatment in medium- and low- secure, and locked rehabilitation services perceive recovery? A grounded theory study

Final Version 2.1, dated 17/01/2018

Name of Researcher: Louise Canacott **IRAS ID:**218917

Name of Participant: **Please initial box**

1. I confirm that I have read and understand the information sheet (Final Version 2.1, dated 17/01/2018) for the above study and have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without my medical care or legal rights being affected. I understand that should I wish to withdraw more than one week after the interview, then the information collected so far cannot be erased and that this information may still be used in the project analysis. ☐

3. I understand that data collected in the study may be looked at by authorised individuals from the University of Nottingham, the research group and regulatory authorities where it is relevant to my taking part in this study. I give permission for these individuals to have access to such data and to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential. ☐

4. I understand that the interview will be recorded and that anonymous direct quotes from the interview/focus group may be used in the study reports. ☐

5. I agree to take part in the above study. ☐

_____ _____ _____

Name of Participant	**Date**	**Signature**
_____	_____	_____
Name of Person taking consent	Date	Signature

Appendix iii. Ethical approval documentation

Health Research Authority

Professor Thomas Schröder
Associate Professor in Clinical Psychology Co-Director
Email: hra.approval@nhs.net

(Academic & Research), Trent DClinPsy Programme,
Division of Psychiatry and Applied Psychology, School of Medicine, University of Nottingham
University of Nottingham
B12 Yang Fujia Building,
Jubilee Campus,
University of Nottingham
NG81BB

16 May 2017

Dear Professor Schröder

Letter of HRA Approval

Study title:	**How do women with borderline personality disorder, receiving treatment in medium- and low-secure services perceive recovery? A grounded theory study.**
IRAS project ID:	**218917**
REC reference:	**17/NW/0231**
Sponsor	**University of Nottingham**

I am pleased to confirm that **HRA Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

Participation of NHS Organisations in England

The sponsor should now provide a copy of this letter to all participating NHS organisations in England.

Appendix B provides important information for sponsors and participating NHS organisations in England for arranging and confirming capacity and capability. **Please read *Appendix B* carefully**, in particular the following sections:

- *Participating NHS organisations in England* – this clarifies the types of participating organisations in the study and whether or not all organisations will be undertaking the same activities
- *Confirmation of capacity and capability* - this confirms whether or not each type of participating NHS organisation in England is expected to give formal confirmation of capacity and capability. Where formal confirmation is not expected, the section also provides details on the time limit given to participating organisations to opt out of the study, or request additional time, before their participation is assumed.

- *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* - this provides detail on the form of agreement to be used in the study to confirm capacity and capability, where applicable.

Further information on funding, HR processes, and compliance with HRA criteria and standards is also provided.

It is critical that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details and further information about working with the research management function for each organisation can be accessed from www.hra.nhs.uk/hra-approval.

Appendices

The HRA Approval letter contains the following appendices:

- A – List of documents reviewed during HRA assessment
- B – Summary of HRA assessment

After HRA Approval

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

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

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

In addition to the guidance in the above, please note the following:

- HRA Approval applies for the duration of your REC favourable opinion, unless otherwise notified in writing by the HRA.
- Substantial amendments should be submitted directly to the Research Ethics Committee, as detailed in the *After Ethical Review* document. Non-substantial amendments should be submitted for review by the HRA using the form provided on the HRA website, and emailed to hra.amendments@nhs.net.
- The HRA will categorise amendments (substantial and non-substantial) and issue confirmation of continued HRA Approval. Further details can be found on the HRA website.

Scope

HRA Approval provides an approval for research involving patients or staff in NHS organisations in England.

If your study involves NHS organisations in other countries in the UK, please contact the relevant national coordinating functions for support and advice. Further information can be found at http://www.hra.nhs.uk/resources/applying-for-reviews/nhs-hsc-rd-review/.

If there are participating non-NHS organisations, local agreement should be obtained in accordance with the procedures of the local participating non-NHS organisation.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/.

HRA Training

We are pleased to welcome researchers and research management staff at our training days – see details at http://www.hra.nhs.uk/hra-training/

Your IRAS project ID is **218917**. Please quote this on all correspondence.

Yours sincerely

Miss Lauren Allen Assessor

Email: hra.approval@nhs.net

Copy to: Ms Angela Shone (Sponsor contact)
Shirley Mitchell, Nottinghamshire Healthcare NHS Foundation Trust (Lead NHS R&D contact)

Appendix A - List of Documents

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

Document	*Version*	*Date*
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Insurance Cert]		20 July 2017
Interview schedules or topic guides for participants [Interview Schedule]	1.0	08 March 2017
IRAS Application Form [IRAS_Form_31032017]		31 March 2017
Letter from sponsor [Letter from Sponsor]		01 March 2017
Letters of invitation to participant [e-mail to clinicians]	1.0	08 March 2017
Non-validated questionnaire [Demographics Questions]	1.0	08 March 2017
Other [Statement of Activities]	1.1	06 April 2017
Other [Schedule of Events]	1.1	06 April 2017
Other [Demographics]	1.0	08 March 2017
Other [Insurance from sponsor]		
Other [Clarification email]		27 March 2017
Other [CV Mark Gresswell]		27 March 2017
Participant consent form	1.1	15 May 2017
Participant information sheet (PIS)	1.1	15 May 2017
Research protocol or project proposal [Research Proposal]	1.0	08 March 2017
Summary CV for Chief Investigator (CI) [Thomas Schroeder CV]		01 October 2015
Summary CV for student [Louise Canacott IRAS CV]		13 January 2017
Summary CV for supervisor (student research) [Anna Tickle CV]		10 January 2015

Appendix B - Summary of HRA Assessment

This appendix provides assurance to you, the sponsor and the NHS in England that the study, as reviewed for HRA Approval, is compliant with relevant standards. It also provides information and clarification, where appropriate, to participating NHS organisations in England to assist in assessing and arranging capacity and capability.

For information on how the sponsor should be working with participating NHS organisations in England, please refer to the, *participating NHS organisations, capacity and capability* and *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* sections in this appendix.

The following person is the sponsor contact for the purpose of addressing participating organisation questions relating to the study:

Name: Ms Angela Shone

Email: sponsor@nottingham.ac.uk

HRA assessment criteria

Section	HRA Assessment Criteria	Compliant with Standards	Comments
1.1	IRAS application completed correctly	Yes	No comments
2.1	Participant information/consent documents and consent process	Yes	No comments
3.1	Protocol assessment	Yes	No comments
4.1	Allocation of responsibilities and rights are agreed and documented	Yes	The Statement of Activities and Schedule of Events will act as the agreement between the sponsor and site.
4.2	Insurance/indemnity arrangements assessed	Yes	Where applicable, independent contractors (e.g. General Practitioners) should ensure that the professional indemnity provided by their medical defence organisation covers the activities expected of them for this

Section	HRA Assessment Criteria	Compliant with Standards	Comments
			research study
4.3	Financial arrangements assessed	Yes	No funding will be provided to the site.
5.1	Compliance with the Data Protection Act and data security issues assessed	Yes	No comments
5.2	CTIMPS – Arrangements for compliance with the Clinical Trials Regulations assessed	Not Applicable	No comments
5.3	Compliance with any applicable laws or regulations	Yes	No comments
6.1	NHS Research Ethics Committee favourable opinion received for applicable studies	Yes	No comments
6.2	CTIMPS – Clinical Trials Authorisation (CTA) letter received	Not Applicable	No comments
6.3	Devices – MHRA notice of no objection received	Not Applicable	No comments
6.4	Other regulatory approvals and authorisations received	Not Applicable	No comments

Participating NHS Organisations in England

This provides detail on the types of participating NHS organisations in the study and a statement as to whether the activities at all organisations are the same or different.

There is one site type. The field supervisor and clinicians at the site will identify potential participants. Consent and interviews will be conducted by the student researcher at the site.

The Chief Investigator or sponsor should share relevant study documents with participating NHS organisations in England in order to put arrangements in place to deliver the study. The documents should be sent to both the local study team, where applicable, and the office providing the research management function at the participating organisation. For NIHR CRN Portfolio studies, the Local LCRN contact should also be copied into this correspondence. For further guidance on working with participating NHS organisations please see the HRA website.

If chief investigators, sponsors or principal investigators are asked to complete site level forms for participating NHS organisations in England which are not provided in IRAS or on the HRA website, the chief investigator, sponsor or principal investigator should notify the HRA immediately at hra.approval@nhs.net. The HRA will work with these organisations to achieve a consistent approach to information provision.

Confirmation of Capacity and Capability

This describes whether formal confirmation of capacity and capability is expected from participating NHS organisations in England.

Participating NHS organisations in England **will be expected to formally confirm their capacity and capability to host this research**.

- Following issue of this letter, participating NHS organisations in England may now confirm to the sponsor their capacity and capability to host this research, when ready to do so. How capacity and capacity will be confirmed is detailed in the *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* section of this appendix.
- The Assessing, Arranging, and Confirming document on the HRA website provides further information for the sponsor and NHS organisations on assessing, arranging and confirming capacity and capability.

Principal Investigator Suitability

This confirms whether the sponsor position on whether a PI, LC or neither should be in place is correct for each type of participating NHS organisation in England and the minimum expectations for education, training and experience that PIs should meet (where applicable).

A Local Collaborator should be identified at the site to facilitate access arrangements for the external research team where needed.

GCP training is not a generic training expectation, in line with the HRA statement on training expectations.

HR Good Practice Resource Pack Expectations

This confirms the HR Good Practice Resource Pack expectations for the study and the pre-engagement checks that should and should not be undertaken

No access arrangements are needed for study activity conducted by staff from the site. External staff (e.g. University) will be expected to obtain Letters of Access to undertake study activity at the site. Disclosure and Barring Service and Occupational Health checks should be confirmed where a Letter of Access is in place.

Other Information to Aid Study Set-up

This details any other information that may be helpful to sponsors and participating NHS organisations in England to aid study set-up.

☐ The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN Portfolio.

Appendix iv. Letter of favourable opinion following substantial amendment

NHS
Health Research Authority

North West - Greater Manchester West Research Ethics Committee

Barlow House
3rd Floor
4 Minshull Street
Manchester
M1 3DZ

Tel: 0207 104 8021 02 February 2018

Ms Louise Canacott

Yang Fujia Building, B Floor

Jubilee Campus

University of Nottingham

NG81BB

Dear Ms Canacott

Study title:	**How do women with borderline personality disorder, receiving treatment in medium- and low-secure services perceive recovery? A grounded theory study.**
REC reference:	**17/NW/0231**
Amendment number:	**2**
Amendment date:	**23 January 2018**
IRAS project ID:	**218917**

The above amendment was reviewed by the Sub-Committee in correspondence.

Ethical opinion

The Sub-Committee had no ethical issues.

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

Approved documents

The documents reviewed and approved at the meeting were:

Document	*Version*	*Date*
Notice of Substantial Amendment (non-CTIMP)	2	23 January 2018
Participant consent form	2.1	17 January 2018
Participant information sheet (PIS)	2.1	17 January 2018
Research protocol or project proposal	2	19 January 2018

Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

Working with NHS Care Organisations

Sponsors should ensure that they notify the R&D office for the relevant NHS care organisation of this amendment in line with the terms detailed in the categorisation email issued by the lead nation for the study.

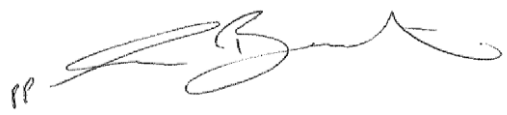
Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

We are pleased to welcome researchers and R & D staff at our Research Ethics Committee members' training days – see details at http://www.hra.nhs.uk/hra-training/

17/NW/0231:	**Please quote this number on all correspondence**

Yours sincerely



Dr Lorraine Lighton Chair

E-mail: nrescommittee.northwest-gmwest@nhs.net

Enclosures: *List of names and professions of members who took part in the review*

Copy to: *Mrs Shirley Mitchell, Nottinghamshire Healthcare NHS Trust*
Ms Louise Canacott

North West - Greater Manchester West Research Ethics Committee

Attendance at Sub-Committee of the REC meeting on 02 February 2018

Committee Members:

Name	*Profession*	*Present*	*Notes*
Mr Jonathan Deans	Consultant in Head & Neck Surgery	Yes	
Dr Lorraine Lighton (Chair)	Retired Consultant in Communicable Disease Control	Yes	

Also in attendance:

Name	*Position (or reason for attending)*
Miss Anna Bannister	REC Manager

Appendix v: E-mail confirming HRA approval following substantial amendment

From: TOTENHOFER, Ashley (HEALTH RESEARCH AUTHORITY) <ashley.totenhofer@nhs.net>
Sent: 15 February 2018 10:43
To: Louise Canacott
Cc: Thomas Schroder; sponsor@nottingham.ac.uk; Mitchell Shirley (NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST)
Subject: RE: 17/NW/0231 IRAS 218917. Confirmation of Amendment Assessment

Dear Louise

Further to the below, I am pleased to confirm **HRA Approval** for the referenced amendment.

You should implement this amendment at NHS organisations in England, in line with the conditions outlined in your categorisation email.

Please contact hra.amendments@nhs.net for any queries relating to the assessment of this amendment.

Kind regards

Ashley

Ashley Totenhofer
Technical Assurance Officer
Health Research Authority
HRA Centre Manchester | 3rd Floor, Barlow House | 4 Minshull Street, Manchester | M1 3DZ
T. 0207 104 8017
E. ashley.totenhofer@nhs.net
W. www.hra.nhs.uk

Appendix vi. Demographics questionnaire



The University of Nottingham

UNITED KINGDOM · CHINA · MALAYSIA

Nottinghamshire Healthcare NHS

NHS Foundation Trust

1. What is your date of birth?

2. What is/are your diagnosis/diagnoses?

3. When were you admitted to this hospital?

4. What Mental Health Act section are you under?

5. What is/are your index offence(s)?

6. What psychological therapies have you taken part in?

Appendix vii. Development of interview schedules

Interview schedule 1.

Definition of personality disorder

1. What is your understanding of your personality disorder diagnosis/diagnoses?

Prompts

- What are the symptoms of your personality disorder?
- Why do you think someone gave you this diagnosis?
- How did you come into contact with services?
- What do you think the future will look like in terms of your personality disorder?
- What are your expectations for getting better?
- What might be the next step?
- What does this diagnosis mean to you?
- What does it mean to other people around you?
- What are the implications of this diagnosis?
- Do you think there is a relationship between personality disorder and offending?

Understanding of recovery

2. What do you understand by the term recovery?

Prompts

- How do you think the word may apply to you?
- What areas of life do you think it applies to?
- What areas of your life were / are in need of change to help you recover?
- What changes have you made?
- How have you made these changes?
- What challenges have you faced?
- What are the signs that you are recovering?
- What would recovery look like for you?
- What challenges face you in the future?
- How would you know you are “recovered”? Can you be recovered?
- Do you think offending behaviour is related to recovery?
- How do you think risk may be related to recovery?

- Where have you gotten your ideas about recovery? Where did you hear about recovery?

Treatment and support

3. What aspects of being in secure care have been helpful in your recovery (if any)?

Prompts

- What treatments have you taken part in?
- Have any treatments helped your recovery? If so, which? how?
- Have any treatments limited your recovery? If so, which? How?
- Is there anything about being in a secure setting that has helped your recovery?
- Is there anything about being in a secure setting that has limited your recovery?
- Who supports you in your recovery? How?

Interview schedule 2.

Interview schedule 2

Definition of personality disorder

1. What is your understanding of your personality disorder diagnosis/diagnoses?

   Prompts

   - What are the symptoms you experience? How long have you had these symptoms?
   - What do you understand about how you came to have this diagnosis? How was it communicated to you?
   - What is your understanding the course of your personality disorder(s)? For example, what the future will be like in terms of your personality disorder and if you can get better?
   - What does this diagnosis mean to you? Does the diagnosis have any benefits or drawbacks for you?
   - What do you think having a personality disorder means for your time in services?
   - Do you think there is a relationship between personality disorder and offending? If so, what?

Understanding of recovery

2. What do you understand by the term recovery?

   Prompts

   - How do you think the word may apply to you?
   - What areas of life do you think it applies to?
   - What areas of your life were / are in need of change to help you recover?
   - What changes have you made? How have you made these changes?
   - What challenges have you faced?
   - What challenges face you in the future?

   - Do you think offending behaviour is related to recovery?
   - How do you think risk may be related to recovery?

   - How much progress do you feel you have made in your recovery?
   - Where do you feel you are in your recovery journey?
   - What are the signs that you are recovering?
   - If you have a bad day or setback, how do you then feel about your recovery?
   - How would you know you are “recovered”? Can you be recovered?
   - What would recovery look like for you? What goals do you have for your recovery?

- You are in forensic services and the tams have a role to play in your recovery, what do you see as your role in your recovery? What could you do?

If transferred from prison:

- Are there any differences between your recovery in prison and your recovery in hospital?
- When you came to hospital where did you see yourself in your recovery? What factors influenced this?

Treatment and support

3. What aspects of being in secure care have been helpful in your recovery (if any)?

Prompts

- What treatments have you taken part in?
- Have any treatments helped your recovery? If so, which? how?
- Have any treatments limited your recovery? If so, which? How?
- Is there anything about being in a secure setting that has helped your recovery?
- Is there anything about being in a secure setting that has limited your recovery?
- Who supports you in your recovery? How?
- When you came to hospital where did you see yourself in your recovery? What factors influenced this?
- How have you adjusted to your time in services?

Interview schedule 3.

Interview schedule 3

Definition of personality disorder

1. What is your understanding of your personality disorder diagnosis/diagnoses?

Prompts

- What are the symptoms of your personality disorder? How long have you had these symptoms?
- What do you understand about how you came to have this diagnosis? How was it communicated to you?
- What is your understanding the course of your personality disorder(s)? For example, what the future will be like in terms of your personality disorder and if you can get better?
- What does this diagnosis mean to you? Does the diagnosis have any benefits or drawbacks for you?
- What do you think having a personality disorder means for your time in services?
- Do you think there is a relationship between personality disorder and offending? If so, what?
- How do you see yourself in relation to your diagnosis?

Understanding of recovery

2. What do you understand by the term recovery?

Prompts

- How do you think the word may apply to you?
- What areas of life do you think it applies to?
- What areas of your life were / are in need of change to help you recover?
- What changes have you made? How have you made these changes?
- What challenges have you faced?
- What challenges face you in the future?

- Do you think offending behaviour is related to recovery?
- How do you think risk may be related to recovery?

- How much progress do you feel you have made in your recovery?
- Where do you feel you are in your recovery journey?
- What are the signs that you are recovering?
- If you have a bad day or setback, how do you then feel about your recovery?
- How would you know you are “recovered”? At what point will you feel you have recovered enough?
- What would recovery look like for you? What goals do you have for your recovery?

- You are in forensic services and the tams have a role to play in your recovery, what do you see as your role in your recovery? What could you do?
- How have your ideas for recovery changed over time? What has influenced these changes?

If transferred from prison:

- Are there any differences between your recovery in prison and your recovery in hospital?
- When you came to hospital where did you see yourself in your recovery? What factors influenced this?
- How did you adjust to secure services? What were the challenging and supportive aspects?

Treatment and support

3. What aspects of being in secure care have been helpful in your recovery (if any)?

   Prompts
   - What treatments have you taken part in?
   - Have any treatments helped your recovery? If so, which? how?
   - Have any treatments limited your recovery? If so, which? How?
   - What do you think the goals of these treatments are?
   - What do you think your clinical team see as recovery? Is this the same for you?
   - Is there anything about being in a secure setting that has helped your recovery?
   - Is there anything about being in a secure setting that has limited your recovery?
   - Who supports you in your recovery? How?
   - When you came to hospital where did you see yourself in your recovery? What factors influenced this?
   - How have you adjusted to your time in services?

Appendix viii. Examples of coding

Coding excerpt 1	**Initial code**	**Focused code**
P: When I went to medium secure I done em…so I done CBT, I done schema therapy and schema therapy is fantastic and then they told me about DBT and I thought what the fuck is DBT but I've come on here and DBT has just been fantastic. And it is ultimately the way forward. I think everybody should have IPU's, DBT and that lot. All these acronyms that people are throwing about but I think everybody should have DBT. L: What have you found these therapies have done for you? So you have said that Schema and DBT in particular have been really helpful, what have they done?	*Schema therapy as helpful* *DBT as fantastic* *DBT is the way forward* *Everybody should have DBT*	*Therapeutic approaches as helpful* *DBT as key approach*
P: So CBT gave me the chance to put a lot of things to rest.so it's like cognitive, it's your thinking, going back to your childhood. Schema again it's going back to your childhood but it's only certain parts so that's what you're built up of. Schema had me going back to my 11 year old self man, cuddling, do you know what I mean. And then DBT gives you everything, DBT just covers like your interpersonal skills and like emotion regulation, just 4 big chunks and it's just repetitive and it just carries it home and it just becomes your way of life until you're talking and you're just fucking chatting DBT till everything just becomes DBT and it just becomes you. But you have to let it become your skillset, it gives you a set of skills that will set you up for life if you want it to so…it's there, it's alright. Have you ever done DBT? L: Yeah sometimes, I've never done the full programme but sometimes just take bits and pieces from it	*CBT as resolving old issues* *Schema taking me to childhood self* *Interpersonal and emotional skills in DBT* *DBT becomes your way of life* *Let DBT become your skillset* *DBT skills last for lifetime*	*Therapy allowing context for old issues to be addressed* *Therapy allowing connection to childhood parts of self* *Skills building and practicing DBT* *Building interpersonal and emotional skills* *DBT-preparing for future challenges*

because there some helpful parts, not everyone will do the full course, is it 2 years you do here? P: Mmm it's a year but most people will do anything over. L: Like the same cycles again..And the schema you said, it's quite intense? P: Schema's massively intense, I did for 8 months but I know people who have been doing it for 2-3 years. Schema's fantastic and the therapist that I had, she was brilliant. I cried when my therapy come to an end. I've just said that on tape haven't I [laughs]..shit L: Well the recording is confidential and I don't actually work here so I've no, I don't feed this back to anybody. It's anonymised and it goes into my thesis but your name's going to be changed and anything that would identify you would be changed. And it's actually a space as well for anything you don't like about it you can say it here because there's no repercussions, so don't worry about that. P: Ok..well my therapist is great, I cry to her on a weekly basis. My therapist, I've known her, she come to assess me when I was in jail and there's not a bad word I can say about her. She is, she is the love of my life in very platonic way. I've had two therapists on this ward, [name], I cried when she left, I see her as a mother figure. But not in a way where I want her to be my mother, just in a way where like. I get emotional just thinking about her. She was just, she was just so brutally honest, yet so compassionate, you could just tell	*Therapist was brilliant* *Crying at the end of therapy* *Good relationship with therapist* *Therapist as platonic love of life* *Therapist as mother figure* *Valuing staff honesty* *Valuing staff compassion*	*Benefitting from therapy due to therapeutic alliance* *Intense connection with therapist* *Loss of valued relationships* *Safety in therapeutic relationship* *Output for emotion in therapy* *Qualities of staff contributing to safe and trusting relationships*

that she just cared so much. And then [name], I wanted [name] from when I came over as my therapist then when [other name] left, she was like you've got [name]. [name] knows everything about me, there's not one thing I wouldn't feel confident saying to [name], even the most stupidest thing or the most horrific thing or even the most randomest thing, I tell [name] and yeah we have a really good relationship because I know that there's..I tell her more things than I tell my mum, I tell my mum everything but I tell [name] the rawest things because if I need help, she's the one I go to because she helps me with even the slightest little thing. It's just like, even the stupid things she's like oh, [ppt name], *imitates*, even if it's something stupid, well not stupid but naughty, she just tells it straight. Even when I was struggling with medication, she was like [ppt name] you need to go back on medication and that's just it, and I took her up on it and I was like right, straight back on medication, but I take her word as gospel..that's what it is. I take her word and I run with it. I trust her 100%.	*Confidence to be open with therapist* *Tell the rawest things to therapist if I need help* *Directness of therapist* *Taking therapist word as gospel* *Trusting therapist 100%*	*Contained in relationship* *Able to seek help from therapist due to strength of alliance* *Valuing honesty and transparency from staff* *Trust with therapist facilitating change*
Coding excerpt 2	**Initial code**	**Focused code**
L: How do you deal with that? P: You know I do it. Cos if I don't I just, I take a big step and I take a big gulp and and swallow my pride and I do it. Cos I know that 9 times out of 10 they are waiting for a reaction that they're not going to get, cos each time they don't get that reaction that's a step closer to me going home..but each time they don't get the reaction that's another little turn up on my pressure cooker..waiting to explode. I can tell you this cos it's not going no further, and then that pressure cooker just goes up a lot and then I just go [explosion	*Swallow my pride* *Each situation well-managed is a step closer to home* *Build-up of badly managed situations leading to explosion*	*Compliance* *Behaviour as progressing or impeding movement* *Having no release for building frustrations- fearing consequences of expression*

motion]…and then one day I explode. L: That's what I was thinking you said you know I just do it and get on with it and in theory that all sounds fine, you put on a different face and you go ahead with it but inside it must be a struggle to hang on to what you have inside and not show it P: That's why I have to be so honest in my therapy sessions cos I have to sit there and cry. Cos if I don't cry I just fucking go off and I did the other week, I went off and they had to come out and they had to IM me because I was so uncontrollable and mmm..they had to Acuphase me and I just went no..please don't Acuphase me but they didn't, they didn't restrain me they just gave me and IM but I was off my head. L; There was an idea in what you said there about having to submit yourself to go along with the way things are done. Do you find that's something you have to do? P: Yes,mmm.. there's a saying it's hard to be an individual among the flowers whereas it's easier to go along with the current or whatever..yeah…sometimes you have to go along to everyone else's tune just to, just to pretend…cos if you go against the grain, you get fucked up... You have to play they game…and I don't mean play the game where you just tick a box because I genuinely do like DBT, but out there, out there is one big game L: Can you say what you mean, a bit more about that. P: Like, yes sir, no sir, three bags full sir. You know when I'm in DBT,	*Telling me is safe?* *Therapy to manage built up emotions* *Restraint as consequence* *"Please don't acuphase me"* *go along with the masses* *Go along to everyone else's tune* *If you go against the grain you get fucked up* *You have to play the game* *One big game*	*Caution in being open* *Therapy-safe place to express anger* *Needing safe space* *Restraint looming* *Conform with ward* *Compliance as easier* *Fearing negative consequences if non-compliant* *Having to play the game*

when I'm learning, I love it. But when I talk to the staff, it's all a false pretence. If I'm having a 1:1 with a member of staff that I genuinely get along with then I'm having a 1:1 with them and I'm telling them my true feelings but when I'm sitting there with them patients and that, none of them know me. They know my name, some of them know where I come from, none of them know what I'm in for. I wouldn't tell anyone about me because fucking news travels like the plague and it's dangerous. It's a dangerous environment to be in this is. And the staff, the staff are worse than the patients sometimes and I just keep myself to myself. And it's sad when you have to live like that but then you have to protect yourself over others don't you, so..	*Yes sir, no sir, three bags full sir* *Relationships with staff as false* *Other patients don't know me* *Keeping information about self from patients* *Environment is dangerous* *Keep myself to myself* *You have to protect yourself*	*Compliance* *inauthentic relationships* *Presenting false staff to patients* *Feeling unsafe/uncontained within ward* *Witholding self for protection*
L: How do you think that related to your recovery? You know, you said you're further along in your recovery than you were in the other ward?		
P: I've only just started learning this so..you know I think, I think it has a massive negative impact on my recovery because..at some point in your life you have to learn to trust someone. But if you can't learn to trust someone in this environment where the fuck are you going to learn to trust someone..I do trust some people. It's taken me 5.4 years. Along my journey there's been a handful of staff that have helped shape and mould me into something and them staff I will never forget because they made me, they helped me become the person I am today and they are just like fixtures in my life. And then there's staff that have hindered me and held me back.	*Witholding information as impeding recovery* *learn to trust* *Journey to trust people* *Staff have helped me trust* *Staff helped me become who I am today* *Staff as hindering recovery*	*Feeling I should be able to trust staff* *Learning to trust* *Trust takes time* *Relationships with staff as hindering or enabling recovery*

L: Can you tell me about that P: Some of the staff, you can tell the staff that don't see the true potential in you that don't want to help you and those that go out of their way to put barriers and blocks in your way and the ones that judge you. I know that I've done bad things but I'm not a bad person. And you can tell by the way staff look at you that they think you're the aggressor, and you're the one who deserves to be here and I think I'm not, I'm not..I need help.	*Not all staff see your potential* *Staff as blocking recovery* *Staff as judging* *Done bad things but not a bad person* *Staff believe you deserve to be here* *Here for help*	*Staff as blocking recovery* *totalising view* *Punishment vs treatment*
L: What does that do for your recovery when you feel that staff are looking at you as the aggressor and the person in the wrong P: It cuts me deep man. Not really much I can say, it cuts me deep. It's like the other day, there's a patient on here that keeps trying to attack me for some reason, she keeps trying to attack me and this member of staff said to me the other day, she said this other patient, she ain't the aggressor, [participant] is the aggressor. Now I've done nothing but show kindness to this patient, I've shown no aggression towards her. I've shown no signs of intimidation or anything and all she does is go for me and yet this member of staff thinks I'm the perpetrator and I just think what the fuck. And like maybe she sees something in me that I don't see in myself. I know I can be violent, I know that but I've never done anything to this patient and then it's	*Feeling hurt by staff's perceptions* *Being attacked by other patients* *Being accused as aggressor* *Staff see something in me that I don't*	*Managing negative judgements of staff* *Staff encounters as causing negative emotions* *Unsafe environment* *Questioning true self as staff views conflict with own*

like I was saying to you ages ago, maybe there's something in me that people see as violent and that makes me sad. But then who is she to have an opinion like that. How can she bring a personal opinion like that into the workplace with no judgements…do you know what I mean..is that fair me saying that?	*Feel saddened by others views of me* *Unfair that staff bring opinions to work*	*Staff views creating upset* *Anger at staff judgements* *Feeling unsure whether own opinions should be spoken* *Caution in openness*

Appendix ix. Example memo

20/10/17- Caution in disclosure

I came to meet the participant having been informed by my field supervisor yesterday that she had increased in risk and lost her leave. I checked with staff who informed me of the circumstances surrounding her losing her leave. The narrative focussed around the participant subverting security for what was assumed to be a significant period of time and taking alcohol to the unit, assisting her with sleeping. They informed me that this raised issues relating to her true ability to cope without alcohol.

Throughout our interview I became aware of my alignment shifting throughout the process. I was not as attached to my interview schedule as previous interviews, perhaps because I was aware of her emotional state. Throughout, she was motivated to let me know of her innocence and this moved towards anger at her team. She spoke about the conflict that arose within her having to manage what she says and keep her true feelings to herself. As she spoke I became aware that that had been my experience working in secure services. People appear fearful of disclosing issues which whilst they are close to discharge or transition may pose a threat to this progress. I reflected on my previous interviews where I detected a level of guardedness from participants and sensed that they were cautious about saying too much. Their responses often seemed to imitate the ethos of services and were at times depersonalised. I wondered whether a level of depersonalisation became a strategy for these women, minimising true desires, limiting true connectedness and feeding into disempowerment.

Appendix x. Charmaz (2014) tool for evaluating qualitative analysis

Credibility

- Has your research achieved intimate familiarity with the setting or topic?
- Are the data sufficient to merit your claims? Consider the range, number and depth of observations contained within the data.
- Have you made systematic comparisons between observations and between themes?
- Do the themes cover a wide range of empirical observations?
- Are there strong logical links between the gathered data and your argument and analysis?
- Has your research provided enough evidence for your claims to allow the reader to form an independent assessment and agree with your claims?

Originality

- Are your themes fresh? Do they offer new insights?
- Does your analysis provide a new conceptual rendering of the data?
- What is the social and theoretical significance of this work?
- How does your grounded theory challenge, extend, or refine current ideas, concepts and practices?

Resonance

- Do the themes portray the fullness of the studied experience?
- Have you revealed both luminal and unstable taken-for-granted meanings?
- Have you drawn links between larger collectivises or institutions and individual lives, when the data so indicates?
- Does your grounded theory make sense to your participants or people who share their circumstances? Does your analysis offer them deeper insights about their lives and worlds?

Usefulness

- Does your analysis offer interpretations that people can use in their everyday worlds?
- Do your analytic themes suggest any generic processes?
- If so, have you examined these generic processes for tacit implications?
- Can the analysis spark further research in other substantive areas?
- How does your work contribute to knowledge? How does it contribute to making a better world?

Academic Poster

How do women with a diagnosis of Borderline Personality Disorder detained in secure and locked services perceive recovery? A Grounded Theory.

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Background

Personal recovery may be conceptualised as a personal journey and "*a way of living a satisfying, hopeful, and contributing life even within the limitations caused by illness*". Recovery principles have been translated in mainstream mental health services, though challenges in engaging with recovery principles in specialist services have been noted. Research into recovery in forensic services has paid little attention to experiences of service-users with personality disorder. Studies of recovery in personality disorder is an emerging research area, though studies have largely recruited from community settings. Thus little is known about how recovery may experiences by women with BPD in forensic settings.

Aims

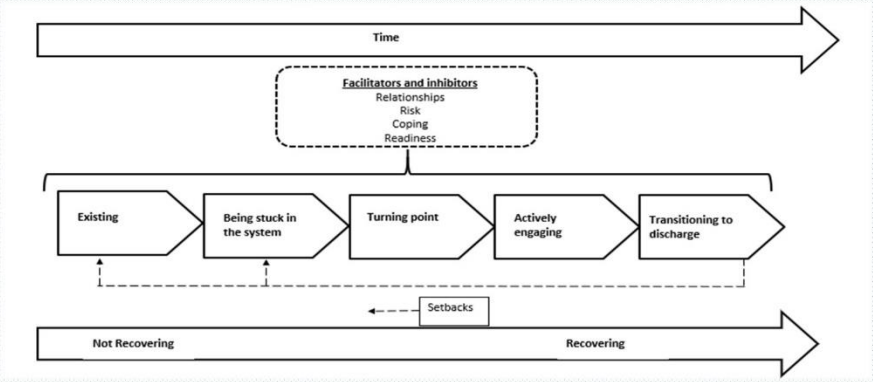
The study aimed to explore female service-users' views of and experiences of recovery; to relate findings from these accounts to extant theory; and to develop a theory that contributes to understanding the process of recovery for women with BPD in medium- and low-secure and locked rehabilitation services.

Method

Seven women with BPD diagnoses were recruited from secure and locked services in the UK. These women took part in semi-structured interviews which were conducted in an open-ended and non-directive manner. Constructivist grounded theory methodology was employed. Key features of this methodology involved theoretical sampling, the revision of interview schedules throughout analysis and the process of constant comparative analysis. Recruitment and analysis continued until theoretical sufficiency was achieved.

Results

Participants described recovery as an ongoing process comprising five sequential stages; existing, being stuck in the system, turning point, actively engaging, and transitioning to discharge. As participants progressed, they made a number of psychological adjustments towards recovery, but also experienced setbacks returning them to earlier stages. Factors such as risk, coping abilities, readiness and most significantly, relationships functioned as both facilitators and inhibitors of recovery. Constructs of coping and self-management were reflected as key recovery objectives. This is reflected in the grounded theory model below:



Conclusion

Relationships were described as the key facilitative factor for recovery, with safe relationships enabling the recovery process. Establishing safety in the secure environment and relational safety appeared unique to women with BPD in secure services. The absence of this disempowered participants, impacting upon motivation and perceived ability to recover. Tasks of coping and self-management, increasing self-awareness, finding relational security and coming to terms with harm done to them and the harm they have done to others represented unique tasks to this client group. The model reflects the ongoing nature of recovery.

Clinical Implications and Recommendations

Clinical implications include the emphasis which women with BPD place on relational aspects of the secure experience. The model extends beyond previously established change models through locating movement through stages as a function of relationships. Findings of the research could be strengthened through follow-up studies in the community post-discharge. Further research employing a longitudinal design may enhance these findings by mapping recovery progress over time.

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