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Doctoral Thesis:

Narrative Identities and Self-constructs of Individuals with Histories of Sexual and Violent Offences

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Word Counts

	Main Text	Appendices (including abstracts, tables, figures, footnotes, and references)	Total
Thesis abstract	300	-	300
Literature Review	8000	8482	16,482
Research Paper	8000	13,747	21,747
Critical Appraisal	4000	629	4629
Ethics Section	4634	5964	10,598
Total	24,934	28,822	53,756

Abstract

This thesis explores the narrative identities and self-constructs of individuals with histories of sexual and violent offences. It comprises of three sections: a systematic literature review of individuals' accounts of sexually abusing children, an empirical research study exploring the narratives of individuals with violent offending histories after engagement in schema therapy, and a critical appraisal reflecting on the relational aspects of doing qualitative research in forensic contexts.

The literature review is a meta-synthesis integrating eleven studies. The findings indicate individuals who have sexually abused children develop narratives of negating harm or of mutuality, facilitating ongoing abuse and leading to self-constructs dis-identifying themselves from dominant discourses of "sex offender" identities. The review presents a framework for considering offence processes within diverse forms of sexually harmful behaviours, identifying shared perspectives among heterogeneous groups. It also highlights how social constructions of this population can distance professionals, and individuals themselves, from personal narratives thus inhibiting meaningful considerations of risk and rehabilitation.

The research study explores the narratives of nine individuals from medium and high secure settings with histories of violent or sexual offending, who have engaged in schema therapy. Narrative analysis of transcripts identified self-constructs presented in interviews. Developing coherent and holistic narratives through schema therapy facilitates integration of offender identities within a more holistic self-construct integrating a multiplicity of selves. Individuals can then relate differently to themselves and others, suggesting reductions in risk of reoffending. Relationally secure contexts were crucial for therapeutic gains, and the study emphasises the fundamental importance of relational security for effective forensic rehabilitation.

The focus of the critical appraisal is congruent with the central role of relational aspects throughout the literature review and research study. Reflections are presented on interactions with participants, relating to written and spoken data, supervision, therapeutic relationships, and impacts of these on the thesis.

Declaration

This thesis records work undertaken for the Doctorate in Clinical Psychology at Lancaster University (Division of Health Research) from May 2013 to October 2014. The work presented here is the author's own, except where due reference is made. This work has not been submitted for the award of a higher degree elsewhere.

Name: Irram Walji

Signature:

Date:

Acknowledgements

I am grateful to the men who courageously shared their stories with me – I hope I have done justice to the narratives I was privileged to hear. My thanks also to my field supervisors, Lisa and Louise, whose passion and commitment to their work helped make this research possible.

Huge thanks to my fellow trainees of the 2011 cohort – I feel so lucky to have shared this journey with such incredible people, and I hope our cohesiveness, caring, and other cake-related values will continue to connect us. And thank you to my wonderful tutor, Jen, for your constant, gentle encouragement and for modelling compassion so beautifully.

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My heartfelt thanks to Riaz, who is always inspiring me not to be satisfied with the stories that come before me, but to unfold my own. Thank you for everything. The last three years would not have been possible without your love and support - I couldn't have done it without you.

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Abstract

This meta-synthesis of individuals' accounts of sexual offending towards children explores how such individuals conceptualise themselves and their victims. Findings of eleven qualitative studies were integrated to construct five core concepts: (1) *pre-empting consequences: preventing disclosure and discovery*; (2) *inter and intra-personal processes: sexualised coping, self-esteem, and social status*; (3) *objectification and ownership: commodity to conquer, control, or collect*; (4) *mutuality: love, care, and consent*; and (5) *I am not a sex offender: stigmatised sexuality and disassociation from doing harm*. A line of argument derived from these concepts offers a hypothetical framework for considering different stages of offence processes within diverse forms of sexually harmful behaviours, highlighting shared perspectives among heterogeneous groups. Individuals' offence accounts can offer rich insights for understanding child sexual abuse, therefore creating space within research and clinical contexts for these narratives to be heard has implications for best practice in psychotherapeutic interventions and risk management.

Keywords: child sexual abuse; paedophilia; sex offender; qualitative; review; meta-synthesis

Accounts of engaging in sexually abusive behaviours towards children: A meta-synthesis

The offence accounts of individuals engaging in sexually harmful behaviours towards children are used in criminal justice processes for determining sentences (Read & Powell, 2011), in correctional or secure services for assessment and risk management (Sullivan, 2005), and in rehabilitation for identifying therapeutic targets (Adshead, 2012; Ward & Marshall, 2007). An individual's offence account is therefore likely to be experienced differently by different professionals according to the motivations of those eliciting that account (Adshead, 1998). Despite these differences, underlying objectives for hearing such accounts share aims of understanding offending behaviours and reducing recidivism (Adshead, 2012; Ward & Marshall, 2007).

Offending behaviours constitute a significant impetus for professionals and clinicians to develop credible hypotheses, and this explicatory imperative is stronger for behaviours appearing more incomprehensible such as child sexual abuse (Adshead, 1998). However, understanding individuals' perceptions of their own behaviour is necessary for facilitating rehabilitation and reducing risk of reoffending (Duff, 2011; Mann & Hollin, 2007). It is only by hearing such stories in research or therapeutic contexts that professionals can develop hypotheses and theories about sexual offending on which further research and clinical approaches can be based (Ward & Marshall, 2007). The process of constructing a narrative offence account indicates how individuals understand their experiences, and offers insight into beliefs about self and others, attitudes towards risk, motivations and goals, and values influencing how goals are achieved (Adshead, 2012; Ward & Marshall, 2007).

However, individuals' accounts of offending behaviours are often medicalised, stigmatised, or sensationalised, reducing rather than enhancing understanding (Waldram, 2007).

While victim accounts are justifiably given priority and attention, narratives of those who have offended are often viewed dismissively or sceptically (Presser, 2010; Waldram, 2007). The voices of those who have sexually abused children are seldom heard other than in the contexts mentioned earlier. This may be due to personal or social aversion against hearing such stories (Roberts, 2011), moral viewpoints considering these individuals to have lost the prerogative of presenting their perspectives (Waldram, 2007), or because these stories are deemed valueless under the assumption events will be minimised, denied, or distorted (Bartlett & Canvin, 2003; Presser, 2009).

Such obstacles to meaningfully considering these perspectives mean societal prejudice and stigma toward this group remains uninformed by professional discourse, thus perpetuating social constructions of "paedophiles" based upon dominant narratives in which such individuals are evil, predatory, and inherently irredeemable (Gavin, 2005). Professionals are constituents of society and may therefore find it difficult to engage critically with its dominant narratives (Gavin, 2005), and the emotional impact of hearing subjective experiences of sexual offending may further reinforce professional avoidance (Roberts, 2011; Sollund, 2008; Waldram, 2007). These constructions are therefore infrequently challenged across most contexts and implicitly considered as realities rather than societal narratives, inadvertently maintaining stigmatising attitudes and avoidance of meaningful professional engagement (Gavin, 2005).

Consequently, expert discourses rather than perspectives of individuals themselves are often primary sources for developing assessments, care plans, and interventions (Adshead, 2012; Sullivan, 2005). However, this frequently results in eisegetical understandings of individuals' narratives, serving to corroborate pre-conceived clinical frameworks that inherently emphasise and privilege the legitimacy of professional perspectives (Sullivan, 2005). This can lead to therapeutic and risk management strategies incongruent with the ethos of person-centred care (Mann & Hollin, 2007). While professional conceptualisations are valuable in formulating strategies for managing risk and reducing reoffending, there also needs to be space for individual narratives (Gilgun & Connor, 1989; Sullivan, 2005).

Furthermore, a significant proportion of those who sexually abuse children have been victims of such abuse themselves (Glasser et al., 2001), so engaging with the narratives of these individuals can provide unique insights into breaking this cycle (Colton, Roberts, & Vanstone, 2012; Elliott, Browne, & Kilcoyne, 1995; Garrett, 2010; Thomas et al., 2012). Enactments of reciprocal roles of 'abuser' and 'abused' are often significant factors in offending behaviour, and compassion and care should not be dependent on whether individuals represent one or both of these roles (Waldram, 2007). Eliciting offence accounts can also facilitate further psychotherapeutic interventions, as fragmented narrative identities can reveal unresolved distress, dissociation, or trauma, which may be pertinent to rehabilitation and risk management strategies (Adshead, 2012).

Previous Research and Rationale for Review

Research within this domain has largely been quantitative in nature (Sullivan, 2005), and theoretical efforts to understand sexual offending are therefore primarily based on measurement of factors associated with offending behaviours, treatment

outcomes, and recidivism, usually through structured questionnaires, clinical data, and reoffending figures (Gannon & Polaschek, 2006). However, information required to develop theoretical models and enhance clinical practice cannot be captured exclusively through such methods, and the richly detailed and nuanced products of qualitative methodologies can triangulate data to produce innovative hypotheses.

For example, the recent increased use of grounded theory and discourse analysis to examine cognitions and schemas of individuals with histories of sexual offending has led to significant theoretical developments such as Ward's implicit theories model (Ward & Keenan, 1999). This model suggests individuals develop theories shaping their perceptions and understanding of interactions and relationships with children (*children as sexual objects*, *entitlement*, *dangerous world*, *uncontrollability*, and *nature of harm*) (Ward & Keenan, 1999). However, relatively few other models with equivalent impact have emerged in this domain since Finkelhor's four-factor model (Finkelhor, 1984), which was one of the first comprehensive multi-factorial theories (Gannon & Polaschek, 2006; Gannon, Ward, & Collie, 2007). This model suggests four factors underlying the reasons individuals sexually abuse children: *emotional congruence*, *sexual arousal to children*, *blockage*, and *disinhibition*. The first three of these four factors comprise one of four pre-conditions (*motivation to sexual abuse*) needed for sexual abuse to occur; other pre-conditions are *overcoming internal inhibitions*, *overcoming external inhibitions*, and *resistance by child* (Finkelhor, 1984).

Subsequent paradigm shifts in research attitudes, focussing on offence narratives rather than static measurement of cognitions, have produced richer data leading to coherent theory development; this enhances clinical practice and strategies for managing risk thereby potentially reducing reoffending (Burn & Brown, 2006).

Recognition of valuable outcomes from qualitative studies has encouraged further use of such methodologies (Webster & Marshall, 2004), but there remains a relative dearth of such research on this topic (Colton, Roberts, & Vanstone, 2009). Even within studies adopting qualitative approaches, accounts are often paraphrased or reduced to be presented in categories constructed by the researcher, and minimal raw data is presented as direct excerpts (Sullivan, 2005). Findings are therefore frequently less representative of participants' voices, and more reflective of the researcher's interpretation of how such accounts fit with pre-conceived hypotheses and theories, limiting opportunities for narratives to be analysed without expert discourses influencing how they are heard. While it would be erroneous to assume either researcher or participant constructions are exclusively valid, privileging one perspective unduly may overlook sources of potentially valuable information (Sullivan, 2005).

Nevertheless, there are an increasing number of published qualitative studies engaging directly with offence accounts of individuals who have sexually offended against children. No systematic review or meta-synthesis of such studies has been identified, so this is a timely opportunity to consolidate the qualitative evidence gathered to date, providing a foundation from which to consider directions for further research. While quantitative systematic reviews and meta-analyses aim to aggregate findings of similar studies, a systematic synthesis of qualitative studies requires an interpretative approach (Finfgeld, 2003).

Accordingly, it is proposed a systematic meta-synthesis of the growing body of empirical research eliciting individuals' accounts of child sexual offences would collate and re-interpret findings, clarifying emerging models and concepts (Finfgeld, 2003). Meta-synthesis conceptualises different studies relative to each other whilst

retaining the individual richness of participants' experiences, enabling multiple facets of similar findings to be explored (Sandelowski, Docherty, & Emden, 1997). This offers a higher level of understanding, and increases the transferable value of current findings for development of policy and practice, as well as improving their accessibility for clinicians (Downe, 2008).

A search of electronic databases identified one published (non-systematic) review in this area (Lawson, 2003), which aimed to examine thoughts, behaviours, and relationships of individuals with offending histories in order to explore and understand such behaviours from their own perspectives. Points of difference from the current proposed review are presented in Table 1.

_____Table 1_____

Aims

This meta-synthesis of individuals' accounts of sexual offending towards children aims to explore how such individuals conceptualise themselves and their victims, including an understanding of offending behaviours encompassing motivations, emotional and relational processes, and cognitive strategies used to normalise or justify such behaviours to others and themselves. The inclusion of a heterogeneous sample of studies may also highlight similarities or differences in these accounts between intra and extra-familial offences and contact and non-contact (internet) offences.

Method

Search Strategy

Five electronic databases were searched (PsycINFO, CINAHL, ScienceDirect, Academic Search Complete, and Web of Science), during April and May 2013 using the following search terms: [Subject / Keyword: ("sex* offen*" OR "sex* abuser*"

OR incest OR "incest offen*" OR pedophil* OR paedophil* OR "child abuser*" OR "child molest*" OR "child pornography")] AND [Abstract / Text: (qualitative OR "grounded theory" OR theme* OR phenomenological OR quotations)] NOT [Title: (survivor* OR victim* OR recover* OR disclos*)]. Some modification was needed as search functions differed within databases (see Appendix B for database-specific searches). Subsequently, recent editions of journals relevant to the research question were searched by hand, and references of articles pertaining to the review were also checked for any further studies of relevance (Sandelowski et al., 1997).

Inclusion and exclusion criteria. In total, 1040 studies were found through the systematic search strategy (see Figure 1).

_____Figure 1_____

Studies considered relevant to this meta-synthesis were then reviewed with the inclusion and exclusion criteria presented in Table 2.

_____Table 2_____

Final sample of studies. A total of eleven articles were suitable for inclusion in this meta-synthesis (see Table 3). This was deemed an appropriate number of studies for a qualitative review, as large numbers can reduce interpretive validity by preventing sufficient depth of analysis (Sandelowski et al., 1997). To maximise results, the search was not limited by date, and the final sample included studies conducted between 1994 and 2012.

Five of the studies (Gilgun, 1994, 1995; Hartley, 1998, 2001; Phelan, 1995) were included in the previous review (Lawson, 2003); however, the inclusion of six further studies published after 2001 (Brown, Walker, Gannon, & Keown, 2012; Holt, Blevins, & Burkert, 2010; Quayle & Taylor, 2002; Sheehan & Sullivan, 2010; Winder & Gough, 2010) enabled a more current and broader conceptualisation of child sexual

abuse. This also included studies considering internet-related offences, as differences and similarities with non-internet sexual offending warrant further exploration (Williams, Elliott, & Beech, 2013).

_____Table 3_____

Methodology

Meta-synthesis aims to explore significant similarities and differences around a specific topic in order to expand interpretive possibilities of findings through constructing larger, more encompassing narratives (Sandelowski et al., 1997). The findings from the eleven qualitative studies included in this review were synthesised using the meta-ethnographic method proposed by Noblit and Hare (1988) as shown in Figure 2.

_____Figure 2_____

Table 4 presents an overview of the process to demonstrate how the final iteration of core concepts emerged.

_____Table 4_____

Findings

Five core concepts emerged from this metasynthesis of qualitative studies focussing on individuals' accounts of engaging in sexually abusive behaviours towards children: (1) *pre-empting consequences: preventing disclosure and discovery*; (2) *inter and intra-personal processes: sexualised coping, self-esteem, and social status*; (3) *objectification and ownership: commodity to conquer, control, or collect*; (4) *mutuality: love, care, and consent*; and (5) *I am not a sex offender: stigmatised sexuality and disassociation from doing harm*. These concepts and their comprising sub-themes are presented in a thematic map (Figure 3).

_____Figure 3_____

Inter and Intra-personal Processes: Sexualised Coping, Self-esteem, and Social Status

Many individuals reported using sexualised coping for negative or distressing emotions, with limited alternative coping strategies (Quayle & Taylor, 2002). Such emotions were most frequently triggered by unsatisfactory emotional and sexual relationships (Hartley, 2001; Quayle & Taylor, 2002). When individuals experienced emotional rejection or a lack of affection, they sought consolation from children who were powerless to refuse their sexual advances: "…the sexual contact was just a way for me to feel better, to feel accepted. To feel wanted..." (Hartley, 2001, p. 465), and sometimes imagined themselves as peers of their victims: "…I had friends…I'd go right back to damned loneliness after the weekend was over, even with my wife there…with kids there, the loneliness went away…" (Gilgun, 1994, p. 474).

Accessing images of child sexual abuse was also effective for coping with negative emotions by enabling individuals to create and inhabit a secret space, providing alternative sources of pleasure and excitement (Quayle & Taylor, 2002; Sheehan & Sullivan, 2010). This emotional and physical escapism facilitated avoidance of aversive situations or relationships through sexual arousal as "…it shut out the…part of my life that I was finding difficult to deal with…it was sort of my time, it was my space…" (Quayle & Taylor, 2002, p. 349). Furthermore, viewing abusive images also enabled individuals to gain a sense of control and power missing in their lives, since "…it was just a picture…they couldn't talk back to you…they couldn't argue…they couldn't run away..." (Quayle & Taylor, 2002, p. 349). Abusive images facilitated development of new sexual fantasies, and masturbation to these compensated for unsatisfying relationships (Quayle & Taylor, 2002; Sheehan & Sullivan, 2010). Moreover, some individuals considered masturbation to such images

an acceptable alternative to satisfying sexual needs without committing contact offences (Quayle & Taylor, 2002; Sheehan & Sullivan, 2010).

Viewing, trading, and producing abusive images allowed individuals to feel connected to others, as "…pornography was there almost as much to facilitate the on-line relationship as an end in itself…" (Quayle & Taylor, 2002, p. 345). Exchange and trading of abusive images facilitated access to a community where "…these images were currency…because it allowed me to maintain my relationship with the people…" (Quayle & Taylor, 2002, p. 348). Individuals who produced images themselves, especially of their own children, enjoyed greater social status (Quayle & Taylor, 2002; Sheehan & Sullivan, 2010), increasing their self-esteem: "…the only reason I was getting all the, this attention was that it was known that I was a producer…" (Sheehan & Sullivan, 2010, p. 163). This created hierarchies where membership of select groups facilitated privileged access to personal images (Quayle & Taylor, 2002). Social status also increased with the number of images possessed, encouraging individuals to develop large collections accessible to selected others, also enabling them to feel they were serving the online community (Quayle & Taylor, 2002).

Pre-empting Consequences: Preventing Disclosure and Discovery

Individuals' offence accounts frequently referred to planning and preparatory behaviours prior to or during initiation of sexually harmful activities. Such behaviours were covert to avoid detection; for example: "…look at the boys with their mothers next to them. If a friend notices that your attention is elsewhere, just comment on the mother…" (Holt et al., 2010, p. 18). Individuals engaging in incestuous behaviours incorporated sexual advances within normative family activities: "…I would put her to bed, I would give her a goodnight kiss, another hug,

and then little-by-little I started touching her and caressing her…I started caressing her under her dress and stuff like that, inside her panties…" (Phelan, 1995, p. 11). Moreover, subtle approaches avoided eliciting negative reactions from the child, who would initially be unsure whether touching was intentional thus inhibiting disclosure, and meant individuals could withdraw and seek alternative opportunities if children became suspicious (Phelan, 1995). However, if children did not resist or complain, sexual activity gradually progressed in both frequency and severity.

Conversely, some individuals did not consider their behaviour harmful, especially if they had not had intercourse (Gilgun, 1995), and were therefore unconcerned with potential consequences or discovery:

> …I just caressed her. I didn't grab her breasts or try to have sex with her or anything like that. Or make her touch me or anything like that. I was just caressing her. And I kept telling myself…I didn't really do nothing that was that bad (Hartley, 1998, p. 131).

Others thought children did not mind or actively wanted to continue sexual activities (Hartley, 1998; Phelan, 1995), or formulated pre-emptive justifications for their behaviour to render it permissible to others: "…although I wasn't drinking, I could say I was. 'Cause I knew there was a huge tolerance for crimes committed by people who were drinking…the alcohol made him do it…" (Hartley, 1998, p. 30).

Nevertheless, the majority of individuals were aware such behaviours were impermissible; some considered moral or religious perspectives, while others mentioned societal taboos around incest and child sexual abuse (Hartley, 1998; Phelan, 1995; Sheehan & Sullivan, 2010). Most individuals were apprehensive about the impact of discovery on their lives and relationships (Gilgun, 1995; Hartley, 1998; Holt et al., 2010; Phelan, 1995), although such fears lay on a continuum with some

preoccupied with discovery and others claiming they never thought about it or blocked out such thoughts (Hartley, 1998). Similarly, awareness of legal consequences ranged from knowing it was illegal to realising one could face long custodial sentences (Gilgun, 1995; Holt et al., 2010; Phelan, 1995). While many individuals were aware of legal sanctions against child sexual abuse, others had only considered familial and social penalties: "…I figured that 'All I got to do is deny this…I never am going to get prosecuted for it.'…I don't remember fear of the law, just the embarrassment of losin' my family…" (Hartley, 1998, p. 30).

Given the seriousness of potential consequences, most individuals attempted to pre-empt and prevent disclosure / discovery. Some used bribery, threats, or manipulation to avoid disclosure and compel the child to continue engaging in sexual activity (Gilgun, 1995; Phelan, 1995). If children became aware such behaviours were impermissible, individuals portrayed responsiveness in order to continue the abuse:

> …I'd tell her, "Yeah, I know that. I'm sick, and someday I'll get help,"
> …If I'd tell her that, she would usually leave her guard down…I told her it was wrong because that's what she wanted to hear. I didn't really feel it was wrong (Gilgun, 1995, p. 273).

Individuals also pre-empted accidental discovery through precautionary measures such as only engaging in sexually harmful behaviours when they could ensure privacy, which included steps to maintain anonymity online (Gilgun, 1995; Holt et al., 2010). Some planned denials that sexual abuse had occurred, and considered measures to conceal evidence including encryption and secure destruction of computer software and hardware (Hartley, 1998; Holt et al., 2010). Awareness of the impermissibility of sexually harmful behaviours did not lead to cessation of such

activity, as potential consequences were outweighed by the pleasure and excitement derived from sexual contact with children (Gilgun, 1995; Phelan, 1995).

Objectification and Ownership: Commodity to Conquer, Control, or Collect

Sexual gratification was frequently identified as a primary motivation for engaging in sexually abusive behaviours (Gilgun, 1994; Hartley, 2001; Phelan, 1995; Quayle & Taylor, 2002). Some individuals stated sex was important to them generally, and perceived children as sources of stimulation to overcome sexual frustration (Gilgun, 1994; Hartley, 2001; Phelan, 1995). There were nuances in how they attained this, with some stating:

> …I didn't want to physically hurt her, but…I was after more of what I wanted for me…[If she said it hurt]…I would say, "OK. We'll wait a minute and we'll try again." And just continue like that until I got what I wanted (Gilgun, 1994, p. 472).

Others acknowledged "…I knew I was hurting her the whole time I was doing it…" (Gilgun, 1994, p. 472), but continued because there was no compulsion to stop (Hartley, 2001; Phelan, 1995). Individuals did not consider the appropriateness of sexual contact with children, and children often became equivalent to adults as sexual partners (Hartley, 2001; Phelan, 1995). Others saw children as additional, accessible sources of sexual gratification available to them (Phelan, 1995). Some were sexually aroused by the child through developing sexual fantasies, increasing desire and frustration until they felt compelled to initiate sexual contact (Hartley, 2001). Sexual fantasies involving children were forbidden and novel and therefore exciting, and abusive images were one way of developing these, although satiation led to searching for more extreme images (with regard to age of children or type of sexual activity) to maintain arousal (Quayle & Taylor, 2002).

Motivations other than sexual gratification were frequently reported. Some behaviours were expressions of anger, punishment, or revenge directed towards a third person who loved the child, such as a partner who had been unfaithful or withholding sex (Gilgun, 1994; Hartley, 2001). Anger could also be directed toward persons who had abused them during their own childhood (Hartley, 2001), or toward the child perceived as being sexually provocative (Gilgun, 1994) or disrespectful (Phelan, 1995).

For several individuals, sexual gratification was a secondary consideration: "…there was some [sexual] excitement, but it was also power and control…I remember saying to myself, 'This person is not 10 years old, it is an adult-size body—a female that I have control over'…" (Phelan, 1995, p. 14). Sexual pleasure derived from dominance and control was frequently mentioned (Gilgun, 1994, 1995; Phelan, 1995; Quayle & Taylor, 2002), with manipulation enhancing this: "…this is going to be my conquest…I was setting her up to be a person the way I wanted her to be for my gratification and my needs…" (Gilgun, 1994, p. 473). Individuals used power from caregiving or authoritative roles to take advantage of children's vulnerability, trust, and dependence: "…in your daughter's eyes, Dad can do no wrong…If Dad says it's okay, it's okay…" (Gilgun, 1995, p. 276); however, they also used bargaining, threatening, or blackmailing tactics for overcoming resistance (Gilgun, 1994). There was therefore a sense of the child as an object to provide sexual gratification or elicit feelings of power and control (Gilgun, 1995; Phelan, 1995; Quayle & Taylor, 2002).

Objectification removed consideration of the child as a person with their own mind and enabled a sense of ownership over them, especially apparent when individuals discussed paternal rights: "…she's my daughter. She needs to take care of my needs…" (Gilgun, 1995, p. 276); they felt they were entitled to sexual contact

because the child was "theirs", whereas sexual abuse of children outside the family was unacceptable (Gilgun, 1995; Phelan, 1995).

This sense of the child as a possession was most explicit in relation to abusive images, where these functioned to depersonalise children so "…it wasn't a person at all it was…it was just a flat image…it was a nothing…" (Quayle & Taylor, 2002, p. 344). Since the image was an object, the child also became an object: "…there was a sense that…although these represented real people…because they were photographs…that kind of material…was in no way really connected with the original act…" (Quayle & Taylor, 2002, p. 344). Language used to describe how images were collated, organised, and commercially valued was similar to that describing other collectibles or commodities, and collections were compared to stamps or baseball cards (Quayle & Taylor, 2002).

Mutuality: Love, Care, and Consent

The majority of individuals indicated they considered children as sexual beings (Brown et al., 2012; Durkin & Bryant, 1999; Gilgun, 1994, 1995; Hartley, 1998, 2001; Holt et al., 2010; Phelan, 1995). This sometimes originated from personal experiences of childhood sexual abuse (Brown et al., 2012) but often, certain behaviours of children were perceived as implicit invitations to initiate sexual contact: "…we were wrestling, afterwards she sat on my lap and kissed me on the mouth and put her tongue in mine [daughter was 6 years old]…" (Phelan, 1995, p. 16). Another common example was the child coming into the bed of the individual (Brown et al., 2012; Hartley, 1998; Phelan, 1995), and such behaviours did not need to be of a sexual nature: "…I would go in and say goodnight to my stepdaughter. I'd kiss her on the cheek…I got the impression that she was giving me a signal…She'd put her arms around my neck and she would hold me to her…" (Phelan, 1995, p. 16). Children's

lack of resistance or overt negative responses were interpreted as acceptance and active participation, thereby reinforcing understandings of children as sexual beings (Brown et al., 2012; Hartley, 2001; Phelan, 1995).

Progression of abuse resulted in sexualisation of children's behaviour, confirming individuals' perceptions of children's sexuality and the reciprocity of sexual activity (Brown et al., 2012; Gilgun, 1995; Phelan, 1995). Individuals therefore conceptualised children as capable of consenting to or requesting sexual activity, and having desires to provide and experience sexual arousal and pleasure:

> …I'd ask him if he enjoyed this or that. He'd say, "Yes, Dad, I love it," and I'd say, "Do you want to quit…he'd say, "No," and when he would masturbate me or fellate me, he would tell me, "I'm going to make you feel good" (Gilgun, 1995, p. 272).

Some argued children had equivalent rights to adults regarding sexual relationships (Durkin & Bryant, 1999; Holt et al., 2010) because "…a child is a sexual being…children can and do have the ability to decide for themselves what they want…children that are sexually active should be left to themselves to decide who should be their sex partner…" (Durkin & Bryant, 1999, p. 117).

Considering children as sexual beings often resulted from perceptions of the child consenting to sexual activity when they could have objected (Brown et al., 2012; Gilgun, 1995; Hartley, 1998; Phelan, 1995). Such perceptions were based on observations such as the child "…just seemed to accept it as normal part of life and attitudes towards me didn't change so still hugged us still cuddled us, I was still dad…" (Brown et al., 2012, p. 10); when relationships with children did not change as anticipated, individuals assumed the child assented to sexual contact (Brown et al., 2012; Hartley, 1998; Phelan, 1995). Some perceived tacit consent in a lack of

physical resistance (Hartley, 1998; Phelan, 1995) or ongoing interaction (Brown et al., 2012; Hartley, 1998; Phelan, 1995).

Many individuals reported they had not forced sexual contact but only engaged in activities children agreed to (Brown et al., 2012; Gilgun, 1995; Hartley, 1998; Phelan, 1995), and gave examples of asking for permission: "…I would have oral sex with her, and I would ask her if she wanted to try something else. If she had said, 'No, no, no.'…I'd say, 'OK.' But if she would have said OK then it would have…progressed…" (Hartley, 1998, p. 35). Instances of resistance confirmed children were capable of refusing if they wished to, and individuals reported responsivity when this occurred (Hartley, 1998; Phelan, 1995). Some extended this to a greater degree by designating children as gatekeepers: "…I was afraid that it was going to come to actual intercourse, and I told her at that time that if I made any advances to her that she was to reject them…" (Gilgun, 1995, p. 276); however, individuals admitted continuing despite resistance, confusing the child as to where responsibility for subsequent abuse lay (Gilgun, 1995).

Many individuals felt they were in love with the child and consequently, language describing relationships with children referred to infatuation, love affairs, going out, cuddling, and making love (Brown et al., 2012; Durkin & Bryant, 1999; Gilgun, 1994, 1995; Hartley, 2001; Holt et al., 2010). Some saw children in the role of a partner: "…I thought I could leave my wife and take my daughter with me, and we would go off to wherever. It was like I had two wives…" (Gilgun, 1995, p. 271). Individuals who experienced intense feelings of bliss or closeness valued this more than sexual contact (Gilgun, 1995). Many expressed a deep sense of caring for the child, and used sexual contact to make children feel loved (Brown et al., 2012) or demonstrate their own love (Hartley, 2001). Some individuals used sexual contact to

offer comfort when they identified with loneliness or emotional pain they perceived (or projected) in a child (Gilgun, 1995). Others stated sexual relationships with adults could be beneficial for children's self-esteem and development (Durkin & Bryant, 1999).

I am not a Sex Offender: Stigmatised Sexuality and Disassociation From Doing Harm

Many individuals felt their sexual behaviour was not harming children (Brown et al., 2012; Durkin & Bryant, 1999; Gilgun, 1995; Holt et al., 2010; Quayle & Taylor, 2002; Sheehan & Sullivan, 2010; Winder & Gough, 2010). This was most strongly emphasised by those whose offending behaviours related to abusive images, and who felt they had not created any victims (Quayle & Taylor, 2002; Sheehan & Sullivan, 2010; Winder & Gough, 2010). Fantasising and masturbating over images did not constitute child abuse because

> …there was no harm in looking at pictures… any abuse that had happened to the children, whether it was a bad or a good thing, had happened, and my looking at the pictures was not going to change it and my fantasizing and masturbating was not going to hurt anybody (Sheehan & Sullivan, 2010, p. 155).

Some individuals were aware of abuse associated with production of sexual images, but avoided pictures depicting distress and sought those portraying happy children, as smiling indicated they had not been hurt or coerced and were therefore unharmed (Quayle & Taylor, 2002; Winder & Gough, 2010). This perception was not limited to abusive images but was also applicable to sexual activity (Durkin & Bryant, 1999).

Several individuals acknowledged sexual contact with children was abusive, but denied intent to cause harm (Brown et al., 2012; Quayle & Taylor, 2002; Winder

& Gough, 2010). Some stated personal experiences of childhood sexual abuse predisposed them to abuse children, or to believe such contact was permissible or not harmful (Brown et al., 2012). Others felt their sexually harmful behaviours were uncontrollable due to substance misuse, over-whelming emotions such as anger (Brown et al., 2012), or irrepressible sexual arousal to children (Brown et al., 2012; Winder & Gough, 2010). Responsibility for harm was therefore placed with others who had failed to provide appropriate supervision and support (Brown et al., 2012).

There was also a discourse where sexual attraction to children was seen as an alternative sexuality: "…BoyLove is a natural thing, like being born gay or even straight. It's something you can't control or choose…" (Holt et al., 2010, p. 10), with frequent references to being an oppressed sexual minority, and comparisons with previous stigma around homosexuality (Durkin & Bryant, 1999; Holt et al., 2010; Quayle & Taylor, 2002; Sheehan & Sullivan, 2010; Winder & Gough, 2010). Marginalisation by others reinforced a sense of virtual community (Holt et al., 2010), and individuals shared frustrations that their sexuality was unacceptable to society (Durkin & Bryant, 1999; Holt et al., 2010). There was an assertion that "…child rape [not consensual child love] is bad…" (Holt et al., 2010, p. 14), and terms such as "minor attracted adult", "child-love" and "boy-lover" were used in reference to these relationships (Durkin & Bryant, 1999; Holt et al., 2010). They disagreed with sanctions on sexual relationships between children and adults (Sheehan & Sullivan, 2010), and highlighted varying ages of consent in different countries emphasising the arbitrariness of illegality (Quayle & Taylor, 2002; Winder & Gough, 2010).

Many individuals emphatically differentiated themselves from "sex offenders" or "paedophiles" who sexually abused children (Brown et al., 2012; Gilgun, 1995; Holt et al., 2010; Quayle & Taylor, 2002; Winder & Gough, 2010). They did not

consider their behaviours abusive: "…what I was doing was different. I was making love to my daughter…" (Gilgun, 1995, p. 275), or as offences because "…rape was, um when you fought someone…you didn't rape a person if um they…were there waiting…" (Brown et al., 2012, p. 7). Hence they did not wish to be grouped with "sex offenders" who "…deserve to be castrated and then tossed into prison…See how they like being used and abused…" (Holt et al., 2010, p. 15). This was especially pertinent for those with offences related to abusive images (Quayle & Taylor, 2002; Sheehan & Sullivan, 2010; Winder & Gough, 2010) who did not want to be considered non-contact offenders either because

> …non contact can include flashers…flashers see their victims, it can also include people who um do sexual things to themselves in front of people…again they're creating victims…I've not had any contact whatsoever with any human being…all these children on the internet pictures…I have never met any of them, I have never seen any of them (Winder & Gough, 2010, p. 135).

Discussion and Conclusions

This meta-synthesis aimed to explore how individuals who engage in sexually abusive behaviour towards children conceptualise themselves and their victims. The findings of this review are summarised by proposing a line of argument encompassing the core concepts identified through the meta-synthesis. The findings are also considered in relation to previous research on this topic, and clinical implications are discussed.

Line of Argument

This serves as a hypothetical framework for considering child sexual abuse from the perspectives of individuals who have such offence histories, elicited through

integrating data from offence accounts presented in the eleven qualitative studies included in this review (see Figure 4).

_____Figure 4_____

This framework suggests individuals enact inter and intra-personal processes maintaining and reinforcing sexualised coping strategies. It is hypothesised individuals who already use sexualised coping to compensate for negative self-states may be predisposed to seeking sexual contact with children when experiencing emotional or relational difficulties. Accessing abusive images and sexual contact with children may enhance mood and self-esteem, and facilitate social interactions with others, thereby reinforcing and maintaining further sexually harmful behaviours.

As well as emotional factors, the framework hypothesises there are several practical factors facilitating sexually abusive behaviours. Awareness of legal and societal penalties for child sexual abuse means pre-empting consequences of discovery may be an important consideration even prior to instigating sexually harmful behaviours. Gradually initiating children into progressively serious sexual activity, with corresponding efforts to prevent detection, may increase perceptions of permissibility when no immediate negative consequences are experienced. This further reinforces and maintains sexually harmful behaviours, as well as facilitating their continuation through ongoing efforts to avoid discovery or disclosure.

The framework hypothesises individuals may develop certain narratives enabling them to continue sexual contact with children. One such narrative focuses on mutuality, where desires for connection and intimacy take precedence over considering harm. In such instances, individuals develop beliefs around the reciprocity of sexual relationships with children, convincing themselves they are providing love and care. The absence of physical resistance, objection, or disclosure,

coupled with feelings of love and ongoing normative interactions and sexualised behaviour by the child, serves to reinforce the mutuality narrative thus rendering issues of harm and consent irrelevant.

An alternative narrative focuses on objectification and ownership, where children are depersonalised and perceived as objects for sexual gratification. Some individuals feel familial roles entitle them to sexual contact with children considered "theirs", while others perceive sexual activity with children as conquests where evoked feelings of control, dominance, and power become compelling drives to continue such behaviour. Alternatively, the child is considered irrelevant, and sexual abuse perceived as a means of inflicting pain or taking revenge on others. Objectification and depersonalisation is extended further for abusive images where children become pictures and therefore commodities to be collected, traded, or used. In all these instances, consent and harm are not considerations, as these concepts are inapplicable to possessed objects.

The proposed framework[1] suggests such narratives result in self-constructs enabling sexually abusive behaviour to be incorporated within an individual's identity while disassociating from acknowledging harm caused. When children are considered objects to be owned or consensual partners in a relationship, harm is minimised or negated. The belief that sexual attraction or arousal towards children is uncontrollable also nullifies harm by mitigating personal responsibility and intent. Individuals therefore dis-identify from being "sex offenders", and may position themselves in condemning roles in relation to others convicted for similar offences

[1] This framework has been developed solely from data in the studies reviewed, therefore factors not identified by this analysis may also need to be considered. For example, some individuals may accept and disregard transgression of societal or legal codes thereby making no effort to prevent discovery of offending behaviours. Gradual progression of sexual activity may also serve purposes other than preventing disclosure, such as overcoming personal inhibitions or children's resistance. Similarly, mutuality narratives may have other effects not highlighted here, such as reinforcing sexualised inter and intra-personal processes.

but who transgress boundaries of behaviours considered permissible. Some individuals extend this concept further and perceive sexual attraction to children as an alternative sexuality, albeit one stigmatised and marginalised by society.

Previous Research

The findings of this meta-synthesis are considered in relation to models offering a framework for understanding child sexual abuse from the perspectives of individuals committing such offences, namely Ward's implicit theories (Ward & Keenan, 1999) and Finkelhor's four-factor model (Finkelhor, 1984) since these are frequently cited in the literature and form the basis of many empirical studies on this subject. While the focus of this meta-synthesis was not on cognitions and beliefs underlying sexually harmful behaviours towards children (as in these two models), these findings complement both models through triangulation via qualitative methodologies, thus enriching understandings.

There are many overlaps and similarities between Ward's implicit theories and the concepts emerging from this review's findings (see Figure 5).

_____Figure 5_____

Outcomes of empirical studies providing support for Ward's model often consider these implicit theories as *a priori* themes when analysing data (e. g. Mannix, Dawson, & Beckley, 2012; Marziano, Ward, Beech, & Pattison, 2006). The current review lends further support to this model by presenting core concepts (derived from integrating qualitative studies on this topic) congruent with implicit theories, despite not holding them as *a priori* categories for developing these concepts. Furthermore, the concepts identified by this meta-synthesis provide a richer and more nuanced description of many of the beliefs and cognitions comprising the implicit theories, as well as identifying links between them. Similarly, the core concepts identified by the

current review also map onto Finkelhor's four-factor model as presented in Figure 6**.**

_____Figure 6_____

Implications

The core concepts emerging from this review offer a framework for considering different stages of offence processes and encompassing diverse forms of sexually harmful behaviours. The line of argument (Figure 4) constructs an over-arching narrative integrating individuals' accounts of intra and extra-familial child sexual abuse, as well as contact and non-contact (internet) offences. Although studies included in the review tended to focus on specific offence types, derivation of core concepts from across these heterogeneous studies (see Appendix J) indicates underlying similarities between perspectives of individuals engaging in a range of sexually harmful behaviours. There were variations in how concepts were applicable, for example, *objectification and ownership* was pertinent in a different way to individuals involved with abusive images than to individuals engaging in incestuous behaviours, but both groups shared perspectives based on this core concept thus demonstrating the capacity of the framework to incorporate nuanced interpretations.

The finding that individuals with contact and non-contact offending histories share some perspectives indicates risk management strategies and therapeutic interventions need to consider underlying beliefs and motivations for child sexual abuse rather than the behavioural manifestations of these. However, individuals committing internet offences often receive shorter sentences and are not offered the same therapeutic opportunities as those committing contact offences (Winder & Gough, 2010). Moreover, most abusive images are produced in the home by individuals known to the child (Sheehan & Sullivan, 2010), further indicating it may not be helpful to consider internet offences as separate to other child sexual offences.

Individuals who had committed non-contact offences disassociated from causing harm or creating victims, thereby differentiating themselves from those with contact offence histories; supporting such individuals to understand the process of producing abusive images, and their harmful impact in reinforcing sexual attraction / arousal to children, may be beneficial.

However, many individuals with histories of contact offences also refused to identify themselves as "sex offenders". Those who had not physically coerced children into sexual activity, who perceived sexual contact as consensual or as providing love or comfort, or who abused children within their families, could not identify with dominant societal narratives of predatory "paedophiles" (Gavin, 2005). They agreed "sex offenders" should be punished but perceived their own behaviours as incongruent with societal discourses around child sexual abuse by violent strangers. Social constructions around those who sexually abuse children can therefore inhibit insight into the consequences and permissibility of such behaviours, and may contribute to denial and reluctance to engage in rehabilitation (Hudson, 2005).

Furthermore, this has a corresponding impact on child victims who are warned of the dangers of strangers and urged to disclose sexually inappropriate advances to parents or caregivers, but not of the possibility that familiar individuals could harm them despite the fact that most child sexual abuse occurs in the home (Schultz, 2005). While it is certainly not suggested children should be encouraged to be suspicious of those close to them, these dominant narratives may inhibit disclosures of abuse and engender feelings of confusion, complicity, and guilt in victims; especially since child sexual abuse is already under-reported, and tends to be disclosed to family members (Finkelhor, 1984).

Although many individuals mentioned childhood abuse in their narratives, most were unable to connect such experiences to their own offences (Hartley, 2001) apart from those who described abusive behaviours as a means of expressing unresolved anger. Therapeutically supporting individuals to process such experiences can result in positive outcomes and reduce reoffending (Eldridge & Findlater, 2009). Understanding and incorporating these experiences into a coherent narrative identity (Adshead, 2012) can increase awareness of the long-term impact of abuse, potentially forming a basis for developing victim empathy and addressing beliefs about children as sexual beings (Drake, Ward, Nathan, & Lee, 2001; Hartley, 2001; Jones, 2009).

However, psychoeducation on the impact of childhood sexual abuse would still benefit individuals without such histories through learning about what constitutes sexual abuse, children's lack of capacity to consent to sexual activity regardless of objection, resistance, or acquiescence, and the aetiology of sexualised behaviours taken as cues to maintain abusive behaviours and reinforce abuse-supportive perspectives (Phelan, 1995). This review's findings suggested children who displayed sexualised behaviours inadvertently reinforced their roles as victims, strongly indicating such intervention is necessary in managing risk and promoting rehabilitation for those with sexual offending histories.

It is therefore suggested addressing individuals' beliefs and conceptualisations of themselves and their victims requires therapy focussing on these underlying maladaptive schemas developed through previous experiences (Bernstein, Arntz, & Vos, 2007; Mann & Shingler, 2006; Young, Klosko, & Weishar, 2003). Current practice around addressing "cognitive distortions" focuses on statements or thoughts identified as justifications or minimisations but frequently fails to explore the origins of these (Ward, 2000). This approach isolates such cognitions from individuals' life

contexts and can be experienced as confrontational and pathologising, leading to increased defensiveness and self-monitoring of utterances in therapy (Auburn, 2005).

Creating therapeutic spaces for more contextual narratives to emerge would facilitate self-generated understandings regarding the origins of such cognitions, as well as linking them to broader relational patterns; this reduces defensiveness through normalising and validating the development of such beliefs from life experiences, and encourages more meaningful engagement (Drake et al., 2001). Schema-focussed therapy can therefore promote more effective and enduring changes in offending behaviour than relapse prevention techniques based on monitoring and restructuring cognitions alone, and have greater impact on future reoffending as individuals become aware of how underlying schemas may be triggered in different contexts and relationships (Bernstein et al., 2012; Drake et al., 2001; Jones, 2009; Ward, 2000).

Furthermore, this review's findings suggested individuals' conceptualisations of themselves and their victims facilitated and justified using sexually harmful behaviours to cope with negative emotions, experience positive self-states, and connect with others. These conceptualisations communicate the values and goals of these individuals, as well as preserving their sense of self whilst engaging in harm towards others (Waldram, 2010). Efforts to create explanations for offending behaviours suggest recognition of impermissibility (Ó Ciardha, 2011) thereby indicating capacity for moral agency (Waldram, 2010).

This is congruent with the Good Lives Model (GLM) of sexual offending suggesting all human beings seek certain goods such as relatedness, mastery, autonomy, and well-being through various means; when individuals lack personal resources to achieve goods in healthy and prosocial ways, they resort to alternative antisocial means (Ward, 2002). Indeed, this review highlighted a search for

connection to others, emotional dysregulation, and needing to feel powerful. Such issues are frequently identified as therapeutic targets and risk factors (Mann & Marshall, 2009; Serran & Marshall, 2006), but would be effectively addressed by the GLM which suggests individuals should be supported to understand how offending behaviours were efforts to obtain these goods, alongside exploring alternative means to achieve the same goals (Ward, Collie, & Bourke, 2009; Ward & Fisher, 2006).

This approach facilitates the development of a new narrative identity, consistent with values and goals of one's old self, but achieved through a new self capable of utilising socially functional strategies thereby reducing reoffending (Ward & Marshall, 2007). Relapse prevention is more effective with approach rather than avoidance strategies (Ward, 2002), and accounts reviewed in this meta-synthesis were congruent with this concept as individuals acknowledged the sexual gratification and positive emotions experienced through sexual contact with children meant they made no attempt to avoid high-risk situations, and consequences of discovery did not deter them.

Narrative identity as conceptualised by the GLM implies individuals who have sexually abused children are capable of reflecting on contexts and experiences leading to offending behaviours, and reconstructing their identities with the aim of avoiding recidivism (Ward, 2012). However, this needs to be mirrored by reconstruction of dominant societal narratives to reflect that such individuals are social beings whose contexts have contributed to their offences, but who are capable of change if offered appropriate opportunities (Schultz, 2005).

Limitations and Further Research

This meta-synthesis reviewed eleven studies from a total of 1040 identified by the systematic search strategy, and a larger sample may have facilitated further

development of the core concepts or emergence of other interpretations improving the applicability and validity of the proposed framework. However, this review did not aim to produce unequivocal and universally generalisable findings but rather to develop greater understanding of individuals' perspectives of their sexually abusive behaviours towards children through integrating the (currently limited) qualitative literature on this topic, although it is hoped the interpretations offered will be meaningful in professional and clinical contexts (Finfgeld, 2003).

It should be noted the process of integrating qualitative studies is iterative and reflexive, therefore the derivation of core concepts is influenced by the researcher conducting the meta-synthesis. However, the inclusion of Table 4 and the mind-maps in Appendices D-H increase transparency around the process of constructing these concepts. Furthermore, evidentiary quotations demonstrating the original context of the data are presented to improve credibility and support the inferences made (Finfgeld, 2003).

The paucity of qualitative research on this topic meant a heterogeneous sample was utilised, including offence accounts of various sexually harmful behaviours. The proposed framework is broad enough to capture these experiences as it is based on collective narratives, but important nuances differentiating perspectives of individuals convicted for different offences could have been overlooked. Although Table 3 presents contextual details for participants from each study, this highlights the importance of conducting further research in this domain.

Future meta-syntheses could then focus on homogenous groups with regard to type of offence, enabling more detailed understandings to emerge and improving the robustness of findings. Moreover, there are even fewer qualitative studies in this domain focussing on female, adolescent, and learning disability populations therefore

further research with such individuals is needed to explore how their perspectives may differ. Creating spaces within research contexts for these narratives to be heard would enable clinicians to consider how diverse groups of individuals understand their offending behaviours, with significant implications for enhancing responsivity of risk management and person-centred care.

Conclusion

Individuals' offence accounts detailing perspectives of sexually abusive behaviours can offer valuable and rich insights for understanding child sexual abuse, with implications for psychotherapeutic interventions and risk management. However, this meta-synthesis has also indicated how social constructions of individuals who have sexually abused children can distance professionals, and individuals themselves, from such stories thus inhibiting meaningful considerations of risk and rehabilitation factors. Emotional aversion to hearing, reading, researching, and working therapeutically with such narratives reinforces this distance at the expense of holistic considerations of an individual's context, thereby maintaining a position where individuals who have sexually harmed children become defined by their offences and continue to be perceived as "others" who cannot (and should not) be understood. Without greater engagement by professionals in research and clinical contexts, valuable opportunities to reduce risk or provide care may continue to be lost, ultimately perpetuating cycles of abuse, re-victimisation, and reoffending.

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Table 1

Comparison of Previous Review (Lawson, 2003) and Proposed Meta-synthesis

	Previous review	Current review
Search strategy	Databases searched: • PsycINFO • CINAHL • Medline	Databases searched: • PsycINFO • CINAHL • Academic Search Complete • Science Direct • Web of Science
	Minimal details of search strategy	Systematic search strategy
Characteristics of studies included in review	Fifteen studies included, published between 1982-2001	Eleven studies included, from all studies published to date (additional 12 years)
	(Note: studies before 2001 do not include offences related to sexually abusive images of children)	
	Participants from prisons or outpatient settings	Participants from any setting
	Mainly open-ended interviews	Also include studies based on written / audio records
	Mainly grounded theory or IPA	Include studies using any methodology
Methodology	Identified as meta-synthesis in the Implications section, but actually used a selective reading approach (van Manen, 1990): • Identified phrases used to describe thoughts, behaviours, relationships • Considered what statements / phrases seemed particularly revealing about the phenomenon or experience being described • Statements then grouped by similarities into themes	Meta-synthesis to integrate findings of individual studies with each other to produce new themes and emerging concepts, rather than grouping by existing themes
Findings	Three themes emerged from the analytic process: *isolation* (in early childhood, in adolescent / adult relationships, of victims), *gratification* (sexual / non-sexual, entitlement, intimacy, self-esteem / affirmation, offence pathways), and *justification* (excuses, cognitive distortions, reframing behaviour as non-abusive).	-

Figure 1. Flowchart of Study Selection

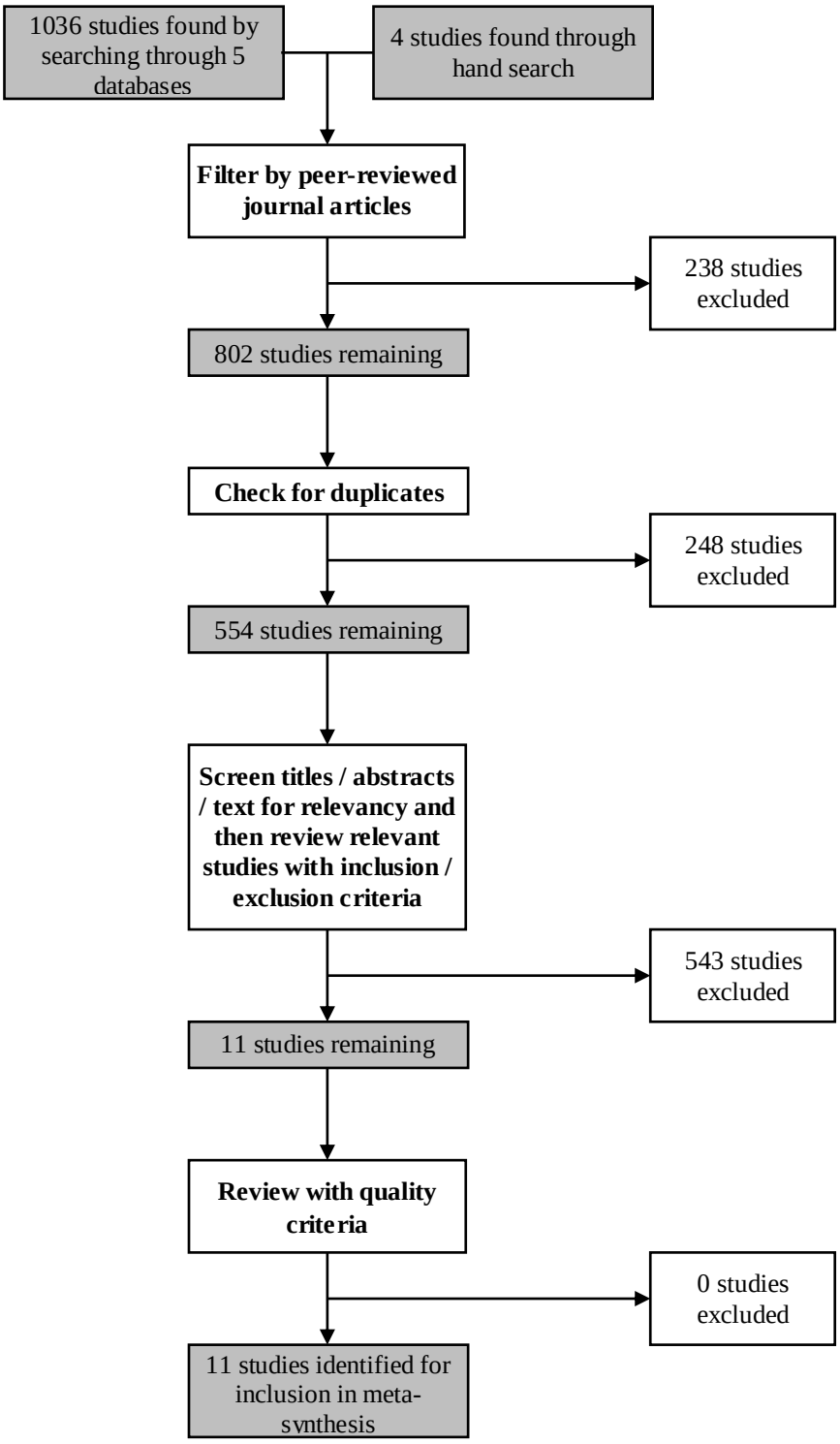

Figure 1. Only studies from peer-reviewed journals were considered as they had undergone a quality review, and since meta-synthesis relies on secondary data analysis, it is important to consider the quality of the original data source (Finfgeld, 2003). Following the removal of duplicates, studies were screened for relevance to the topic of this review using the following criteria: (1) use of qualitative methodology; (2) participants previously charged / convicted with a sexual offence against children (under the age of sixteen). Screening was initially conducted by checking article titles, but abstracts and / or full texts were also read if there was any ambiguity regarding the relevance of the study. Due to the relatively limited number of qualitative studies on this topic, studies were not excluded according to type of offence or victim as long as it was categorised as a form of child sexual abuse, hence intra- and extra-familial offences as well as contact and non-contact offences were included. Relevant studies were then reviewed with the inclusion / exclusion criteria presented in Table 2.

Table 2

Inclusion and Exclusion Criteria

Criterion	Application
Participants	Only studies with adult male participants were included, as the majority of the body of qualitative research in this domain is conducted with this demographic. Since a sufficient number of studies are required to conduct a credible meta-synthesis (Finfgeld, 2003) and there is limited qualitative research in this area, it was decided to conduct the review focussing on the perspectives of those individuals most frequently recruited as participants. Studies with adolescent (under eighteen years) or female participants were excluded on this basis, as were studies that recruited individuals with learning difficulties. Similarly, studies presenting findings related to specific groups (for example, priests or professionals working with children) were excluded, as contextual factors relating to such roles may have had specific effects on the perspectives of these individuals. Inclusion of mixed populations would have reduced the robustness of any findings, thereby impacting on their transferability and generalisability.
Study focus	Articles focussing solely on physical actions and behaviours when committing an offence were not included, as the aim of this meta-synthesis is to develop insight into individuals' perspectives of their offending behaviour from their offence accounts, rather than exploring descriptive processes of how offending behaviours are carried out. While such descriptions were frequently a part of included studies, studies focussing exclusively on these were not included in this review due to their topical dissimilarity (Sandelowski et al., 1997).
Raw data	Studies where findings were inadequately evidenced through the use of raw data were excluded (Finfgeld, 2003); for example, some studies used only brief quoted phrases to evidence the interpretations offered, and others did not present any raw data for some of the themes emerging from their analysis. Meta-syntheses rely on qualitative interpretations as their primary data source, rather than raw data from interview transcripts, therefore the credibility of further interpretation in this review would be limited if findings of included studies were not appropriately supported by raw data in the form of quoted material (Downe, 2008).

Methodologies	Studies using any qualitative methodology were included provided their findings were presented thematically so they were comparable (Sandelowski et al., 1997). The final sample contained studies using a variety of approaches including thematic analysis, interpretative phenomenological analysis (IPA), and grounded theory. Although these methods vary in their epistemologies, triangulation of different perspectives can enhance the credibility of this review's findings by allowing strengths and weaknesses of differing methods to complement one another (Finfgeld, 2003), and the inclusion of studies based on different approaches provides a multi-faceted perspective of the topic (Jensen & Allen, 1996).
Quality criteria	An adapted version of a quality framework proposed by (Walsh & Downe, 2006) was used to evaluate the studies considered for inclusion. This framework was chosen because it enables quality criteria to be applied reflexively rather than rigidly, thus accounting for the variety inherent within qualitative research generally (Walsh & Downe, 2006) and the studies identified through the systematic search strategy specifically. Instead of focussing on the generalisability of results, which would be incongruent with qualitative approaches, this framework considers whether findings have "credibility, transferability, dependability and / or confirmability" (Downe, 2008, p. 6). Furthermore, this framework could be easily adapted for this review to allow each criterion to be rated thus increasing the transparency of the grading system. The following aspects were considered for each study: • Clear outline of the research question and the rationale • Apparent and appropriate choice and use of methodology • Apparent & appropriate methods of data collection • Appropriate sampling strategy used • Apparent & appropriate choice and use of analytic methods • Whether interpretations were plausible and evidenced appropriately with raw data • Whether findings increased understanding of the topic • Discussion of clinical implications • Discussion of any ethical issues and appropriate managed of these • Presence of an audit trail • Discussion of limitations of the study For each study, a rating was given for each of these aspects; these ratings were then summed to produce a total. Although Walsh and Downe (2006) provide a grading system of A to D, adapting the framework to provide an individual rating for each of these aspects within each study facilitated a more thorough and transparent consideration of the quality of each paper.

Numerical cut-offs were decided for each grade, and each study was then graded accordingly (see Appendix C).

Studies under consideration for inclusion received scores from B to C-. Although Walsh and Downe (2006) exclude studies scoring below C+, they do not advocate prescriptive or rigid application of any quality criteria, including their own. There is some debate over the use of quality criteria to exclude studies from meta-syntheses (Downe, 2008). Some argue appropriate appraisal is essential (Dixon-Woods, 2004), but Sandelowski et al. (1997) have suggested methodological flaws should not be a criterion for excluding findings that may still be useful since they describe unique elements of human experience. For this review, this latter approach was adopted whilst acknowledging the potential impact of using poor quality data for secondary analysis. No studies were therefore excluded based on quality criteria provided they scored C- or above according to the framework.

Table 3

Details of Studies Included in this Review

Study	Aims of Study	Participants	Offences	Therapy [a]	Setting	Country	Data Collection	Methodology	Themes	Quality Rating
Winder, B., & Gough, B. (2010) ''I never touched anybody - that's my defence'': A qualitative analysis of internet sex offender accounts	To facilitate person-centred accounts about downloading and possessing child pornography, explore how such offences are rationalised and defended	7 Aged 30-60	Internet-based sexual offences (downloading and viewing images of children) Sexual assault of a minor	Yes	Prison	UK	Semi-structured interviews	IPA	Distancing from victims Dis-identifying from the label of "sex offender" Minimising responsibility for offending Reduction of distancing following treatment	B
Holt, T. J., Blevins, K. R., & Burkert, N. (2010) Considering the pedophile subculture online	To explore the subculture / enculturation process through Web forums of individuals with sexual interests in children, to explore the norms / values of this subculture	n/a	All forum users expressed having a sexual interest in / fantasising about / being aroused by children	n/a	n/a	USA	Analysis of web forums	Grounded theory	Marginalisation Sexuality Law Security	B

Study	Aims of Study	Participants	Offences	Therapy [a]	Setting	Country	Data Collection	Methodology	Themes	Quality Rating
Hartley, C. C. (2001) Incest offenders' perceptions of their motives to sexually offend within their past and current life context	To explore motives to sexually offend against children, the connections between life contexts and motives, and how life context may create precursors to motivation	8 Mean age 35.4	Sexual contact with biological / step / adoptive daughter (voyeurism, exhibitionism, fondling, oral sex, intercourse)	Yes	Community	USA	Interviews	Grounded theory	A need for sexual gratification Seeking an outlet from dissatisfaction Contact as an expression of anger Contact as an inappropriate way to show love/affection	B-
Gilgun, J. F. (1994) Avengers, conquerors, playmates, and lovers: Roles played by child sexual abuse perpetrators	To elicit descriptions of how individuals see themselves in relation to children they have sexually abused	23 (20 men, 3 women) Aged 21-56	Intra-familial and extra-familial contact child sex offences	Varied	Maximum security prison Medium security prison Community treatment programmes Support groups	USA	Interviews	Grounded theory with phenomen-ological approach	Avengers Takers Controllers Conquerors Playmates Lovers Soulmates	C

Study	Aims of Study	Participants	Offences	Therapy [a]	Setting	Country	Data Collection	Methodology	Themes	Quality Rating
Phelan, P. (1995) Incest and its meaning: The perspectives of fathers and daughters	To explore how incestuous relationships are initiated, maintained and ended, and the meaning surrounding the events for those involved	40	Sexual contact with biological / step-daughter(s) (fondling, oral sex, intercourse / penetration)	Yes	Outpatient	California	Interviews	Findings grouped by themes but not stated whether thematic analysis	Sexual gratification Control, power and anger Rights and responsibilities vis-a-vis their role as father or stepfather What fathers thought daughters were thinking Fathers' definitions of activity and thoughts about consequences	C-
Gilgun, J. F. (1995) We shared something special: The moral discourse of incest perpetrators	To test hypotheses derived from the literature on care and justice and to modify them to fit in-depth subjective accounts of individuals with incest offence histories	11 (including 1 female) Aged 32-54	Intra-familial and extra-familial contact child sex offences	Yes	Maximum security prison Medium security prison Community	USA	Interviews	Modified analytic induction (similar to grounded theory but hypotheses / concepts pre-selected)	Care and justice Distortions of justice and care The absence of considerations of justice and care Other findings that were not part of the care-justice framework.	B-

Study	Aims of Study	Participants	Offences	Therapy [a]	Setting	Country	Data Collection	Methodology	Themes	Quality Rating
Brown, S. J., Walker, K., Gannon, T. A., & Keown, K. (2012) Creating a psych-ologically comfortable position: The link between empathy and cognitions in sex offenders	To develop a model of individuals' use of empathy and cognition when recounting sexual offences against children	50 Mean age 52.4	Intra-familial and extra-familial contact child sex offences	82% not engaged	Prison	New Zealand	Semi-structured interviews	Thematic analysis	Complete denial Partial denial Justifications: beliefs and attitudes to support offending behaviour Excuses: ignoring the perspectives of others Taking responsibility for own actions	C+
Quayle, E., & Taylor, M. (2002) Child pornography and the internet: Perpetuating a cycle of abuse	To examine the ways in which individuals talk about child pornography and the function this plays in their offence accounts	13	Possessing illegal and obscene images of children Producing pornographic pictures of children Child sexual assault	Varied	Varied	UK	Semi-structured interviews	Qualitative analysis within discursive framework	Sexual arousal As collectibles Facilitating social relationships As a way of avoiding real life As therapy In relation to the Internet	C

Study	Aims of Study	Participants	Offences	Therapy [a]	Setting	Country	Data Collection	Methodology	Themes	Quality Rating
Hartley, C. C. (1998) How incest offenders overcome internal inhibitions through the use of cognitions and cognitive distortions	To explore the victimisation process of incestuous child sexual abuse, focusing on cognitions / cognitive distortions used to overcome initial inhibitions against offending and to maintain offending behaviour once begun	8 Aged 28-42	Sexual abuse of a biological / step / adoptive daughter (offences varied from voyeurism to intercourse)	Yes	Treatment agency	USA	Interviews	Grounded theory	Cognitions related to sociocultural factors Cognitions used to overcome the fear of disclosure Cognitions used to diminish responsibility Cognitions related to permission seeking	C+
Durkin, K. F., & Bryant, C. D. (1999) Propagand-izing pederasty: A thematic analysis of the on-line exculpatory accounts of unrepentant pedophiles	To examine the accounts of individuals expressing sexual interest in children who use internet newsgroups, to explore the attitudes they hold in regard to deviant orientation and behaviour	41	Admission of a paedophiliac orientation involved using "boy lover" self-descriptively, speaking of having relationships with boys, or indicating an affiliation with a paedophile organisation	n/a	n/a	USA	Analysis of postings on online newsgroup	Content analysis	Condemnation of condemners Denial of injury Claim of benefit BIRGing (basking in reflected glory) - like other great men	B-

Study	Aims of Study	Participants	Offences	Therapy [a]	Setting	Country	Data Collection	Methodology	Themes	Quality Rating
Sheehan, V., & Sullivan, J. (2010) A qualitative analysis of child sex offenders involved in the manufacture of indecent images of children	To explore the experiences of individuals convicted of child pornography offences, and to identify similarities / differences in their experiences, perspectives, and behaviours	4 Aged 28-46	Taking / possessing / trading indecent images of children Rape / sexual assault / taking indecent images of daughter / stepdaughter Produced indecent photographs of himself sexually molesting sons	Only 1 engaged in therapy	Prison Community	UK	Semi-structured interviews	IPA	Formative life experiences Blocks to offending Overcoming blocks to offending Abuse-supportive thinking Role of fantasy in subsequent offending Planning and preparation for abuse Offending behaviour Function of taking images	B

[a] Many of the studies reviewed for inclusion in this review considered previous or current engagement in therapy as part of their inclusion criteria. Engagement in therapy would be expected to impact on an individual's narrative through restructuring their perceptions and understanding of their offending behaviours. Accordingly, there may be differences in the offence accounts of individuals who and have not engaged in psychotherapeutic interventions, although this review did not include / exclude any studies on this basis.

Figure 2. Process of Meta-synthesis

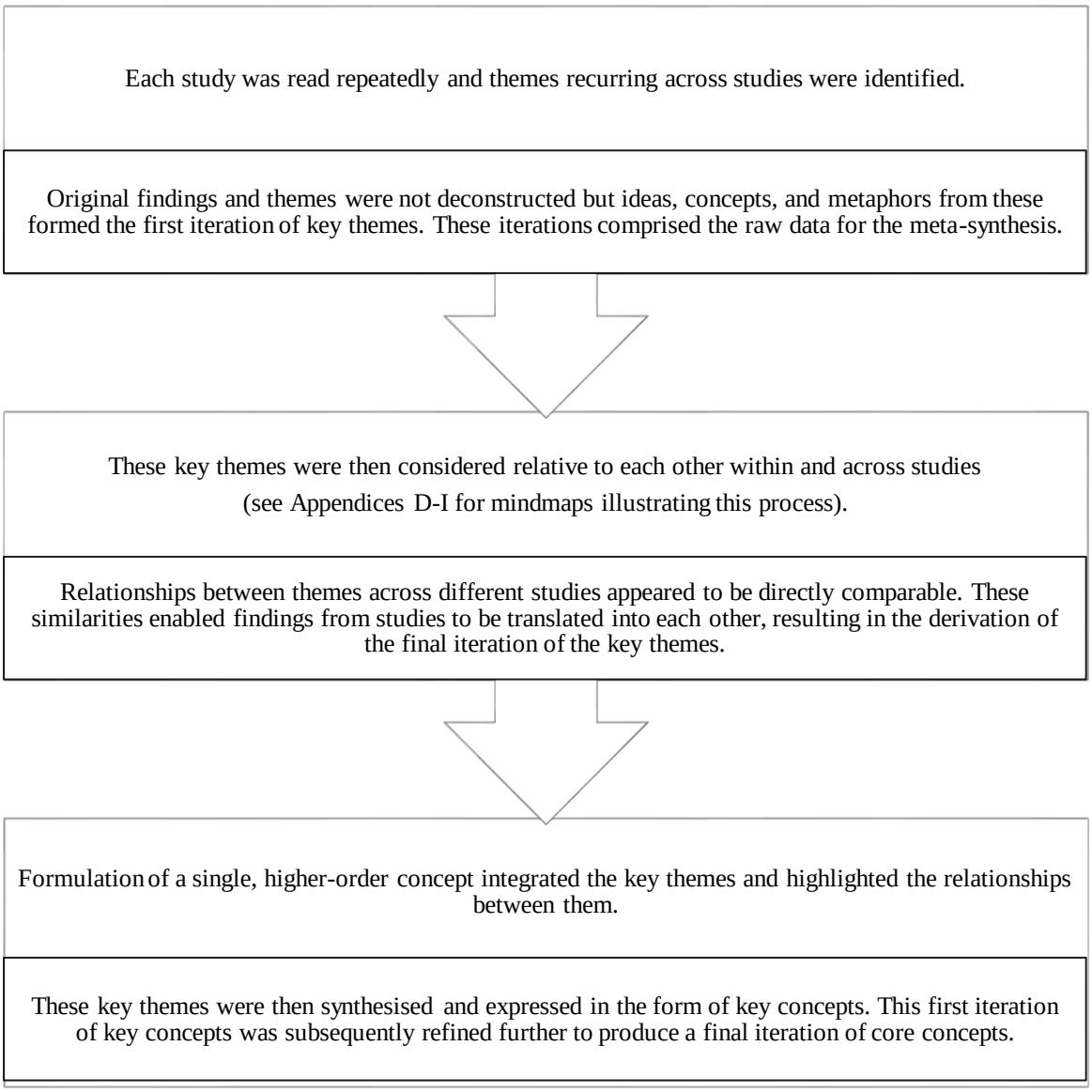

Table 4

Development of Core Concepts from Preliminary Themes

Themes identified in studies	Content of themes	Key themes: first iteration	Key themes: final iteration	Core concept: first iteration	Core concept: final iteration	Relevant studies
• Minimising responsibility for offending • Viewpoint that ignores the perspectives of others	• Ways in which responsibility for their actions was reduced • Offender as the victim, externalising locus of control	Can't help it, not my fault				Winder, B., & Gough, B. (2010)
• The internet and child pornography • Dis-identifying from the label of ''sex offender'' • Law • Partial denial	• Internet as a medium to facilitate interests • Distance themselves from label / stigma of sex offender • Influence of law in structuring ways of relating to children and others in / out of the sub-culture • Do not deny sexual contact occurred but deny it could be defined as abuse	Not really a sex offender if no contact / didn't use force / child agreed, sex offenders should be punished	Not a sex offender because no harm done, haven't hurt anyone, not at fault, stigmatised due to sexuality	Stigmatised sexuality, nobody harmed / hurt, not a sex offender	I am not a sex offender: stigmatised sexuality and disassociation from doing harm	Sheehan, V., & Sullivan, J. (2010) Gilgun, J. F. (1995) Brown, S. J., Walker, K., Gannon, T. A., & Keown, K. (2012)
• Overcoming blocks to offending • Distancing from victims • Child pornography and sexual arousal	• Distortions, abuse-supportive thinking • Distance themselves from notion that they had created victims – lack of contact, images as innocuous, child appeared happy • Child pornography as means of achieving sexual arousal	Nothing wrong with looking / fantasising, children were enjoying it, no harm done	Subthemes: • Not like those sex offenders • No harm done • Others do not understand			Holt, T. J., Blevins, K. R., & Burkert, N. (2010) Quayle, E., & Taylor, M. (2002)
• Marginalisation • Not incest • Condemnation of condemners • BIRGing (like other great men)	• Relationship with society at large • Love / care rather than abuse • Attempts to shift the focus from paedophiles and their behaviour to the actions of those who condemn them • The assertion that ''great men'' have also been paedophiles	Others don't understand, child love rather than child abuse				Durkin, K. F., & Bryant, C. D. (1999)

Themes identified in studies	Content of themes	Key themes: first iteration	Key themes: final iteration	Core concept: first iteration	Core concept: final iteration	Relevant studies
• Life context prior to onset of offending • Seeking an outlet from dissatisfaction	• Life stresses • Needing an outlet for dissatisfaction, coping with unhappiness	Coping with stress or feeling unwanted / unaccepted	Wanting to feel better about oneself, sexualised coping, making friends / social relationships Subthemes: • Sexualised coping • Enhancing self-esteem • Impact on social status	Feeling better emotionally and relationally through sexualised coping	Inter and intra-personal processes: sexualised coping, self-esteem, and social status	Sheehan, V., & Sullivan, J. (2010) Hartley, C. C. (2001) Quayle, E., & Taylor, M. (2002) Gilgun, J. F. (1994)
• Child pornography as a way of avoiding real life • Accessing child pornography as therapy	• Social support to replace unsatisfactory relationships in the real world • Satiation, addiction, controlling interests	Escapism, feeling in control				
• Child pornography facilitating social relationships • Function of taking images • Playmates	• Social contact with others who trade images • Feeding arousal, power and control, social function, self-esteem • Viewed themselves as peers of the child	Social status, developing social relationships, making friends				

Themes identified in studies	Content of themes	Key themes: first iteration	Key themes: final iteration	Core concept: first iteration	Core concept: final iteration	Relevant studies
• A need for sexual gratification • Sexual gratification • Takers	• As a primary motive, generally important in their lives • Sexual gratification / curiosity as primary motivating factor • Children as a commodity to be used and then discarded	Sexual gratification / desire, taking what you need	Can do what you want when child belongs to you, child as an object to use for sexual gratification / to control / to collect Subthemes: • Sexual gratification • Control, power, and anger • Something that belongs to me	Objectification: commodity to be owned, used, controlled, or collected	Objectification and ownership: commodity to conquer, control, or collect	Hartley, C. C. (2001) Phelan, P. (1995) Gilgun, J. F. (1995) Quayle, E., & Taylor, M. (2002) Gilgun, J. F. (1994)
• Control, power and anger • Contact as an expression of anger • Controllers • Avengers	• Wanting to have control / power over the child, anger • Expression of anger towards wives / own abuser • Controlling routine activities of children by bargaining for sexual favours • Objective was to harm the child or someone who loved the child	Control, power, anger, revenge				
• Conquerors • Children's vulnerability • Rights and responsibilities vis-a-vis their role as father or stepfather	• Used age-'appropriate' ploys to get children to become sexually involved • Taking advantage of children's lack of knowledge / trust / dependence to keep relationship going • Having special / unique rights based on status as 'father', offence not so serious because their own child	Belongs to me, taking advantage of trust				
• Child pornography as collectibles	• The importance of collecting pictures	Like any other collection				

Themes identified in studies	Content of themes	Key themes: first iteration	Key themes: final iteration	Core concept: first iteration	Core concept: final iteration	Relevant studies
• Incest as wrong • Blocks to offending	• Explicit / implicit recognition that it was wrong, inconsistent / confused about whether it was wrong • Conflicted core beliefs, detection apprehension	It's wrong / illegal / taboo	Planning abuse, progression of sexual activity, preventing disclosure / discovery, potential consequences Subthemes: • Permissibility • Planning and preparation • Preventing discovery	Planning, pre-empting consequences, and preventing disclosure / discovery	Pre-empting consequences: preventing disclosure and discovery	Sheehan, V., & Sullivan, J. (2010) Phelan, P. (1995) Gilgun, J. F. (1995) Holt, T. J., Blevins, K. R., & Burkert, N. (2010) Hartley, C. C. (1998).
• Planning and preparation for abuse • Sexual activity and its progression	• Victim identification and selection, manipulating perceptions of victims / others, creating opportunity to offend, preventing suspicion / disclosure / discovery • Progressed slowly and became increasingly more serious, initiation using nonverbal means as extension of routine activities, child initiated and / or enjoyed it if no overt negative reaction	Planning, preparing, progression of sexual activity without arousing suspicion				
• Cognitions used to overcome the fear of disclosure • Security	• Knowledge of mother-daughter relationship, lack of disclosure after first incident taken as interest, not thinking about disclosure at all • Careful management of personal information and activities to avoid legal sanctions	Not getting caught, pre-empting discovery				
• Fathers' definitions of activity and thoughts about consequences • Cognitions related to sociocultural factors	• Aware it was wrong from moral / marital / legal standpoint, legal ramifications, concerned about wife finding out, guilt over moral rather than legal aspect • Messages / images / expectations of society used to overcome internal inhibitions	Considering consequences, continuing despite fear of discovery, nothing wrong so nothing to worry about				
• Verbal interaction about participation and disclosure • Unresponsiveness to children's attempts to stop	• Threats of family splits or jail, bribing • Unresponsive or cruel when child wanted to stop	What the child might say, preventing discovery and lowering resistance through persuasion / threats				

Themes identified in studies	Content of themes	Key themes: first iteration	Key themes: final iteration	Core concept: first iteration	Core concept: final iteration	Relevant studies
• Lovers • Contact as an inappropriate way to show love/affection	• Being infatuated with or in love with the child • Way of showing love / affection	We were in love, it was a real relationship	In love with / caring for child, mutual relationship, children as sexual, child consented / responsible for continuation Subthemes: • Being in love • Children as sexual beings • Child consented, could have objected	Consensual / caring / loving relationship, child as sexual partner	Mutuality: love, care, and consent	Hartley, C. C. (2001) Phelan, P. (1995) Gilgun, J. F. (1995) Brown, S. J., Walker, K., Gannon, T. A., & Keown, K. (2012) Holt, T. J., Blevins, K. R., & Burkert, N. (2010) Quayle, E., & Taylor, M. (2002) Gilgun, J. F. (1994) Hartley, C. C. (1998) Durkin, K. F., & Bryant, C. D. (1999)
• Love • Sexuality • Mutuality	• No love, sexualised affection, believing self to be in love, intense drive for connection • Normative order sexuality, acceptance of sexuality by society • Love was mutual, wanting sexual activity to be mutually enjoyed					
• Soulmates • Promoting the child's welfare	• Confusing themselves with children, drawn to / seeing self in child victim • Teaching, satisfying, increasing sexual awareness, showing love, comforting, consoling	Providing care / love / comfort				
• Cognitions to support offending behavior • What fathers thought daughters were thinking • Cognitions used to diminish responsibility	• Offloading responsibility to the child, normalisation of the situation, sex demonstrates love • Presuming child was asleep / unaware but some ambiguity, child initiated / acquiesced / positively participated in sexual activity • Seeing sexual contact as game, not using force, starting accidentally or initiated by child, child's 'positive' reaction	Child wanted me to do it, child didn't object, child initiated / participated / enjoyed it				
• Cognitions related to permission seeking • Children as gatekeepers • Claim of benefit	• Asking child directly for permission, assessing / interpreting child's response as permission • Asking children to be gatekeepers for incestuous acts by delegating authority / responsibility • Such behaviour is actually beneficial for the child involved	It was up to the child, child could have stopped it if they wanted to				

Figure 3. Thematic Map

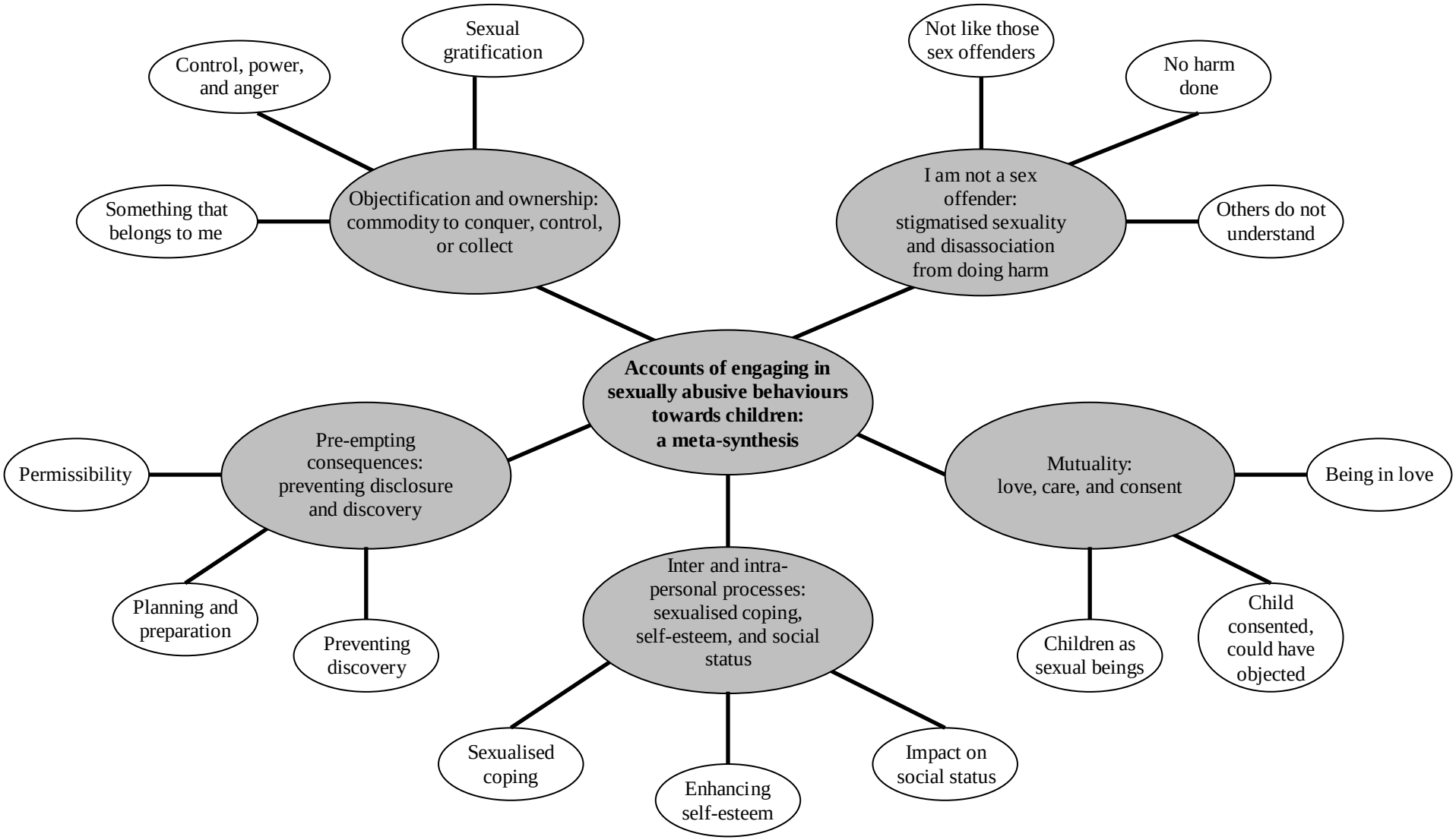

Figure 3. Shaded ovals represent the core concepts, and clear ovals represent sub-themes within these.

Figure 4. Diagrammatic Representation of the Line of Argument

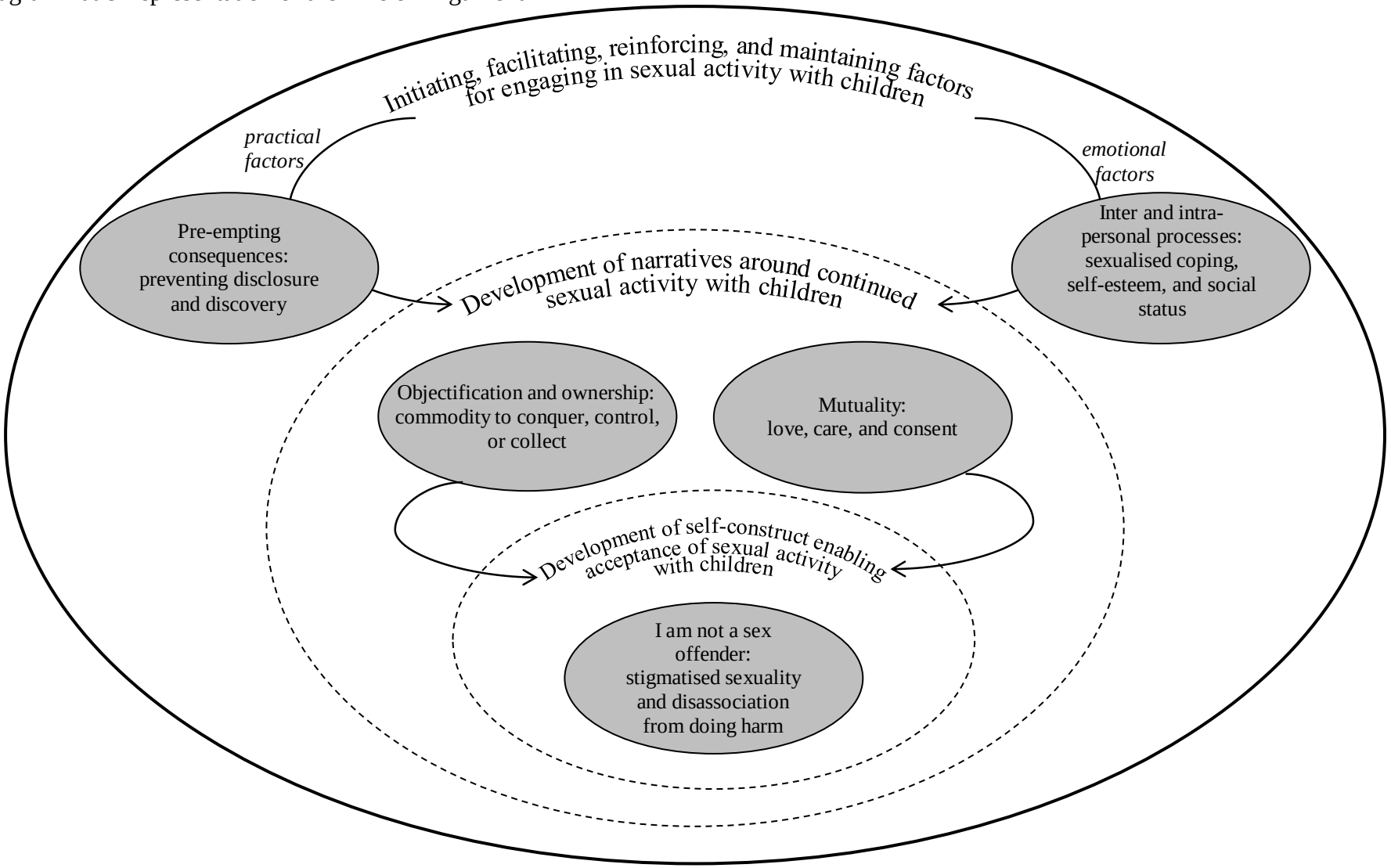

Figure 4. The framework suggested by the current findings aims to develop further understanding of individuals' perspectives of their sexually harmful behaviours towards children. Emotional factors related to inter and intra-personal processes, in conjunction with practical factors preventing disclosure and discover, serve to initiate, facilitate, reinforce, and maintain sexually abusive behaviours towards children. Ongoing abuse results in the development of a narrative facilitating these behaviours and negating issues of harm and consent, so the child is objectified with a corresponding sense of ownership, or the relationship is perceived as mutually consensual and loving. Individuals develop a self-construct dis-identifying themselves from being "sex offenders" by disassociating themselves from harming the child and considering their sexuality as uncontrollable and involuntary, and therefore unfairly stigmatised by others. The three different levels of the framework represent different levels of understanding these behaviours, starting with factors related to motivations, justifications, and functional aspects, moving to cognitions and normalising narratives that indicate how individuals conceptualise their victims, and then hypothesising how individuals may integrate such behaviours into their self-constructs during the above processes.

Figure 5. Findings in Relation to Ward's Implicit Theories (1999)

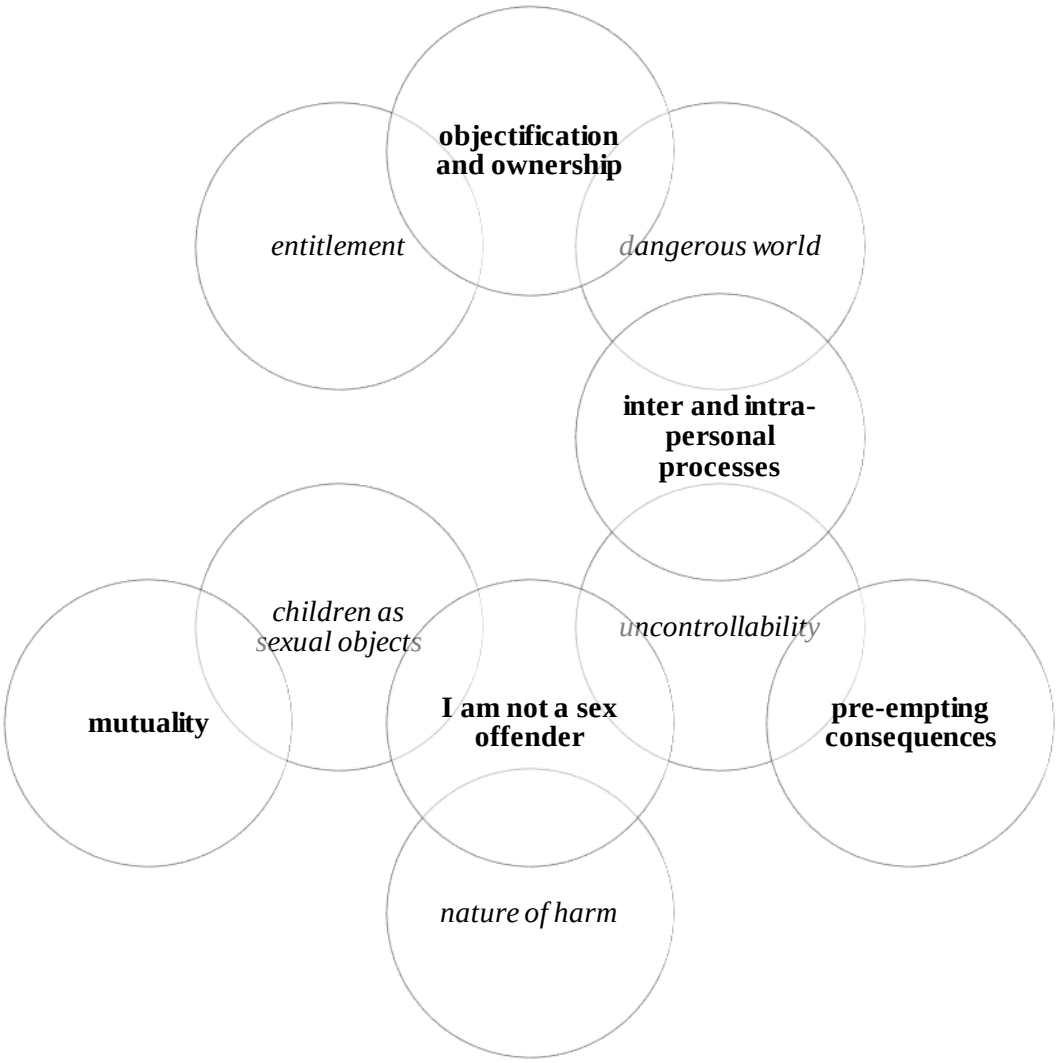

Figure 5. Circles with italicised text represent implicit theories; circles with bold text represent the core concepts emerging from this meta-synthesis. The overlaps between the circles demonstrate how the findings of this review may be positioned in relation to Ward's model. The concept of *objectification and ownership* involves entitlement to sexual gratification, the right to have sex with a child, perceptions of conquest and control, and using the child as a means of revenge; this overlaps with implicit theories of *entitlement* and *dangerous world*. The concept of *inter and intra-personal processes* is based on difficulties in coping with adult relationships and seeking compensatory relational experiences involving sexual activity with children, which overlaps with elements of *dangerous world* and *uncontrollability*. The concept of *pre-empting consequences* also overlaps with *uncontrollability* as they both include content based on understandings around permissibility of sexually harmful behaviours. *I am not a sex offender* is a concept that shares aspects with implicit theories of *nature of harm*, *children as sexual objects*, and *uncontrollability*; these include denial of harmful intent, lack of control over sexual desires / behaviours, assertions that children are not harmed but benefit from sexual relationships with adults, societal prejudices around sexual contact with children, and such behaviours not being considered as abusive or harmful. *Children as sexual objects* also shares similarities with the *mutuality* concept, where children are considered capable of consenting to, initiating, and enjoying sexual activities.

Figure 6. Findings in Relation to Finkelhor's Four-Factor Model (2004)

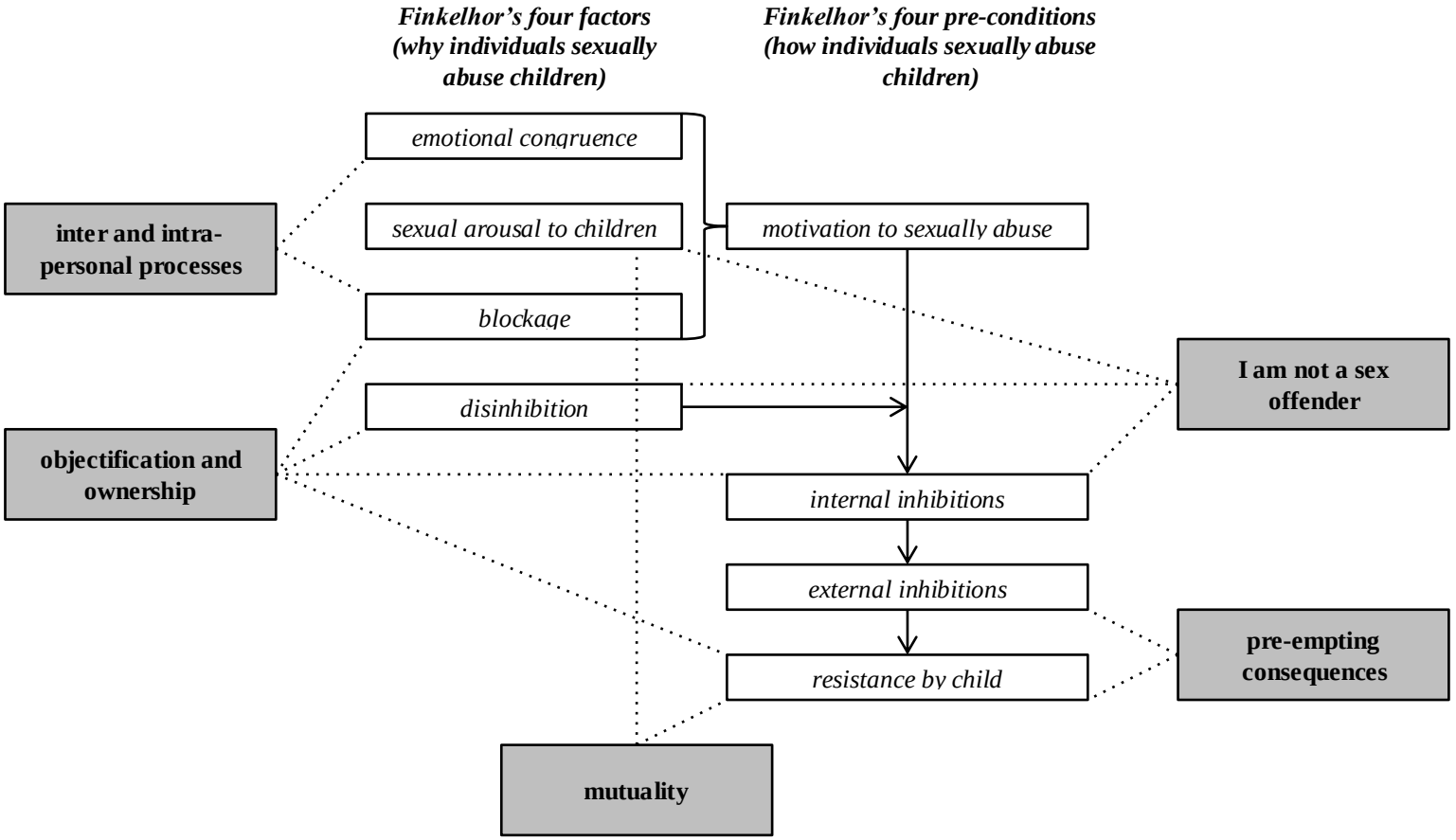

Figure 6. Finkelhor's four-factor model is represented diagrammatically by clear boxes and solid arrows. Shaded boxes represent the core concepts emerging from this meta-synthesis, with dotted lines demonstrating how they may be positioned in relation to Finkelhor's model. The concept of *inter and intra-personal processes* and the factors of *emotional congruence* and *blockage* share underlying similarities including a lack of adaptive strategies to cope with relational difficulties and an increase in self-esteem through engaging in sexual activity with children. *Objectification and ownership* links to the factors of *blockage* and *disinhibition*, as well as the pre-conditions of *internal inhibition* and *resistance by child*, through aspects of using the child for sexual gratification, a sense of entitlement to have sexual contact with the child, feelings of power evoked by being in control of the child, and the use of physical force when needed to dominate the child. The concept of *mutuality* also links to *resistance by child* as well as the factor of *sexual arousal to children* through considering the child as a sexual being capable of consenting to and voluntarily engaging in sexual activity with an adult. *Pre-empting consequences* maps onto the pre-conditions of *external inhibitions* and *resistance by child* as it is concerned with how sexually harmful behaviours are initiated and continued without being discovered. Lastly, the concept of *I am not a sex offender* relates to the factors of *sexual arousal to children* and *disinhibition*, as well as the pre-condition of *internal inhibition*, through considering sexual contact with children as not harmful and therefore acceptable, and feeling it is permissible to act on one's sexual preference whilst disregarding legal and societal sanctions / consequences.

Appendix A: Author Guidelines for Journal of Sexual Aggression

Routledge

Sample copy

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Manuscript preparation

The Editor welcomes the opportunity to consider papers which examine the nature and impact of sexual aggression, as well as its prevention and treatment. Priority is afforded to articles containing original material and which are likely to contribute to the advancement of knowledge in the field. As such, several types of contribution are welcomed:

a) Research and conceptual developments - papers reporting the findings of empirical research or the development of theory/ conceptual models.

b) Reviews - literature reviews or commentaries focusing upon specific issues of relevance.

c) Practice - articles presenting clinical practice or programme descriptions.

d) Debate - brief responses to articles which have appeared in previous issues of the Journal.

The Editor can be contacted by potential contributors wishing to discuss a proposal or seeking advice or guidance on preparation of a submission. If you are planning to submit an overlength paper, please contact the Editorial Office in advance:

1. General guidelines

- Papers are accepted only in English. British English spelling and punctuation is preferred.
- A typical article (Research and conceptual development) will not exceed **6,000 words** ; 'Reviews' up to **8,000 words** ; 'Practice' articles between **4,000-6,000 words** ; 'Debate' articles up to **5,000 words.** Tables, figures and references are not included in this word count. Papers that greatly exceed this will be critically reviewed with respect to length. Authors should include a word count with their manuscript.
- All the authors of a paper should include their full names, affiliations, postal addresses, telephone and fax numbers and email addresses on the cover page only of the manuscript. One author should be identified as the Corresponding Author.
- Manuscripts should be compiled in the following order: title page; abstract; keywords; main text; acknowledgements; appendixes (as appropriate); references; table(s) with caption(s) (on individual pages); figure caption(s) (as a list).
- Abstracts of 150 words are required for all papers submitted.
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- Section headings should be concise and logically sequenced. Biographical notes on contributors are not required for this journal.
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- Authors must adhere to SI units . Units are not italicised.
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2. Style guidelines and referencing

- Description of the Journal's article style , Quick guide
- Description of the Journal's reference style , Quick guide
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4. Figures

It is in the author's interest to provide the highest quality figure format possible. Please be sure that all imported scanned material is scanned at the appropriate resolution: 1200 dpi for line art, 600 dpi for grayscale and 300 dpi for colour.

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7. Supplementary online material

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Information about supplementary online material

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Manuscripts should be typed, double-spaced throughout, allowing 4 cm minimum margins. A standard 12 point font should be used.

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Appendix B: Database Specific Search Terms

Database	Search terms (based on APA descriptor terms)
PsycINFO	Subject: ("sex* offen*" OR "sex* abuser*" OR incest OR "incest offen*" OR pedophil* OR paedophil* OR "child abuser*" OR "child molest*" OR "child pornography") AND Abstract: (qualitative OR "grounded theory" OR theme* OR phenomenological OR quotations) NOT Title: (surviv* OR victim* OR recover* OR disclos*)
Academic Search Complete	Subject: ("sex* offen*" OR "sex* abuser*" OR incest OR "incest offen*" OR pedophil* OR paedophil* OR "child abuser*" OR "child molest*" OR "child pornography") AND Abstract: (qualitative OR "grounded theory" OR theme* OR phenomenological OR quotations) NOT Title: (surviv* OR victim* OR recover* OR disclos*)
CINAHL	Subject: ("sex* offen*" OR "sex* abuser*" OR incest OR "incest offen*" OR pedophil* OR paedophil* OR "child abuser*" OR "child molest*" OR "child pornography") AND Abstract: (qualitative OR "grounded theory" OR theme* OR phenomenological OR quotations) NOT Title: (surviv* OR victim* OR recover* OR disclos*)
Science Direct	Keyword / abstract / title: ("sex* offen*" OR "sex* abuser*" OR incest OR "incest offen*" OR pedophil* OR paedophil* OR "child abuser*" OR "child molest*" OR "child pornography") NOT Title: (surviv* OR victim* OR recover* OR disclos*) Search within results: Text: (qualitative OR "grounded theory" OR theme* OR phenomenological OR quotations)
Web of Science	Topic: ("sex* offen*" OR "sex* abuser*" OR incest OR "incest offen*" OR pedophil* OR paedophil* OR "child abuser*" OR "child molest*" OR "child pornography") NOT Title: (surviv* OR victim* OR recover* OR disclos*) Search within results: Text: (qualitative OR "grounded theory" OR theme* OR phenomenological OR quotations)

Appendix C: Table Presenting Quality Criteria and Study Ratings

Study	Research question / rationale clear	Methodology apparent & appropriate	Data collection apparent & appropriate	Sampling strategy appropriate	Analytic methods apparent & appropriate	Interpretations plausible & evidenced	Findings increase understanding	Clinical implications discussed	Ethical issues managed	Audit trail	Limitations discussed	Grade
Winder, B., & Gough, B. (2010) ''I never touched anybody - that's my defence'': A qualitative analysis of internet sex offender accounts	Yes	IPA Rationale provided for qualitative methodology & for use of IPA Episteme-ological issues discussed	Interviews audio-recorded & transcribed 1:1 semi-structured interviews (1.5 - 3 hours)	Sample pool of 36 with index offence of child pornography– 11 initially agreed to participate, final sample of 7 who consented Sample of size & homogeneity required for IPA	Interview schedule developed with colleagues No inter-rater coding Brief details of process	Yes Raw data presented to support themes	Yes	Yes	Yes Details of how confiden-tiality, informed consent, & de-briefing were managed	No	Some discussion	B
Rating	2	2	2	2	1	2	2	2	2	0	1.5	18.5
Sheehan, V., & Sullivan, J. (2010) A qualitative analysis of child sex offenders involved in the manufacture of indecent images of children	Yes	IPA Rationale provided for qualitative methodology & for use of IPA	Interviews video / audio recorded & transcribed Multiple semi-structured interviews with each participant (minimum 6 hours each)	First 4 suitable individuals to agree selected as participants Discussed appropriate-ness of sample	Used software for coding Inter-rater coding procedures & review by external researcher Discussed validity	Yes Raw data presented to support themes	Yes	Yes - within results section	Yes Details of how confiden-tiality was managed & ethical approval obtained	No	Some discussion of small sample size	B
Rating	2	2	2	1	2	2	2	1	2	0	1	17

Study	Research question / rationale clear	Methodology apparent & appropriate	Data collection apparent & appropriate	Sampling strategy appropriate	Analytic methods apparent & appropriate	Interpretations plausible & evidenced	Findings increase understanding	Clinical implications discussed	Ethical issues managed	Audit trail	Limitations discussed	Grade
Hartley, C. C. (2001) Incest offenders' perceptions of their motives to sexually offend within their past and current life context	Yes	Grounded theory Rationale provided for qualitative methodology & for use of grounded theory	Interviews video / audio recorded & transcribed 3 x open-ended interviews (1.5 hours) each	Details of purposive sampling strategy including inclusion / exclusion criteria Selected those who were making progress in therapy	Used software for coding No inter-rater coding Details of analysis provided	Yes Raw data presented to support themes	Yes	Yes	No details	No	No	B-
Rating	2	2	2	1.5	1.5	2	2	2	0	0	0	15
Phelan, P. (1995) Incest and its meaning: The perspectives of fathers and daughters	Yes	No details	No details as to whether interviews were recorded 1:1 interviews (2-6 hours)	Large sample size (40) for qualitative study Some details of selection processes provided	No details	Yes Raw data presented to support themes	Yes	Yes	No details	No	No	C-
Rating	2	0	0.5	1	0	2	2	2	0	0	0	9.5
Holt, T. J., Blevins, K. R., & Burkert, N. (2010) Considering the pedophile subculture online	Yes	Grounded theory Rationale provided for use of grounded theory	Raw data was threads from web forums Rationale provided for choice of raw data	Details of selection processes and inclusion criteria provided	No inter-rater coding Details of analysis provided	Yes Raw data presented to support themes	Yes	Yes	No details – mention of effort to maintain anonymity of sample	No	Yes	B
Rating	2	2	2	2	1.5	2	2	2	0.5	0	2	18

Study	Research question / rationale clear	Methodology apparent & appropriate	Data collection apparent & appropriate	Sampling strategy appropriate	Analytic methods apparent & appropriate	Interpretations plausible & evidenced	Findings increase understanding	Clinical implications discussed	Ethical issues managed	Audit trail	Limitations discussed	Grade
Gilgun, J. F. (1995) We shared something special: The moral discourse of incest perpetrators	Yes	Modified analytic induction Rationale provided for use of method Epistemeological issues discussed	Interviews audio-recorded & transcribed 1:1 open-ended life history interviews 6 interviews each, average 12 hours in total	Sample very hetero-geneous but justified variability No details of selection process	Inter-rater coding & analysis Details of analysis provided	Yes Raw data presented to support themes	Yes	Yes	Minimal details	No	Some discussion of reflexivity	B-
Rating	2	2	2	1	2	2	2	2	0.5	0	1	16.5
Brown, S. J., Walker, K., Gannon, T. A., & Keown, K. (2012) Creating a psychologically comfortable position: The link between empathy and cognitions in sex offenders	Yes	Thematic analysis Rationale provided for use of thematic analysis Epistemeological issues discussed	Interviews audio-recorded & transcribed 1:1 semi-structured interviews (20-30 minutes)	Minimal details regarding how final sample was selected Large sample size (23) for qualitative study	Inter-rater coding Details of analysis provided	Yes Raw data presented to support themes	Yes	Yes	Minimal details	No	No	C+
Rating	2	2	1.5	0.5	1	2	2	2	0.5	0	0	13.5

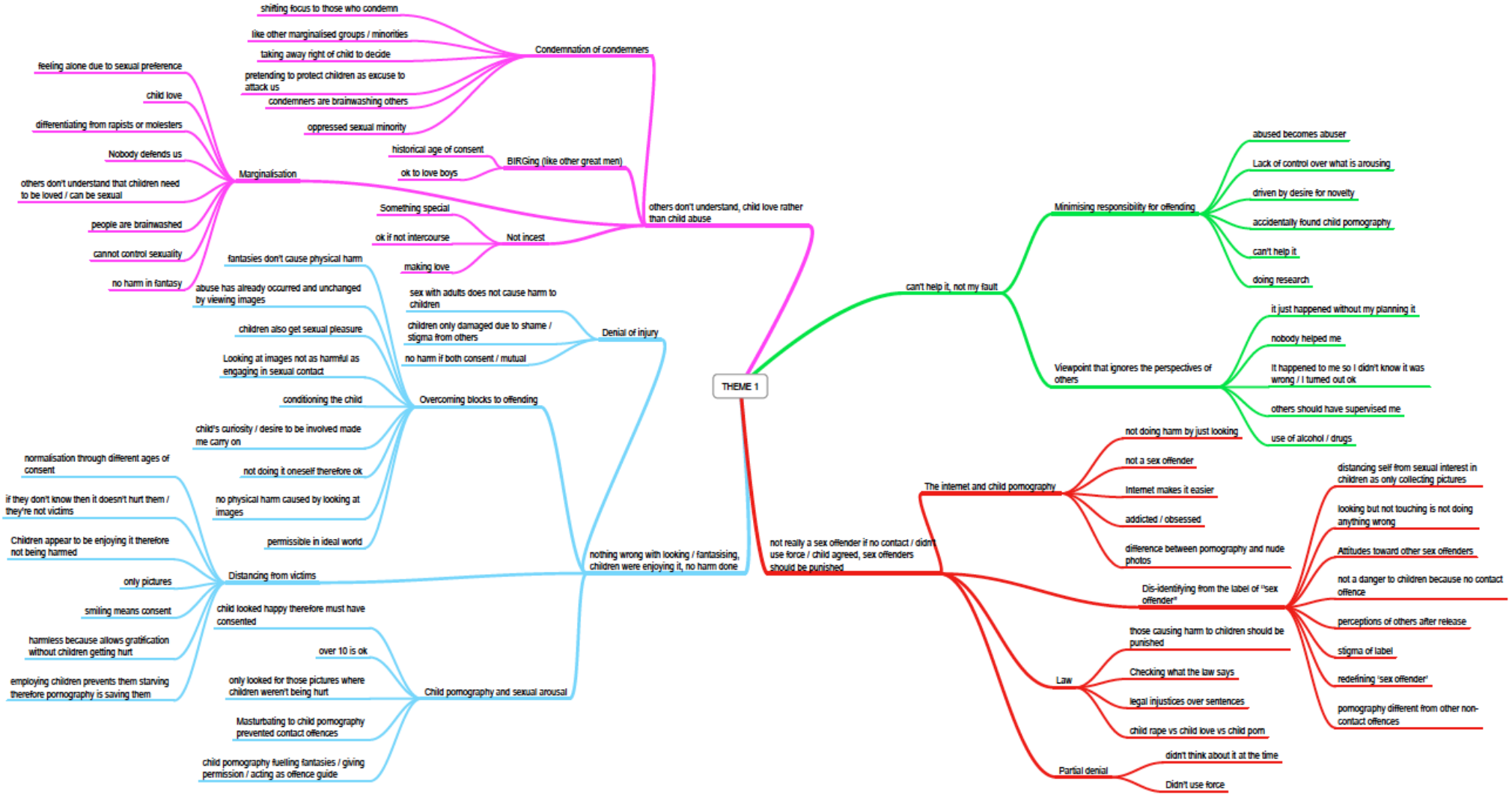
Study	Research question / rationale clear	Methodology apparent & appropriate	Data collection apparent & appropriate	Sampling strategy appropriate	Analytic methods apparent & appropriate	Interpretations plausible & evidenced	Findings increase understanding	Clinical implications discussed	Ethical issues managed	Audit trail	Limitations discussed	Grade
Quayle, E., & Taylor, M. (2002) Child pornography and the internet: Perpetuating a cycle of abuse	Yes	Qualitative analysis within discursive framework – precise methodology unclear Rationale provided for qualitative methodology	Interviews audio-recorded & transcribed 1:1 open-ended interviews	Minimal details regarding how final sample was selected	No inter-rater coding Emphasis on subjective meanings for participants Details of analysis provided	Yes Raw data presented to support themes	Yes	Yes – within conclusions	No details except regarding data storage Used initials to identify quotes	No	No	C
Rating	2	1	2	0.5	1	2	2	1	0.5	0	0	12
Gilgun, J. F. (1994) Avengers, conquerors, playmates, and lovers: Roles played by child sexual abuse perpetrators	Yes	Makes reference to both phenomen-ological approaches and grounded theory techniques – specific methodology unclear	Interviews audio-recorded & transcribed Field notes taken for additional details Wide range of interview sessions / duration with each participant	Volunteers from variety of settings Large sample size (23) for qualitative study	No details of method of analysis Mentioned importance of subjective meanings for participants	Yes Raw data presented to support themes	Yes	Yes	No details	No	Some brief discussion	C
Rating	2	0.5	2	1	0.5	2	2	2	0	0	0.5	12.5

Study	Research question / rationale clear	Methodology apparent & appropriate	Data collection apparent & appropriate	Sampling strategy appropriate	Analytic methods apparent & appropriate	Interpretations plausible & evidenced	Findings increase understanding	Clinical implications discussed	Ethical issues managed	Audit trail	Limitations discussed	Grade
Hartley, C. C. (1998) How incest offenders overcome internal inhibitions through the use of cognitions and cognitive distortions	Yes	Grounded theory Rationale provided for qualitative methodology but not for choice of grounded theory	Interviews audio-recorded & transcribed 3 interviews (1 – 1.5 hours) each	Details of purposive sampling strategy including inclusion / exclusion criteria	Details of analysis provided No inter-rater coding Used software for coding	Yes Raw data presented to support themes	Yes	Minimal discussion	No details	No	Some discussion regarding sample selection	C+
Rating	2	1.5	2	2	1.5	2	2	0.5	0	0	0.5	14
Durkin, K. F., & Bryant, C. D. (1999) Propagandizing pederasty: A thematic analysis of the on-line exculpatory accounts of unrepentant pedophiles	Yes	Content analysis No rationale provided for choice of methodology	Raw data was postings from online newsgroup Rationale provided for choice of raw data	Details of selection processes and inclusion criteria provided	Inter-rater coding with reliability coefficients calculated Details of analysis provided	Yes Raw data presented to support themes	Yes	Yes	No details	No	No	B-
Rating	2	1	2	2	2	2	2	2	0	0	0	15

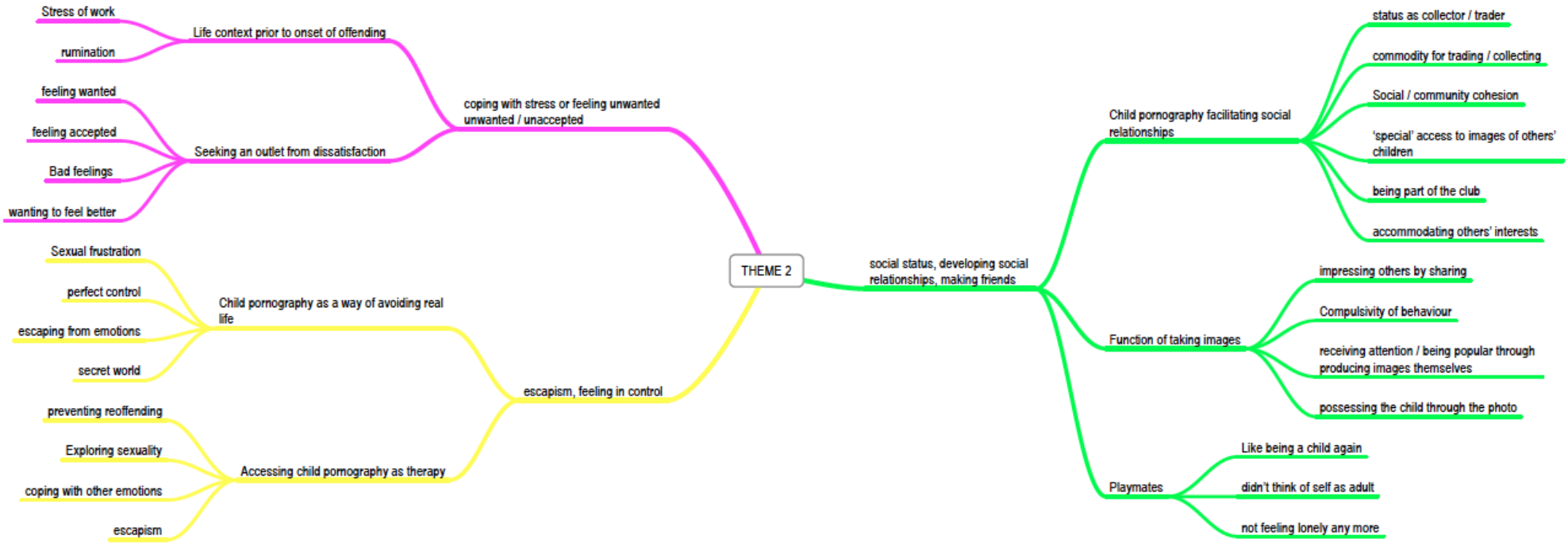
Note. Each criterion was rated as follows: 0: absent; 1: partially present; 2: definitely present. The sum of these ratings was then used to provide a final grade as follows:

A	B	C	D
22 – A+	19-20 – B+	13-14 – C+	<7 – D (reject)
21 – A	17-18 – B	11-12 – C	
20 – A-	15-16 – B-	8-10 – C-	

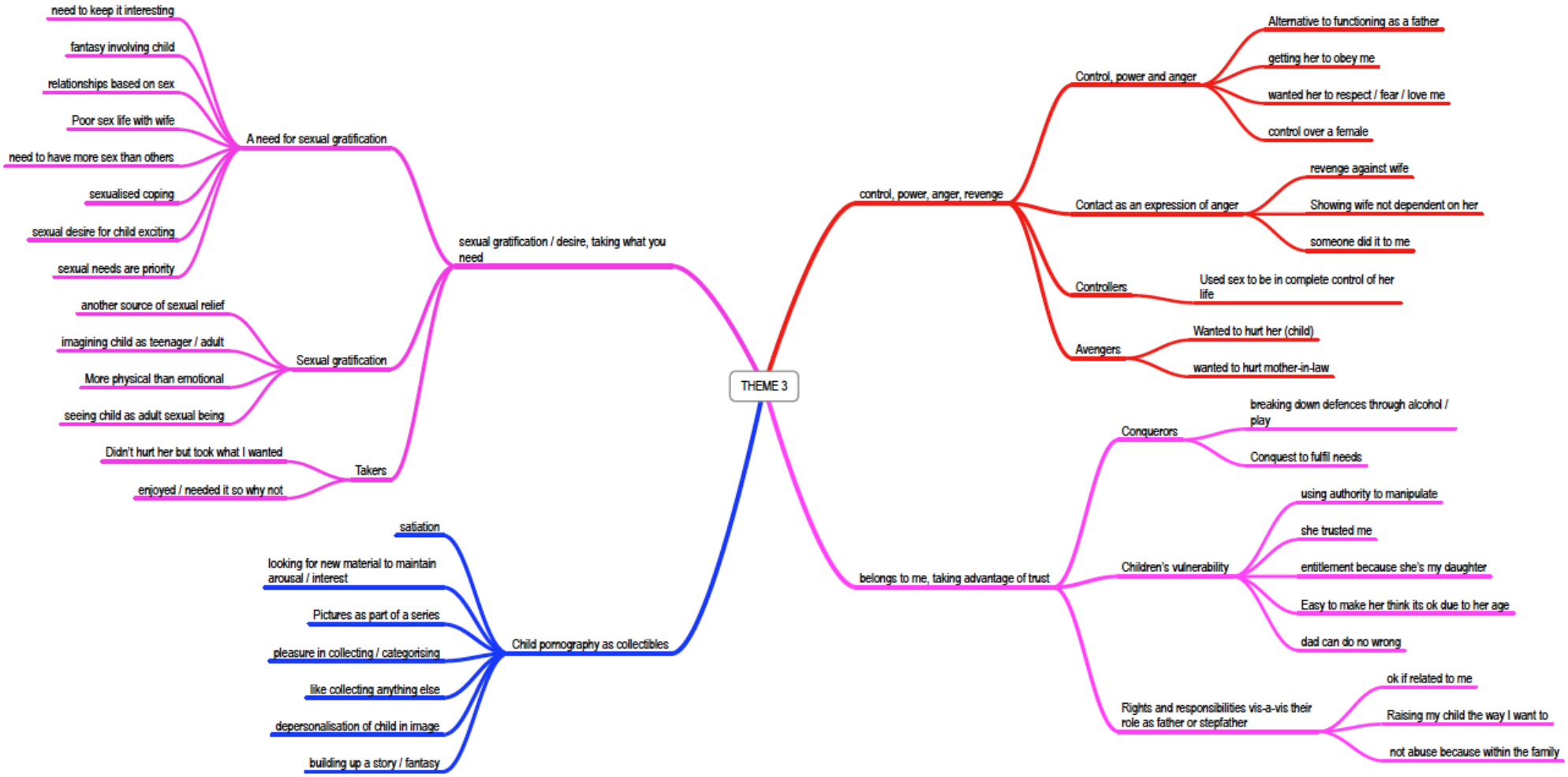
Appendix D: Mind-map of Core Concept - I am not a sex offender: stigmatised sexuality and disassociation from doing harm



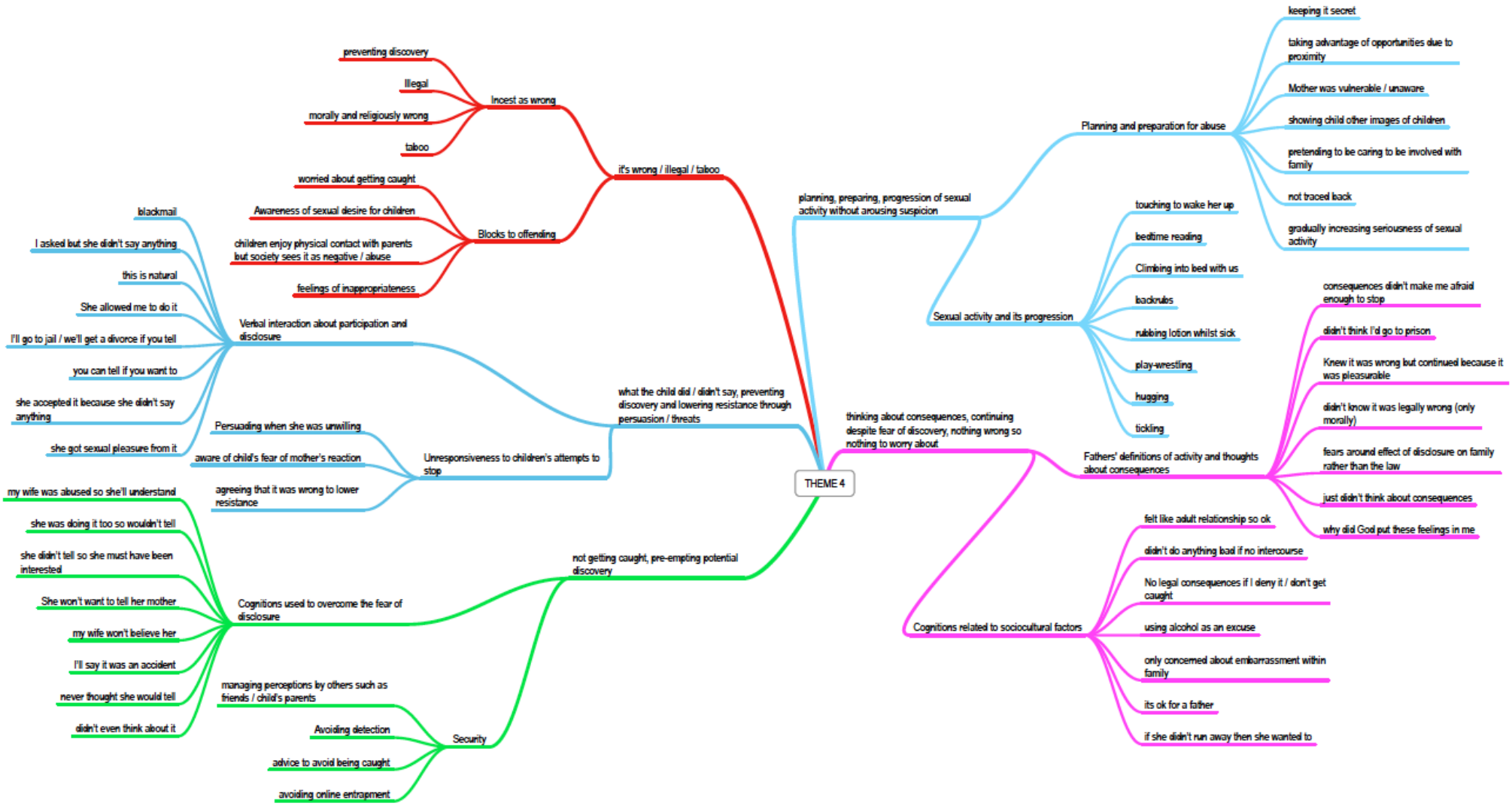
Appendix E: Mind-map of Core Concept - inter and intra-personal processes: sexualised coping, self-esteem, and social status



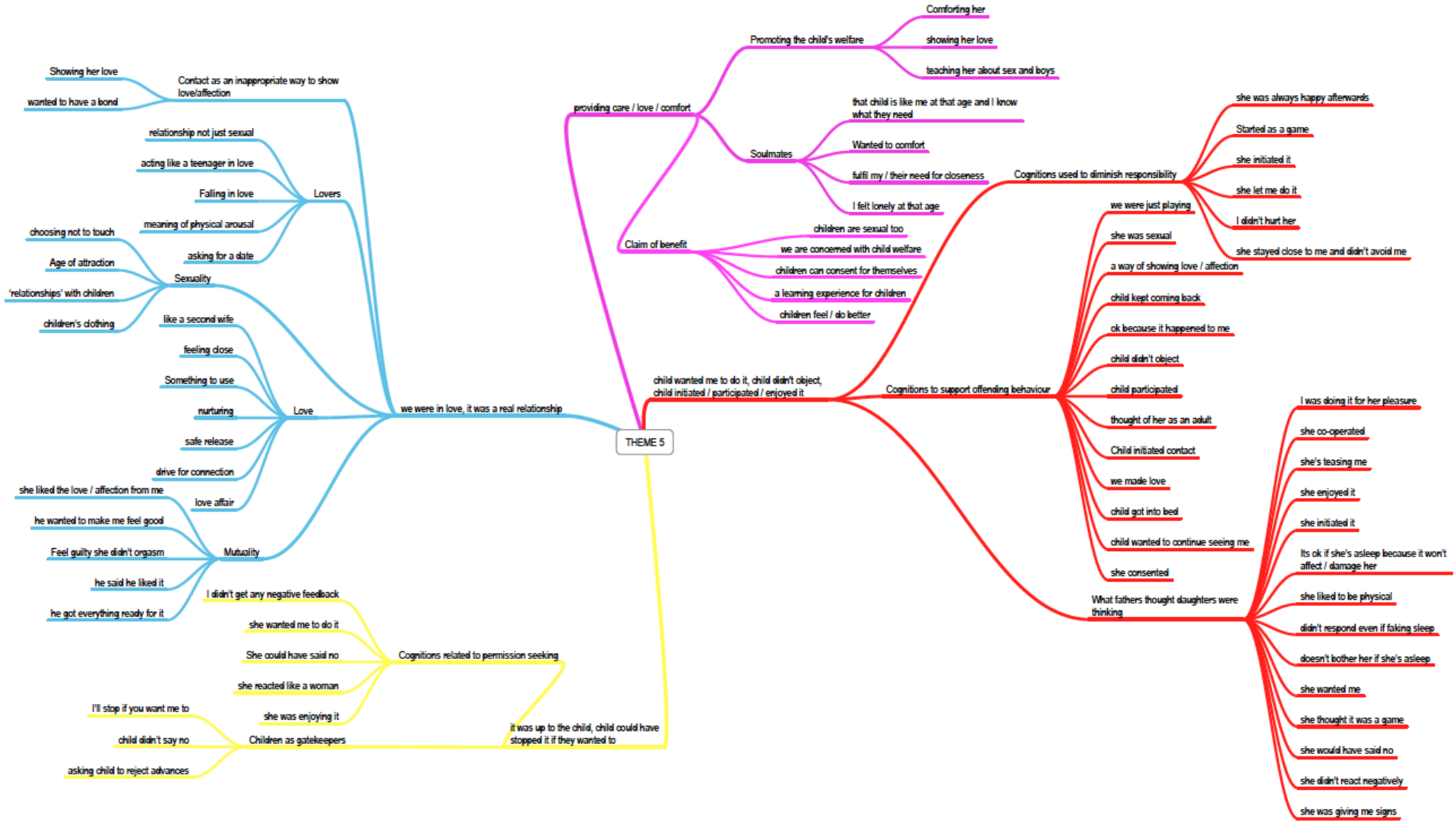
Appendix F: Mind-map of Core Concept: Objectification and ownership: commodity to conquer, control, or collect



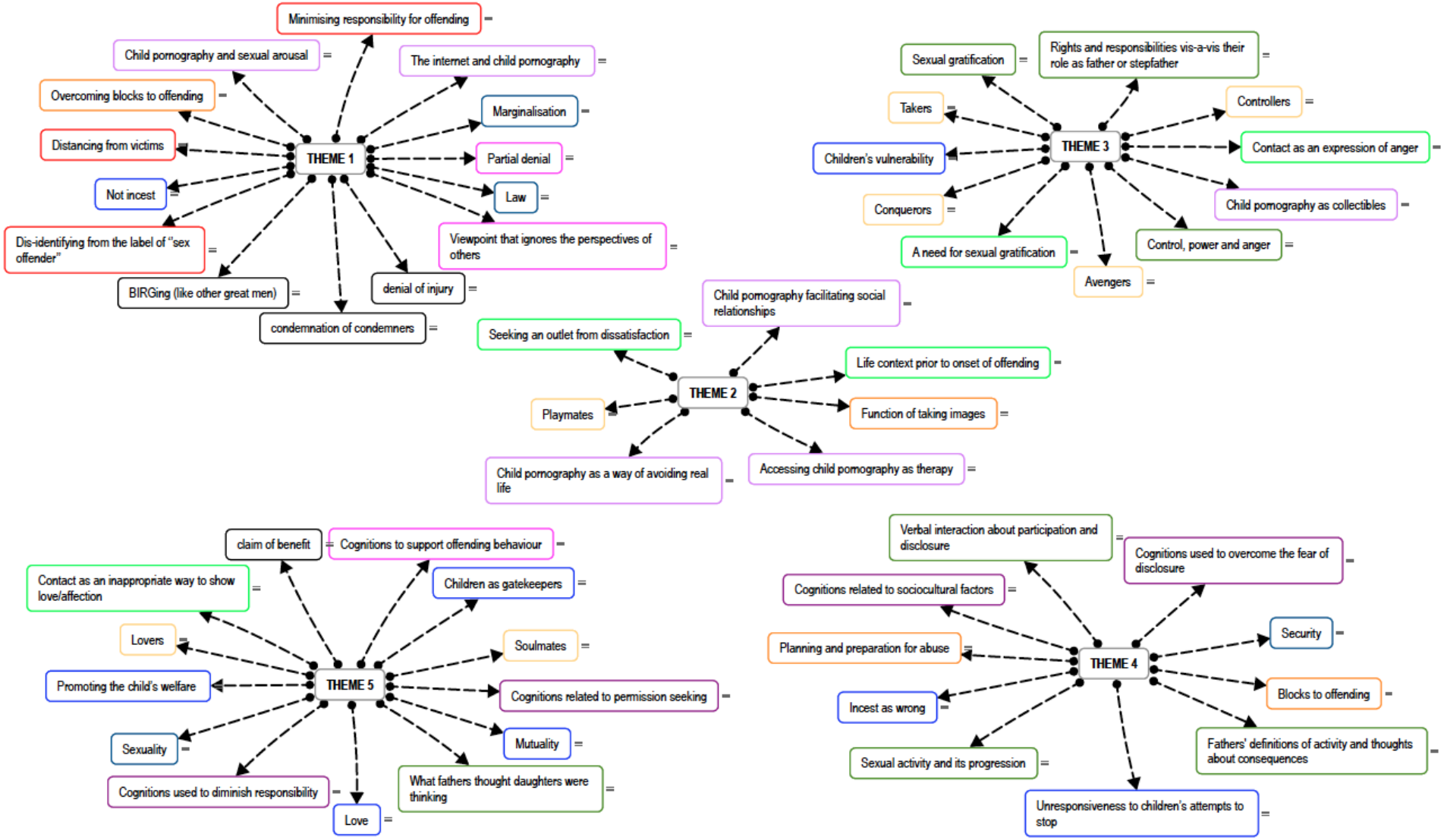
Appendix G: Mind-map of Core Concept - Pre-empting consequences: preventing disclosure and discovery



Appendix H: Mind-map of Core Concept - Mutuality: love, care, and consent



Appendix I: Mind-map of Themes from Studies Grouped by Core Concepts



Appendix J: Table Identifying Studies Contributing to Each Core Concept

Study	I am not a sex offender: stigmatised sexuality and disassociation from doing harm	Sexualised coping, self-esteem, and social status: inter / intra-personal processes	Objectification and ownership: commodity to conquer, control, or collect	Pre-empting consequences: preventing disclosure and discovery	Mutuality: love, care, and consent
'I never touched anybody - that's my defence'': A qualitative analysis of internet sex offender accounts	X				
A qualitative analysis of child sex offenders involved in the manufacture of indecent images of children	X	X		X	
Incest offenders' perceptions of their motives to sexually offend within their past and current life context		X	X		X
Incest and its meaning: The perspectives of fathers and daughters			X	X	X
We shared something special: The moral discourse of incest perpetrators	X		X	X	X
Creating a psychologically comfortable position: The link between empathy and cognitions in sex offenders	X				X
Considering the pedophile subculture online	X			X	X
Child pornography and the internet: Perpetuating a cycle of abuse	X	X	X		
Avengers, conquerors, playmates, and lovers: Roles played by child sexual abuse perpetrators		X	X		X
How incest offenders overcome internal inhibitions through the use of cognitions and cognitive distortions				X	X
Propagandizing pederasty: A thematic analysis of the on-line exculpatory accounts of unrepentant pedophiles	X				X

Section Two: Research Paper

Narratives of Individuals With Violent Offending Histories After Schema Therapy

Word count: 8000

Irram Walji

Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

Prepared for submission to Journal of Forensic Mental Health (see Appendix H for author guidelines)
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Abstract

Schema therapy is an effective intervention for interpersonal difficulties, and has been adapted for forensic populations. This qualitative study explored narratives of nine individuals in medium secure and high secure settings following engagement in schema therapy. Narrative analysis was used to identify the self-constructs presented. Some individuals developed coherent, schema-based narratives integrating multiple selves, including offending identities, and their narratives were congruent with therapeutic changes associated with reductions in risk and reoffending. Self-constructs were shaped by relational experiences and contexts, highlighting the importance of relational security for forensic rehabilitation.

Key words: schema therapy; violent offending; secure hospital; narratives; qualitative.

Narratives of Individuals With Violent Offending Histories After Schema Therapy

Treatability Discourses and Therapeutic Narratives in Secure Settings

The introduction of schema therapy (ST) into forensic contexts is a development in service provision for individuals with both offending histories and mental health difficulties. While such individuals are often diagnosed with personality disorders (PD), comorbid diagnoses of schizophrenia or schizoaffective disorder are also common[2]. Historically, individuals with PD diagnoses were often excluded from many services (National Institute of Mental Health in England, 2003). Professional pessimism prevailed since few therapeutic interventions were deemed effective with this population (Young, Klosko, & Weishar, 2003); especially for those with offending histories (Willmot & Tetley, 2011). However, policy changes highlighting unmet needs (National Institute of Mental Health in England, 2003) led to the development of new therapeutic approaches (such as cognitive analytic therapy, mentalisation-based therapy, and dialectical behaviour therapy), displacing previously nihilistic discourses considering this population as "untreatable" (Willmot & Tetley, 2011)[3].

These individuals' complex presentations mean a significant proportion are admitted to secure settings; forensic populations therefore have a high prevalence of individuals with interpersonal difficulties (Fazel & Danesh, 2002). High rates of recidivism (Jamieson & Taylor, 2004) highlight the importance of appraising what works with this population, and indicate a closer examination of therapeutic

[2] Although debate continues regarding the validity of these terms (Boyle, 2007; Mason, Caulfield, Hall, & Melling, 2010; Reimer, 2010).

[3] Removal of the treatability clause from the Mental Health Act (MHA) in 2007 also had a significant impact in driving these changes forwards, as services now needed to offer interventions for individuals that were not previously detainable (Willmot & Tetley, 2011).

interventions is warranted. Secure settings aim to maintain therapeutic environments whilst providing appropriate restrictions. This is a difficult balance to achieve when dominant societal narratives around "dangerousness" lead to an emphasis on physical and procedural security over a therapeutic milieu (Deacon, 2004). However, relational security is integral to reductions in risk and recidivism (Exworthy & Gunn, 2003).

There is now greater awareness of the damaged attachment histories of this population (Sainsbury, 2011), and disempowerment and marginalisation from childhood trauma can be re-enacted in services (Stowell-Smith, 2006). Relational patterns developed in childhood leading to offending behaviours (Pollock & Stowell-Smith, 2006) also mean engagement can be difficult due to mistrust and hopelessness (Sainsbury, Krishnan, & Evans, 2004), and secure therapeutic relationships are a core feature in forensic rehabilitation (Beckley, 2011b). ST for forensic populations is therefore a significant and timely step forwards in offering a relational approach encompassing features of "what works" from the criminal justice literature and the evidence base for working with interpersonal difficulties (Willmot & Tetley, 2011).

The Schema Model

The original schema model[4] formulated by Young et al. (2003) proposes early maladaptive schemas (EMS) are developed in childhood or adolescence to understand and cope with toxic experiences, but continue to be perpetuated through adulthood even when the individual's immediate relationships and environment have changed, thereby causing significant distress and dysfunction. EMS[5] are pervasive patterns of powerful emotions and cognitions regarding individuals' self-constructs and

[4] See Appendix A for further details on the schema model.
[5] Eighteen different EMS have been identified by Young et al. (2003), including abandonment, mistrust / abuse, defectiveness, emotional deprivation, entitlement, etc.

relationships, and are linked to personality traits and emotional distress (Nordahl, Holthe, & Haugum, 2005; Nordahl & Nysaeter, 2005).

However, Young et al. (2003) found individuals with extremely traumatic early experiences were unable to benefit fully from ST since they had a large number of different schemas, and presented with rapidly shifting emotional states which seemed un-integrated (Young et al., 2003). They therefore developed the concept of schema modes for working therapeutically with these individuals. A schema mode is a dominant state of mind resulting from a characteristic grouping of schemas and coping responses that become activated in response to specific triggers, and manifests as distressing emotions or maladaptive behaviours (Young et al., 2003). An individual may present with a number of different modes[6] and these may be dissociated from each other to different extents, so the individual may appear to shift rapidly from one to another with varying degrees of awareness and control (Young et al., 2003).

ST offers a validating and normalising approach to exploring relational difficulties, and empirical studies (Farrell, Shaw, & Webber, 2009; Giesen-Bloo et al., 2006) and a recent review (Masley, Gillanders, Simpson, & Taylor, 2012) demonstrates its effectiveness.

Schema Therapy in Forensic Contexts

ST is increasingly implemented in forensic settings (Beckley, 2010, 2011b; Bernstein, Arntz, & de Vos, 2007; Bernstein, de Vos, Jonkers, de Jonge, & Arntz, 2012a), and the original theoretical model has been adapted to include four additional over-compensatory modes commonly observed in these populations[7] (Bernstein et al., 2007; Bernstein et al., 2012a). Therapeutic aims remain to moderate or eliminate maladaptive schema modes while strengthening healthy adult modes, enabling

[6] For example, vulnerable child, angry child, detached protector, punitive parent, etc.
[7] Angry protector, conning and manipulative mode, predator mode, and over-controller mode.

emotional needs to be met more adaptively (Young et al., 2003). In forensic populations, ameliorating schema modes also impacts on an individual's risk of violence and recidivism (Bernstein et al., 2007; Bernstein et al., 2012a). ST is offered in individual and / or group sessions and usually consists of approximately two years of intensive therapy (Beckley, 2010).

Previous Research

The only completed study identified focussing on outcomes of ST with forensic populations did not find a statistically significant treatment effect for ST when compared to treatment as usual (Tarrier et al., 2010). Although significant clinical improvements were found, confounding factors meant these could not be conclusively attributed to ST. A study (currently ongoing) exploring the impact of ST for individuals in high secure hospitals has reported encouraging pilot data in the form of reliable improvements in assessment scores for risk and symptomology (Bernstein & Arntz, 2009). Another study (also ongoing) is monitoring changes in affective capacity of individuals diagnosed with psychopathic traits to determine whether ST is effective in producing changes in emotional functioning (Nentjes & Bernstein, 2011). There have been no other studies identified as exploring the impact of ST in forensic populations.

All the studies mentioned previously[8] and those included in the systematic review (Masley et al., 2012) used quantitative methodologies, and there is insufficient research on individuals' actual experiences of engaging in ST. Only one published qualitative study was identified (ten Napel-Schutz, Abma, Bamelis, & Arntz, 2011), and this produced valuable insights and the proposal of clinical practice guidelines for

[8] Bernstein & Arntz (2009); Farrell et al. (2009); Giesen-Bloo et al. (2006); Nordahl et al. (2005); Nordahl & Nysaeter (2005); Tarrier et al. (2010).

improving therapeutic experiences, promoting future responsivity and engagement to enhance implementation of ST (ten Napel-Schutz et al., 2011).

Positive outcomes are paramount with forensic populations, and exploring their therapeutic experiences can be valuable in informing clinical practice and risk management (Sullivan, 2005; Yorston & Taylor, 2009), and complement quantitative findings by capturing data missed by other methodologies (Webster & Marshall, 2004). Furthermore, eliciting personal stories provides opportunities to hear the voices of an often disempowered population (Blagden & Pemberton, 2010) who have few opportunities to express their perspectives (Bartlett & Canvin, 2003). There is also an increased focus on narrative approaches with forensic populations (e.g. Adshead, 2012; Canter & Youngs, 2012; Green, South, & Smith, 2006; Presser, 2009; Ward & Marshall, 2007). Understanding how individuals perceive themselves in relation to others and their contexts informs clinicians' perspectives of individuals' self-constructs, and provides insights into goals, relationships, and therapeutic experiences, enhancing responsivity to individual needs and risks[9] (Adshead, 2012; Ward & Marshall, 2007). Narrative identity has been linked to the Good Lives Model (GLM) (Ward, 2002) and has clinical utility in risk management and relapse prevention (Ward & Marshall, 2007).

Rationale and Aims

Using a narrative approach to explore the experiences of individuals with offending histories who have engaged in ST provides a timely and much-needed insight into ST from their perspective, enabling evaluation of whether personal narratives incorporate ST concepts when reflecting on offending behaviour, and how ST might have influenced their sense of self. A core element of narrative analysis

[9] Individuals in forensic settings often have fragmented and impoverished narrative identities due to unresolved distress, dissociation, or trauma, and the construction of a coherent and holistic self-narrative can be central to rehabilitation (Adshead, 2012; Dimaggio, 2010).

(NA) is uncovering participants' self-constructs, and exploring how the topic under question has impacted on these (Weatherhead, 2011). This method is therefore an appropriate approach for exploring this topic, as ST essentially reformulates self-constructs to develop integrated narratives (Young et al., 2003).

NA allows participants to present stories in their preferred way, reflecting influences of local and wider systems and facilitating exploration of how different contexts have shaped individuals' self-constructs and meaning-making processes (Emerson & Frosh, 2004) – an issue especially pertinent in secure mental health services. Moreover, NA is a useful approach for research where only a small number of individuals fit the inclusion criteria, as each narrative can be explored in depth (Weatherhead, 2011).

Research Question

What are the personal narratives of individuals with a history of violent offending, following engagement in ST? Secondary aims include exploring individuals' narratives of engaging in ST, whether they have found the approach helpful in understanding their previous offending behaviours and risk, and if their therapeutic experiences have impacted on their self-constructs and ways of relating to others.

Method

Design

This qualitative study had ten participants. Individuals meeting the inclusion criteria comprise a small and hard to reach population (Ruane, 2003), and the scarcity of qualitative research with such individuals means there is a high value to hearing their stories. Furthermore, NA does not require large samples as it aims to elicit rich, detailed accounts for developing deeper understandings of a particular phenomenon in

a specific cohort rather than producing generalisable findings (Emerson & Frosh, 2004). However, it is hoped findings will have clinical utility for best practice of ST with forensic populations. Eliciting narrative accounts enabled exploration of whether individuals' stories reflected understandings congruent with ST[10].

NA was conducted on transcriptions of interview recordings. The interview guide was semi-structured rather than open-ended, using reflexive conversational prompts and questions to cover areas not addressed spontaneously by participants. This design was informed by previous research with individuals who have histories of sexually harmful behaviours (Emerson & Frosh, 2004).

Participants

Ten individuals were recruited from a medium secure (MS) service and a high secure (HS) hospital (see Table 1 for demographic information). Individuals who met the inclusion criteria had previous conviction(s) for violent offending, and had engaged in ST on an individual and / or group basis for a minimum of twelve months[11].

_____Table 1_____

Procedure

The project proposal underwent peer review at Lancaster University giving trainee clinical psychologists, research tutors, and service users opportunities to comment. The study was reviewed and approved by the Liverpool East Research Ethics Committee, and research governance approval was sought from relevant NHS Trusts (see Ethics Section).

[10] See Appendix B for further details on the choice and use of NA in this study.
[11] Violent offending includes sexual offending and arson. Individuals were excluded if they were experiencing emotional distress during the recruitment period, or if they had been involved in a recent serious incident (depending on the type of incident and length of time prior to interview – risk assessments conducted by clinical staff on site). Participants were not excluded based on when they completed therapy (e.g. if they had completed therapy at the medium secure service and had been discharged into the community by the time of recruitment).

A phased recruitment strategy was used (Figure 1), where successive stages were implemented as required.

_____Figure 1_____

All processes in relation to data collection and storage were conducted in line with the approved research protocol. Interviews were audio-recorded and transcribed verbatim.

Analysis

The epistemological foundations of NA are incongruent with defining a "correct" method (Mishler, 1991), therefore researchers are encouraged to develop their own frameworks for analysing data (Riessman, 2008). Previous narrative works inform but do not determine how NA is best utilised for analysing a particular dataset, allowing greater independence and flexibility (Emerson & Frosh, 2004). Analysis in this study was informed by a number of key NA texts (Emerson & Frosh, 2004; Gee, 1991; Lieblich, Tuval-Mashiach, & Zilber, 1998; Riessman, 1993, 2008) and other academic NA sources (Burck, 2005; Weatherhead, 2011). Literature focussing on narratives in forensic contexts was also referred to (Maruna, 2001; Presser, 2005, 2008, 2009, 2010, 2012). Based on analytic processes outlined in these works, a framework for examining and deconstructing transcripts was developed (Figure 2).

_____Figure 2_____

Following multiple readings and annotations of transcripts (Appendix C), analytic processes outlined in Figure 3 were followed, and individual summaries were created based on significant narrative threads (Appendix D). Developing summaries at this stage in analysis protected the narrative's gestalt from fragmentation during later stages, when these aspects may not have remained visible. Similarities and differences were examined within and across transcripts, and a shared narrative was

constructed that did not merge stories and minimise diversity, but incorporated nuanced differences reflecting multi-dimensional aspects of individual experiences.

Reflexivity

The researcher is a trainee clinical psychologist with experience of working with individuals in secure settings who have offending histories. Her epistemological position is outlined in Appendix E. The academic supervisor is a clinical psychologist and lecturer with clinical and research interests including narrative approaches. The field supervisors are both clinical psychologists using ST in MS and HS settings.

Forensic research can have an emotional impact on researchers (Sollund, 2008) therefore supervision was accessed to ensure analysis and interpretation were not affected (Roberts, 2011), and a reflective diary was kept to facilitate this. Recruitment and analytic processes were regularly reviewed in supervision, including feedback on interviews and transcripts, and discussion around analysis to minimise potential researcher bias. Audit trails are included in appendices to evidence the analysis.

Findings

Analysis of individuals' narratives after engaging in schema therapy centred on exploring their sense of self, as this created space for reflections on therapeutic experiences without an evaluative focus. Strategies and psychological processes involved in presenting a preferred story of oneself, and wider influences shaping the construction of these stories were also considered. Findings[12] are outlined in Figure

[12] Findings are not presented in chapters as many narrative analyses are since these stories were often fragmented and reflected chaotic lives; framing them within chapters would therefore be incongruent with the nature of these narratives. Instead, they are presented in three sections focussing on self-constructs, processes leading to construction of presented narratives, and influences shaping these. Appendix F presents additional supporting material related to these findings, which offers a more nuanced perspective on these three sections by including more voices than is possible in this section.

4, and a diagrammatic representation of the shared narrative conceptualising relationships between the findings is presented in Figure 5.

_____Figure 4_____

Individual maps are also included in Appendix G to illustrate how this shared narrative retains space for individual differences within it.

_____Figure 5_____

Section One: Self-Constructs Presented in the Narratives

Destruction and deprivation. Nearly all participants described damaging childhood experiences of abuse by family members or caregivers, with the exception of George who mentioned minimal childhood details. Accounts were presented at various points within narratives, and were always framed as starting-points for journeys into secure services: "what started that off was like, because I was abused twice, sexually abused twice when I was younger" (Terry).

Childhood abuse had a shattering impact on individuals' developing identities. For Andy, being "treated like a piece of meat" meant he was "psychologically…[13] destroyed […][14] and suffered sexual abuse, psychological abuse, and…at the hands of my dad". Abuse also influenced how individuals positioned themselves with others; Eddie and Andy noticed other children were loved and cared for, highlighting deprivation in their own lives. These experiences led individuals to develop negative beliefs about themselves and their immediate contexts so "the world were a bad place" (Matthew).

Fear is the path to the dark side. Damaging experiences led individuals to believe others were "after something when they were talking to me […] all my life, I'd never trusted nobody. I didn't trust friends, I didn't trust family, I trusted nobody"

[13] Indicates pause in speech.
[14] Indicates words removed from quote.

(Eddie). They felt vulnerable and expected others to hurt them, consequently taking steps to protect themselves and ensure "I won't ever become a victim again" (Danny). George described fear due to psychotic experiences when he "thought people was after me, were going to kick at me and kill me […] I was walking around the bungalow like, with a knife on me and a hammer in my pocket". Vulnerability led to reactive violence in attempts to retain power and control, and resulted in "fighting all the time" (Ben). For Terry, a sense of loss triggered destructive behaviours as he tried to: 'take something back what other people, or what other men took from me".

Individuals developed "pure violent" (Ben) self-constructs. For most, this identity was shaped and reinforced by behaviours, such as "tearing people's throats out, fighting, violence, using weapons […] very, very violent. Actually, it was horrendous violence. Graphic, brutal violence" (Danny). This violent self was the "dark side" (Danny), referred to by many individuals, which committed the index offence. An inevitable consequence of offending behaviour was detention in secure / custodial settings. All individuals reported previous institutions had been unhelpful with minimal impact on offending behaviours. Eddie experienced re-enactment of previous traumas when staff at another HS hospital physically and emotionally abused him, and Carl also described "being abused by the system", reinforcing disempowerment and mistrust of others.

Connecting and disconnecting narratives. A key feature of ST was realising "we've all had a…sh*t childhood and been abused in one way or another" (Andy). Understanding there was something beyond individual differences contributing to offending behaviours promoted a shift in self-constructs as individuals began to position themselves differently, "because usually, you think it's all just happened to you and it's all in your head, do you know what I mean? You're the

wrong 'un in all this" (Ben). Hearing staff share information about their own schemas was also a powerful, normalising experience.

When individuals started conceptualising themselves as similar and connected to others, they accepted their potential to change their sense of self and their futures. They were aware of negative outcomes for similar others, and felt they "deserve a second chance, the same as anybody else" (Danny). Individuals also disconnected themselves from others based on diagnoses or index offences. Those with PD diagnoses felt "I'm glad I've not got a mental illness […] I've come here as a PD and that's it" (Carl) whereas those with schizophrenia diagnoses felt "I don't want to be classed as a psychopath. I've got no problem being mentally ill" (Dave).

Discovering and disowning identities. The relational context and therapeutic experiences created space for reflections on multiplicities or contradictions in self-constructs. Different identities were reconciled and integrated through awareness that the same self lay underneath varying presentations: "everyone has to wear a different mask for different places" (Ben). Others disassociated from offending selves, considering themselves "a bit like Jekyll and Hyde" (Matthew) and felt "it weren't me" (Matthew) who committed the index offence, echoed by George and Dave considering their index offences as "totally out of character" (George). Disowning this self meant George and Dave struggled to hold compassionate positions in relation to themselves. Neither Dave, George, nor Matthew presented schema-based narratives for index offences.

Regardless of whether different selves had been reconciled, all individuals felt their current self was very different from previous selves: "now I've got a completely different mind" (Matthew). ST was depicted as central in changing self-constructs, which was an arduous process as described in Danny's metaphor:

> …you have to change everything you believe in. You have to change your core beliefs of what you've grown up with. What your foundations have been built on. It's stripping that back to the bare necessities and then building the new person, with new schemas, the right schemas, the right ideas, and the right thought patterns and behaviour.

Individuals who felt they had achieved this spoke at length about their new sense of self.

The hospital at the heart of it all. For individuals in HS, the hospital itself was as essential as therapy in developing different self-constructs. The safe relational context was frequently highlighted, and realising others cared was a significant step in creating space to reflect on narratives always held about oneself and others. Many felt "thankful really, I've been given a chance to come here to do therapy, because obviously there's a lot of people out there that don't" (Andy).

Most individuals felt they had become older and wiser during their stay, and the experience of having spent a long time in hospital was part of their identity. Terry did not want to leave after forty years as "this is my home, and moving from…to somewhere else, I feel is a bit, you know, a bit scary…and you know, going to somewhere where I don't really know anybody, and, you know, it's starting again".

Section Two: Strategies and Processes for Constructing and Presenting Self-Constructs

Reformation: recognition, realisation, and reflections. Individuals presented different measures to demonstrate self-change, including the ability to explore and reflect on emotions, and the amount of medication prescribed. Many individuals used metaphors of physical space or travelling to emphasise how far

removed their current self was from previous selves. Change was conceptualised as a journey, described as "a straight and narrow path" (Andy) leading to "the road to recovery" (Andy), and "keeping on my pathway" (Eddie) was important. Dichotomies were also used to express difference from previous selves, especially by Eddie (for example "violent / non-violent", "good / bad", "right / wrong").

Change was further emphasised by descriptions comparing individuals' progress to others, since they had been "one of the worst ones in here" (Eddie). Carl was proud he had "come far more…ahead of myself in six years than some people have in seventeen years" despite: "my psychologist has told me I've got one of the worst abuse schemas that's she's ever seen" and Terry had been an "equal player" in the ST group notwithstanding learning difficulties. Such changes were the basis for individuals' believing they would desist from offending behaviours. Developing a coherent narrative was a crucial step for Andy

> understanding myself now. I can look back and go…I can look back and see what was going on, and understand why I was acting the way I was acting, why I was doing what I, what I was doing.

In contrast, Terry felt since he had finished therapy and was due to be transferred to MS, "I don't think I'm a risk to anybody else" but offered no connections between this risk and therapeutic experiences.

Dave and George presented narratives describing how mental ill-health led to index offences, and how a lack of insight meant they had not accessed support in time. These narratives meant index offences would "never have happened" (George) in the absence of mental health difficulties, or if support had been available. Both Dave and George used the concept of "insight" repeatedly, and emphasised how awareness of relapse signatures meant they could not become unwell again, and were

therefore unlikely to reoffend since "it happened because I was mentally ill" (George). This "diminished responsibility" narrative left little space for considering other factors influencing offending behaviours; George presented no understandings not based on a mental illness model, and although Dave reflected on how childhood experiences had shaped his adult self, he excluded his index offence from that part of his self-construct.

Evaluating again: empathy and accountability. Reflecting on changes in themselves, individuals emphasised "I'm not a villain. I know I've done wrong in my life. I'm not really a bad person" (Carl). This was conveyed in varying ways; Matthew mentioned his first impulse before committing his index offence had been to leave the victim alone, and Dave described how his index offence had not been premeditated but "on autopilot, I just reacted to things". George explained a Hospital Order rather than a prison sentence proved he had been unaware of his actions. However, Ben described previous experiences of caring behaviour to demonstrate 'goodness': "I used to go and nick rabbits…because they just looked lonely. Now I walk past a garden and saw a rabbit in a shed, I think 'ahh…that's proper lonely, I'll take it home with me' ".

Terry and Matthew both mentioned victim empathy as a measure of change, with Terry making links to his own childhood abuse and Matthew considering ripple effects of offending behaviour: "when I was doing that, I didn't care and it's like, in them times, when you think back how much damage I have caused…sadness". Dave shared responsibility for his index offence with those who failed to help him, whereas Carl saw accountability and regret as drivers for personal change.

The significance of schema therapy – struggling through it with others. ST discourses were reflected throughout narratives, but most individuals also spoke

directly about therapeutic experiences. Nearly all gave ST an active voice at various points in their narrative, positioning themselves as passive, for example, "it's made me into a better person. It's given me insight" (Eddie). Different metaphors were used to describe how ST created space to develop richer, more validating narratives. Dave realised

> you're programmed like a bloody computer, like, from language like a computer as a child, and then you grow up [...] stuff like what worked for you as a child doesn't work for you as you grow up, and it can cause problems in your life.

Danny's metaphor suggested a healing aspect to ST where damage to his narrative identity was repaired:

> you tend to pick yourself up from any relationship […] there's always a piece missing, so when you build yourself up, eventually you see all the cracks inside that need filling and that's where for me schema come in, it filled them cracks for me.

Carl and Eddie felt ST was key in changing their identities, and Andy's definition of recovery included changes in his sense of self: "having self-respect and respect for others is part of my recovery…part of realising…coming to terms, coming to terms with who I am". Developing other narratives about themselves allowed them to relate adaptively to others, and to hold and reflect on distress or negative thoughts differently.

ST was not a significant theme in Matthew's and Terry's narratives aside from some generally positive comments, and George's account of therapy was superficial. He initially emphasised the helpfulness of ST but was unable to describe any specific aspects, mirroring how the theme of ST seemed to disintegrate through the course of

his narrative. Matthew and Terry both referred to schemas in the past tense, suggesting they only considered them applicable to their previous selves.

Most individuals found ST challenging, but acknowledged meaningful engagement was rewarded with powerful changes in self-constructs. Many individuals were encouraged to engage by peers, who were a significant factor in motivation, engagement, and therapeutic changes. Group ST was highly valued as a forum for sharing perspectives, and modelling of trust and honesty by peers could be transformative. Ben shifted to a self-compassionate stance towards his younger self after hearing about others' abuse and being able to talk about his own: "I felt sorry for myself. I thought "f*cking hell, at that age…". Do you know what I mean? Because he f*cked my life up, do you know what I mean? He did f*ck my…before I…I wouldn't talk about it".

Therapeutic relationships with psychologists and group facilitators were central to these processes, and consistency was highly valued:

> my psychologist, it's took her two years to get my trust. Two years of hard work. And she's always been there for me, every time I've seen her. Every week I see her, she's never failed because she's always there. She doesn't go away (Carl).

Despite its challenges, all individuals were glad they had engaged in ST and spoke positively about gains they had made.

Difficult narratives: what was done to me and what I did to others. Most individuals frequently referred to how violent they had been previously, describing harming others and themselves. When describing previous violence, individuals used several strategies; Carl and Eddie repeatedly used "violent" in reference to themselves, others, and their environments, Eddie presented a fate narrative removing

some agency from himself, and Andy's narrative contained vivid imagery. Some experiences were distressing to discuss; Andy seemed to dissociate when discussing his offending self, and Dave's detailed description of his index offence was disjointed. Danny's, Carl's, and Andy's narratives became fragmented when describing childhood abuse, reflecting underlying trauma. Most individuals were wary of exploring traumatic memories in therapy, and of looking too deeply at the "bottom of the pond where you don't want to murk the water up" (Dave). However by doing so, they made links between childhood abuse and offending behaviours.

Constructing narratives including previously dissociated selves meant individuals developed self-constructs reflecting deeper understandings of experiences. For example, Carl's understanding of his diagnosis was more nuanced: "I've got traits of paranoid personality disorder. My paranoia, it's…it's not like I'm paranoid of everybody […] my paranoia revolves around mistrust / abuse, so…it's not like, it's…it's understandable really, you know. I'm wary of people so…especially males". Dave also made links between experiences and diagnoses, but Matthew was unable to integrate his index offence into his narrative and considered it external to himself: "the sex thing […] I don't know where it came from".

Section Three: Influences on Constructing and Presenting Self-Constructs

It's a secure world: managing in the midst of men. Residing in HS could be complex due to "living in a PD environment - it is difficult" (Carl). Physical security processes meant individuals had a constant audience, and Ben experienced many security processes as enactments of power or control rather than care. Carl, Eddie, Ben, and Terry also found it challenging becoming accustomed to largely male contexts as they found it difficult to trust men. This had obvious implications for living together, and for safety in therapeutic relationships. Danny struggled with

relational dynamics in male contexts, especially since previous experiences within gangs and prison meant he had had to constantly position himself within power hierarchies, and construct a self that needed to be powerful if it was not to be vulnerable.

Gender scripts also shaped therapeutic engagement, as "boys don't cry" (Dave) was incongruent with therapy. Danny found it difficult in groups to avoid dominating others and be vulnerable:

> I think you find it hard when you come from, like, cultures that are gangs and roughy-toughy, […] some stuff as a geezer, you don't talk about between other geezers. It's not, it's not the thing to do. You don't sit there and tell your mates, "ah…bit sad this, that…" You just…you just don't do it.

Gender scripts were also evident in narratives about offending behaviours by Eddie, Danny, and Ben, and generally reflected attitudes towards women that were simultaneously protective while enacting power and domination.

While the immediate context of the wards shaped individuals' narratives, wider social constructions about HS also had an influence. The combined stigma of mental health difficulties and offending histories could become unhelpfully internalised in self-constructs. Separation from wider society exacerbated stigmatising narratives and disconnection: "it doesn't really matter where I am as part of society" (Terry), and society became irrelevant and unsafe, so Terry experienced the wall as containing rather than confining:

> I've felt secure here. When we're let out, you know, when I was round HS that was, you know, a big fence and that, I felt that I was secure, that I was in, so to speak, you know. I didn't want to go out of it.

All individuals spoke about the hospital as a helpful and safe space, and gains from ST were placed within this wider context. Relational security was crucial, and experiencing "understanding and caring, really, and…I'm going to use that word again…being given respect, shown respect" (Andy) provided foundations for constructing different narrative identities. Most individuals had pervasive and long-standing mistrust issues and it took many years to develop trusting therapeutic relationships.

The length of time individuals had spent in this setting was largely considered beneficial. Time was essential in changing self-constructs that were damaged and destructive to a degree that short-term interventions would have had minimal benefit. Over forty years, HS had become home for Terry and he struggled to engage with institutional discourses framing moving on as positive when he felt he was leaving his home. The hospital seemed to become a world unto itself with a sharp division between inside and outside, including dichotomies in selves before and after admission. Life on the outside could become unfamiliar and challenging: "I think we're lucky when we're locked up […] life outside is a lot harder" (Matthew).

The power of placement. Although HS was part of a larger mental health and criminal justice system, most individuals mentioned negative experiences in other institutions. The lack of preventative interventions was frequently identified as maintaining destructive self-constructs, but the system was also given an active voice and experienced as a damaging entity: "the system was completely hate back then, and it used to use violence upon people in children's homes, nursing units, all over the system" (Danny), and individuals were "labelled as just being like as a failure" (Danny), further impacting on identities.

Prison was the most frequently mentioned part of the wider system, and was described negatively by Carl, Ben, Andy, George, Terry, Matthew, and Danny. Lack of rehabilitative opportunities meant individuals felt they "just get left to rot" (Carl), reinforcing their sense of being worthless, irredeemable, and excluded from society. In contrast, HS made them feel valued as "it costs a lot of money to treat somebody in here" (Carl). Prison was something to be endured at best, and a "lion's den" (Carl) at worst.

Not mad or bad. Individuals knew societal narratives about them were extremely stigmatising, and were aware of reductionist, dichotomous views so "either we're mad or bad. And I was mad. Not bad. And some people will be mad and bad […] That is a lot of the way that a lot people see us" (Dave). There was reciprocal stigma between diagnoses of PD and mental health, and Dave emphasised "I didn't really want to be classed as a psychopath or a…whatever, you know. There's one thing saying "yes, you've got a mental illness". It's another thing saying that you're a, that you're…that you're a…or are…have a PD". Hospital discourses were also influenced by these wider narratives, and Eddie and Carl both engaged with therapeutic scripts congruent with their diagnosis to present themselves as no longer at risk of reoffending.

Rejection, responsibility and space for rehabilitation. Systemic and societal discourses had powerful effects on how violent or sexual offending was conceptualised as part of identity. Prison greatly reinforced these narratives, although hierarchies of offending identities were somewhat negated in hospital where context conferred a degree of equity. Ben's self-construct was considerably influenced by such prison discourses and he would "try and not to know what people are in for".

Different selves were constructed for different contexts, with relational experiences primarily determining identity:

> you can't be…who you are here. Like if I was talking to a nonce in jail, I'd be as good as that nonce. Do you know what I mean? Or if I was like…like, go to someone and say "look, you did my head last night" when they said this, did my head in - be seen as a pussy, do you know what I mean? A coward (Ben).

Disassociating offending behaviour from identity, and conceptualising the offending self as a part of one's self-construct rather than the whole of it, created space for change. However, dominant societal and institutional discourses about their inherent criminality were significant barriers for feeling changes were validated and accepted by others. While such narratives were previously internalised and sources of hopelessness, relational experiences and therapeutic opportunities meant individuals disengaged from this script and felt deserving of second chances.

Childhood abuse and isolation, and understandings developed subsequently about how experiences had shaped them, meant many individuals struggled to balance responsibility for offences with blaming systems that had failed them. Most individuals emphasised they accepted responsibility for offences, conveying they were not attributing responsibility to others but highlighting the role of wider society in developing self-constructs held previously. A particularly challenging aspect of identity was the role of "victim". Societal splitting of victim and offender roles meant individuals struggled to integrate both into their identities. Most individuals had been victims during childhood, but this felt incongruent with self-constructs after committing violent offences so they saw themselves as offenders, mirroring dominant

societal narratives: "society are very naive and don't realise that, you know…we're the victims too, do you know what I mean? We've actually been a victim" (Carl).

Discussion and Conclusions

This study explored narratives of individuals with violent offending histories who engaged in ST in secure settings. This offered an understanding of how therapeutic experiences impact on self-constructs and relational patterns, and how ST was helpful in understanding previous offending behaviours and risk. Analysing these narratives yielded insights into how individuals' sense of self and meaning-making processes developed and changed due to experiences and contexts. Findings of this study are summarised diagrammatically in Figure 6, presenting a framework for processes of change in self-constructs as elicited from these narratives.

_____Figure 6_____

Childhood abuse was a critical factor in how individuals started to understand themselves and others. Abuse destroyed their identities, damaging their sense of self and leaving them mistrustful of others. Individuals therefore saw themselves as vulnerable, and developed ways of relating and behaving to protect themselves from becoming victims again, often enacted through violence. Abuse also meant individuals positioned themselves as rejected and disconnected from others, evoking drives to punish others or to meet unmet needs in any way they could, frequently manifesting in violent behaviours.

Using violence was another significant factor in how individuals' self-constructs changed. The self had become bad and detention in secure or custodial settings reinforced this. A critical turning point here depended on where individuals were placed. Individuals did not benefit from unsafe or unhelpful settings such as

prisons[15], and continued to be violent within the setting or frequently reoffended upon release, some entering into cycles of reoffending and incarceration, reinforcing bad self-constructs. Having no opportunities for changing this self, and thus no space for holding hope for the future, re-enacted rejection and exclusion from society and reconfirmed individuals' identities as offenders.

Individuals who eventually found safe places (such as HS) could exit from this process through experiencing relational security, meaning they were gradually able to reduce mistrust of others, thereby considering themselves less vulnerable and others as less threatening. Realising they were not alone in their experiences enabled recognition of the role of experience in shaping their sense of self, and awareness that they were not inherently bad as previously concluded. Experiences such as engaging in ST enabled individuals to create new narrative identities incorporating validating perspectives of themselves and integrating different selves including child and offending selves. Understanding how experiences and contexts had shaped self-constructs and behaviours allowed individuals to realise they could develop new narratives and have their needs met through different ways of relating to others.

Previous Research

Findings of this study indicate ST is a valuable approach to assessment, formulation, and intervention in forensic contexts. Table 2 positions these findings in relation to previous research on ST and narrative identities.

_____Table 2_____

Implications

The high prevalence of childhood abuse identified here is typical in forensic settings (Kolla et al., 2013). Since childhood abuse often instigates damaging self-

[15] Or some other institutions such as children's homes or some secure settings.

constructs, increased drive and investment to offer early intervention for families experiencing difficulties could have a significant impact on reducing numbers of individuals eventually detained for violent offences (Lowell, Carter, Godoy, Paulicin, & Briggs-Gowan, 2011). Creating more safe spaces for children / young people would reduce feelings of disconnection, diverting individual trajectories from experiences of rejection and blame towards more supportive and restorative encounters (Corrado & Freedman, 2011). Damaging childhood experiences that are not processed result in fragmented narratives of self (Adshead, 2012), and the focus on such issues in ST means it is particularly suited to this population who may not have had opportunities to do this previously.

The length and intensity of ST means it is infrequently offered in mental health services struggling with ever-decreasing resources (Nadort, 2012), but this does not preclude offering other therapeutic strategies with similar functions. Detention in HS indicates multiple system failures and missed opportunities for changing narratives, and individuals should not need to be admitted into these settings before finding space to change self-constructs. Attempting to resolve years of psychological damage with short-term interventions or in unsafe environments is unlikely to be successful in addressing offending behaviours, and forensic mental health services need to balance resources required to adequately support individuals against costs of repeated reoffending to potential victims and wider society (van Asselt & Bloo, 2012).

Financial differences between prisons and secure services should not justify imprisonment or closing expensive services such as HS hospitals. Violent offending is a relational process (Pollock & Stowell-Smith, 2006) and such relational difficulties cannot be addressed without secure therapeutic relationships in contexts where secure

attachments can develop (Sainsbury, 2011). Forensic rehabilitation cannot occur in environments that are not relationally secure, which is rarely a priority in prisons (Exworthy & Gunn, 2003). Individuals in this study did not consider ST as effective in isolation but in the context of HS offering relationally secure contexts to make therapeutic gains, in contrast to prison reinforcing destructive behaviours. The function and effectiveness of prison for violent offending needs to be re-evaluated (Welldon & van Velsen, 2007) as there is a conflict of values between rehabilitation goals and objectives of the criminal justice system (Welldon, 2007).

Nevertheless, individuals also referred to the stigma of HS. The separateness of HS is a societal demand for physical and psychological exclusion of "dangerous" individuals (Stowell-Smith, 2006), but extreme segregation maintains a lack of awareness among the public (and some mental health professionals) thus increasing stigma (Williams, Moore, Adshead, McDowell, & Tapp, 2011). However, the findings of this study also highlighted how prolonged separation evokes reciprocal fear responses of the outside world. Hospital discourses around discharge are generally encouraging (Madders & George, 2014), but space to voice less positive perspectives is needed.

Much of the fear and stigma around HS is based on social constructions of offending identities, often created through media representations of "monsters" (Adshead, 2012) that are then internalised, as mentioned by many individuals in this study. Dominant narratives about inherently irredeemable identities of those committing violent offences leave little space for meaningful rehabilitation opportunities (Schultz, 2005). Even when offered, privileged institutional discourses often attempt to reconstruct individuals' identities within socially acceptable parameters, defining boundaries around cognitive distortions, justification /

minimisation, and risk (Fox, 2007). Cognitive and behavioural attempts to change self-constructs through discursive and psychological control (Foucault, 1977) do not always correspond to meaningful changes in offending behaviours, as seen by ongoing debate around the effectiveness of manualised therapeutic programmes for sexual offending (Levenson & Prescott, 2013) and comments of individuals in this study regarding previous therapeutic interventions[16].

Some individuals described others (and themselves) doubting their capacity to change. Such individuals were previously "untreatable" under the MHA (Willmot & Tetley, 2011), resulting in hopelessness and stagnation (Stowell-Smith, 2006), and confirming dominant narratives about fixed identities. However, ST holds a more optimistic position, and outcome evidence[17] is promising in its potential for becoming the basis of a new narrative of hope for individuals previously not offered any. Increased dissemination of positive outcomes (including case studies, for example, Chakhssi, Kersten, de Ruiter, & Bernstein, 2014) utilising avenues widely available to the public (such as social media) could contribute to deconstructing negative societal and professional discourses.

While holding hope must be balanced with managing risk, believing individuals can change "their identities from monsters to protagonists in human tragedies" (Adshead, 2012, p. 8) is essential for clinicians and services. A central finding of this study was that understanding oneself through developing integrated narratives was key to reformulating self-constructs. Understanding cannot occur without a capacity for hearing and working with narratives of being hurt and hurting

[16] However, engaging in ST was challenging, and parallels may be drawn with therapeutic programmes for sexual offending where strategies such as offering preparatory motivational sessions, encouraging peer relationships, and additional support around shame elicited by therapy can be beneficial in promoting positive outcomes (Marshall & Moulden, 2006; McAlinden, 2004; Walji, Simpson, & Weatherhead, 2014).

[17] See studies referred to previously (Bernstein & Arntz, 2009; Bernstein et al., 2012b; Farrell et al., 2009; Masley et al., 2012; Nentjes & Bernstein, 2011; Tarrier et al., 2010).

others, but while stories of victimisation are distressing, there is more space to hear these than stories of victimising others (Waldram, 2007). Individuals marginalised by society are frequently also marginalised by services, maintaining the inexplicability of their destructive behaviours (Adshead, 1998) and allowing dehumanising social constructions to continue portraying such individuals as inherently different and deviant (Waldram, 2007).

Essentially, these discourses propound that self-constructs of individuals who have committed violent offences contain no multiplicities and consist only of an offender self (Schultz, 2005). Other identities such as a victim self are split off, without conceiving of the potential for more integrated self-constructs reconciling different identities to include both victim and offender, and yet being more than these. This disempowering and discouraging narrative creates false dichotomies between victimising and victimised reciprocal roles, and inhibits new learning about cycles of abuse (Welldon & van Velsen, 2007). Clinicians can struggle to hold both identities compassionately (Stowell-Smith, 2006), and this study highlighted this is mirrored by individuals who find it challenging to integrate both aspects into self-constructs. Changes in societal and professional beliefs are required to prevent such attitudes being obstacles to change for individuals who already face many barriers. Increased teaching on forensic issues in clinical psychology, psychotherapy, and psychiatry training programmes could be a way forwards in prompting reflections on working with forensic populations.

It should be noted some individuals were unable to arrive at integrated understandings of themselves, and their new narratives reflected self-constructs where offending selves were disassociated and remained inexplicable or were attributed to uncontrollable factors. Violent offending is a traumatic experience (Gray et al., 2003)

and needs to be integrated into personal narratives similarly to other traumas. However, these individuals were unable to hold agency for offending behaviours and therefore could not fully connect their risk of reoffending to changes in self-constructs as their selves did not include their offending self, which they anticipated controlling through skills learnt or medication prescribed. This was especially true for those with diagnoses of schizophrenia as medical understandings of psychosis left no space for personal agency. Professionally privileged discourses became incorporated into personal narratives, reflecting superficial understandings of offending behaviours. While these individuals avoided distress arising from accepting offending selves as part of them, understanding offences through diagnostic lenses meant they were unable to consider any risk factors for reoffending other than a relapse of their mental health. This has obvious implications for managing risk, and offering meaningful, relational explanations for psychotic experiences could help to create more integrated narratives (Taylor, Perry, Hutton, Seddon, & Tan, 2014).

Moreover, the ST model itself can become a categorical framework rather than a language to conceptualise difficulties. Some individuals described schemas as actual traits rather than constructions of interactional patterns, and this can potentially become a new language to label or categorise individuals. ST facilitates individualised, contextual profiles but clinicians may need to take care that schemas do not become alternative PD diagnoses or form foundations of other potentially reductionist narratives.

Limitations and Further Research

NA offers in-depth perspectives and is therefore well-suited for small samples (Weatherhead, 2011). Lengthy interviews with nine participants generated large amounts of data in this study, and fewer participants may have allowed deeper

analysis. Co-constructed narratives and the reflexive nature of analysis mean these findings are influenced by the researcher; however, Appendix C is presented to increase transparency and provide an audit trail. Findings may be further influenced by a response bias as they are based on experiences of a small self-selecting cohort from a limited number of settings. However, the value of these findings lies not in their generalisability but in their utility for developing richer understandings of how individuals in this context understand themselves and their offending behaviours. Qualitative research is a valuable and robust method of capturing voices that remain largely unheard, even though "understanding service users' perspectives and learning from their experiences are crucial to developing secure services" (Centre for Mental Health, 2011, p. 43).

As ST develops and is hopefully offered more widely in forensic contexts, research on narratives of particular populations, such as those with sexual offending histories, could produce new insights into their self-constructs. Such research with women who have committed violent offences is also much needed, especially since social constructions of females who offend are different from those of males (Clements, Dawson, & das Nair, 2014). The importance of relational security was highlighted in these findings, and exploring how different forensic settings are experienced would enhance the responsivity and effectiveness of rehabilitation programmes. Prisons in particular were not seen as safe or helpful spaces by individuals in this study, and research focussing on relational experiences in prison would be valuable in shaping referral pathways for forensic rehabilitation[18].

[18] This may be particularly pertinent for those imprisoned at a young age or who receive life sentences.

Conclusions

Narratives of individuals with violent offending histories in secure settings offer valuable insights into how ST can effect changes in self-constructs. However, this study also highlights the crucial importance of relational contexts in the development of self-constructs, and how connecting with others in safe spaces enables individuals to discover hope, and believe in changes they feel empowered to make. The relational context essentially determines the self, and relational contexts are within wider contexts of society and its institutions.

Detention and incarceration mean these individuals are physically and psychologically removed from society, but societal neglect and stigma remain part of their narratives. Moreover, damaged childhoods and subsequent failures of services to offer exits from destructive patterns of relating mean society is an integral part of their formulations, and therefore of factors contributing to offending behaviours. We expect these individuals to own and change aspects of formulations we hold them responsible for but it is imperative that we, as a society, must also reflect on our roles in constructing offending identities.

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Table 1

Demographic Information

	George	Matthew	Carl	Terry	Danny	Ben	Andy	Eddie	Dave
Site	MS	HS	HS	HS	HS	HS	HS	HS	HS
Age	33	61	53	64	40	34	44	60	49
Length of stay since index offence (years)[a]	7	29 (6-7 in HS)	19	40	16	12 (5 in HS)	7 (4-5 in HS)	20 (10 here, 10 in other HS)	10
Index offence	Manslaughter (adult)	Multiple rapes (adult women)	Rape and violence (adult)	Sexual violence and murder (child)	Grievous Bodily Harm - Section 18 Wounding with Intent (adults)	Murder (adult)	Grievous Bodily Harm - Section 18 Wounding with Intent (adults)	Index offence: Grievous Bodily Harm - Section 18 Wounding with Intent (adults) (Previous sentence for manslaughter)	Manslaughter (adult)
Diagnoses	Paranoid schizophrenia	Antisocial PD Avoidant PD	Antisocial, PD Borderline PD Paranoid PD	Antisocial PD	Antisocial PD Borderline PD Avoidant PD Paranoid PD	Antisocial PD Borderline PD Avoidant PD Paranoid PD Narcissistic PD	Borderline PD Avoidant PD Schizoid PD	Antisocial PD Borderline PD Paranoid PD Schizotypal PD	Paranoid PD Antisocial PD Paranoid Schizophrenia

[a] Rounded up / down to whole years.

Figure 1. Phased Recruitment Strategy

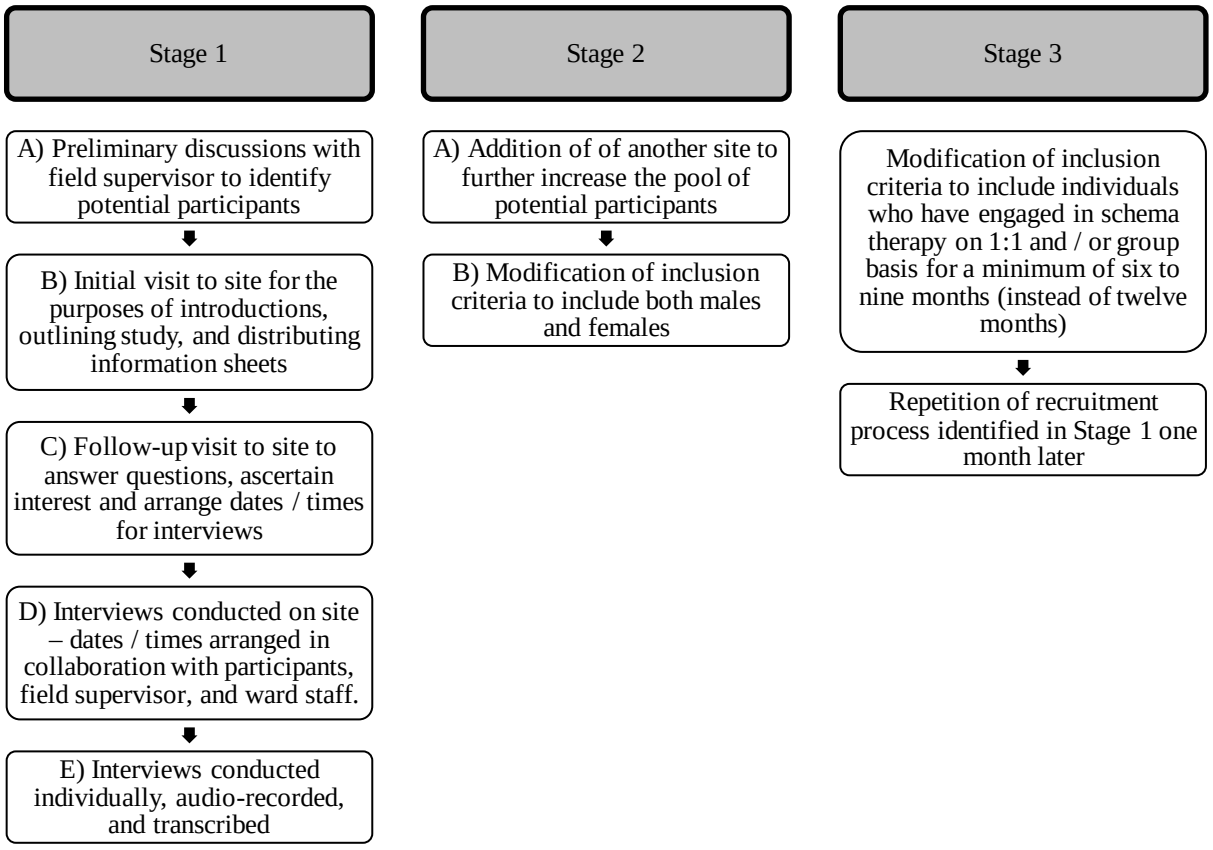


Figure 1. The first stage of recruitment strategies aimed to recruit enough (5-10) participants for the study. If insufficient numbers were recruited from this stage, the subsequent stages would be implemented as required. Stages One and Two needed to be undertaken to facilitate expressions of interest from appropriate numbers of participants. From a potential pool of twenty-five across both sites, twenty individuals were approached. Of the five who were not approached, one was imminently due to be transferred to prison and another was unsettled in presentation. Three were not approached as sufficient other potential participants had already expressed interest. Although a random sample is difficult to achieve with such a small pool of potential participants, individuals were approached as and when they were available on the wards rather than based on any other factors. Of the twenty individuals who were approached, eight declined, ten agreed to participate, and two were unsure. The ten individuals who had expressed interest were recruited, and no more individuals were approached, as an appropriate depth of analysis would have been difficult to achieve with greater numbers. If these individuals had changed their minds or had withdrawn their consent during / after the interviews, interest would have been ascertained amongst the two individuals who were unsure about participating, and the three who had not yet been approached.

Figure 2. Framework Developed for Narrative Analysis

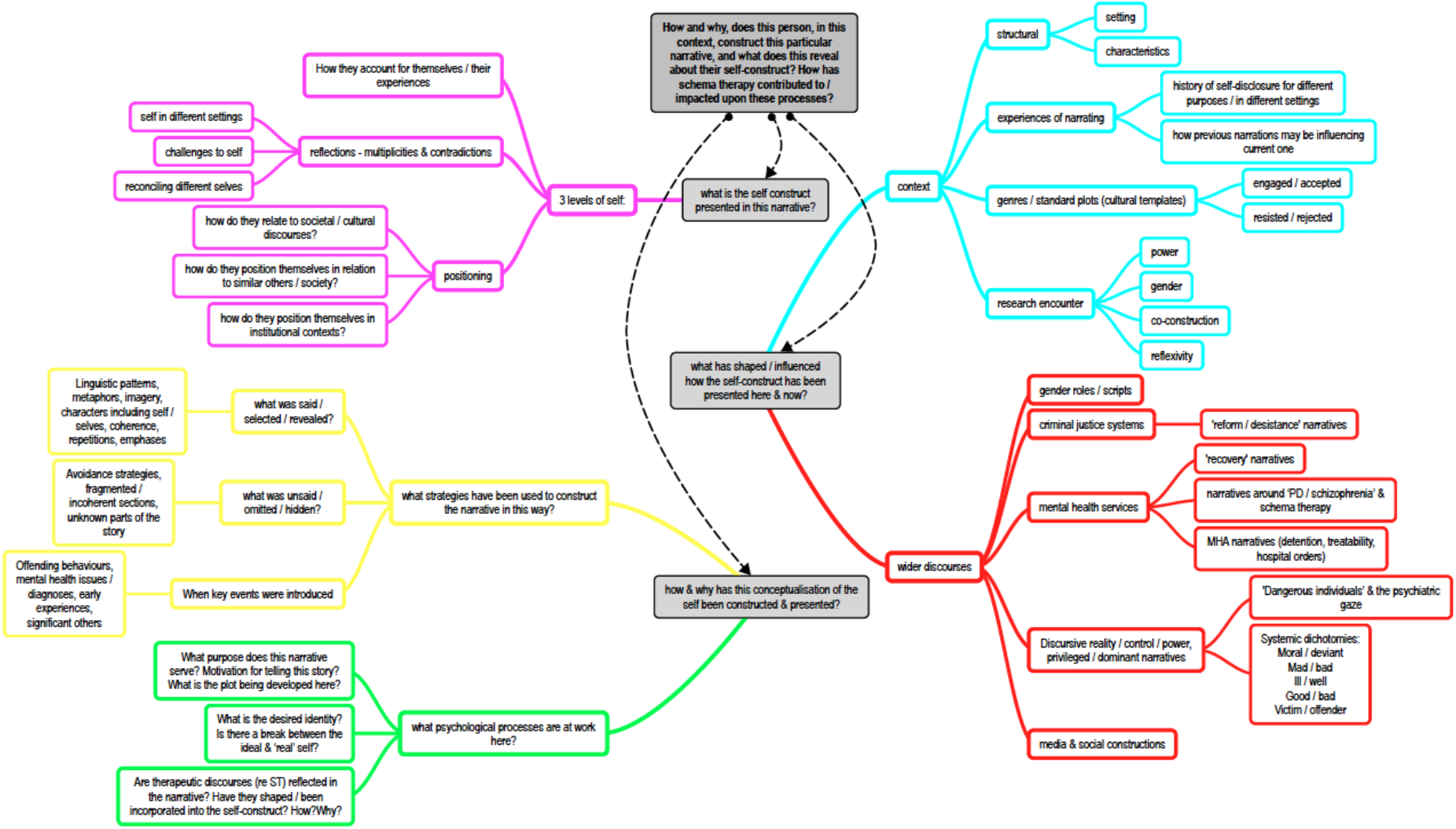


Figure 3. Process of Analysis

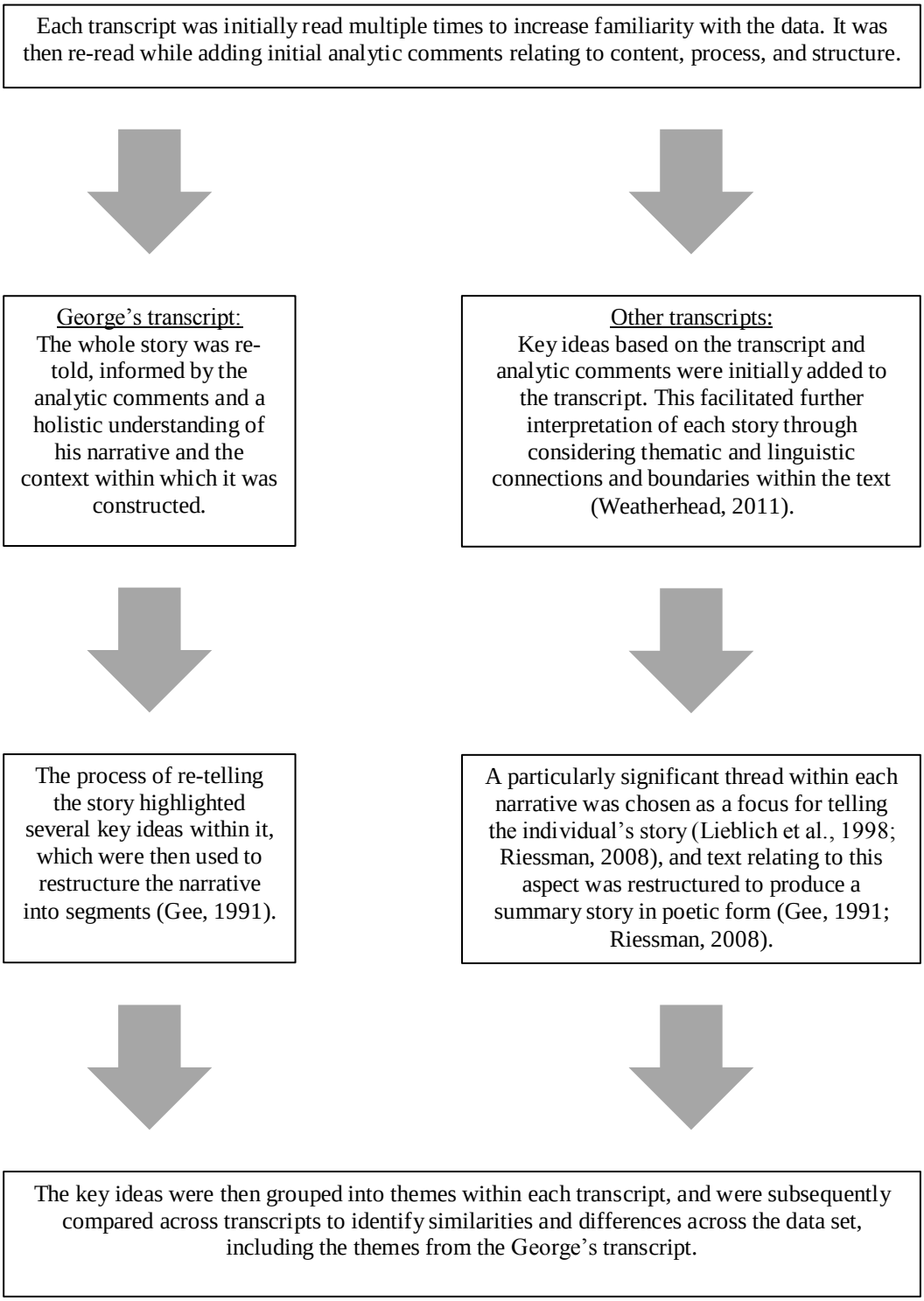


Figure 3. Due to delays between recruitment and transcription from the MS and HS sites, a slightly different process of analysis was used for the first transcript (George).

Figure 4. Outline of Findings

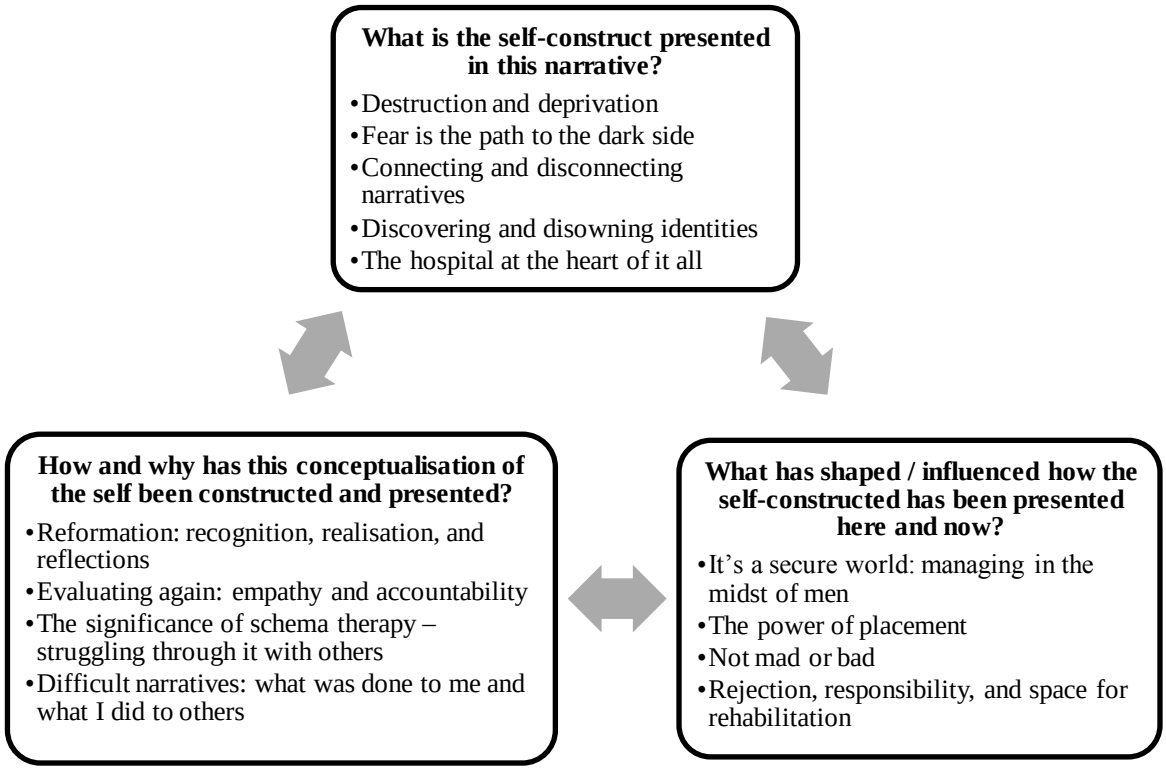


Figure 5. Narrative Map of Findings

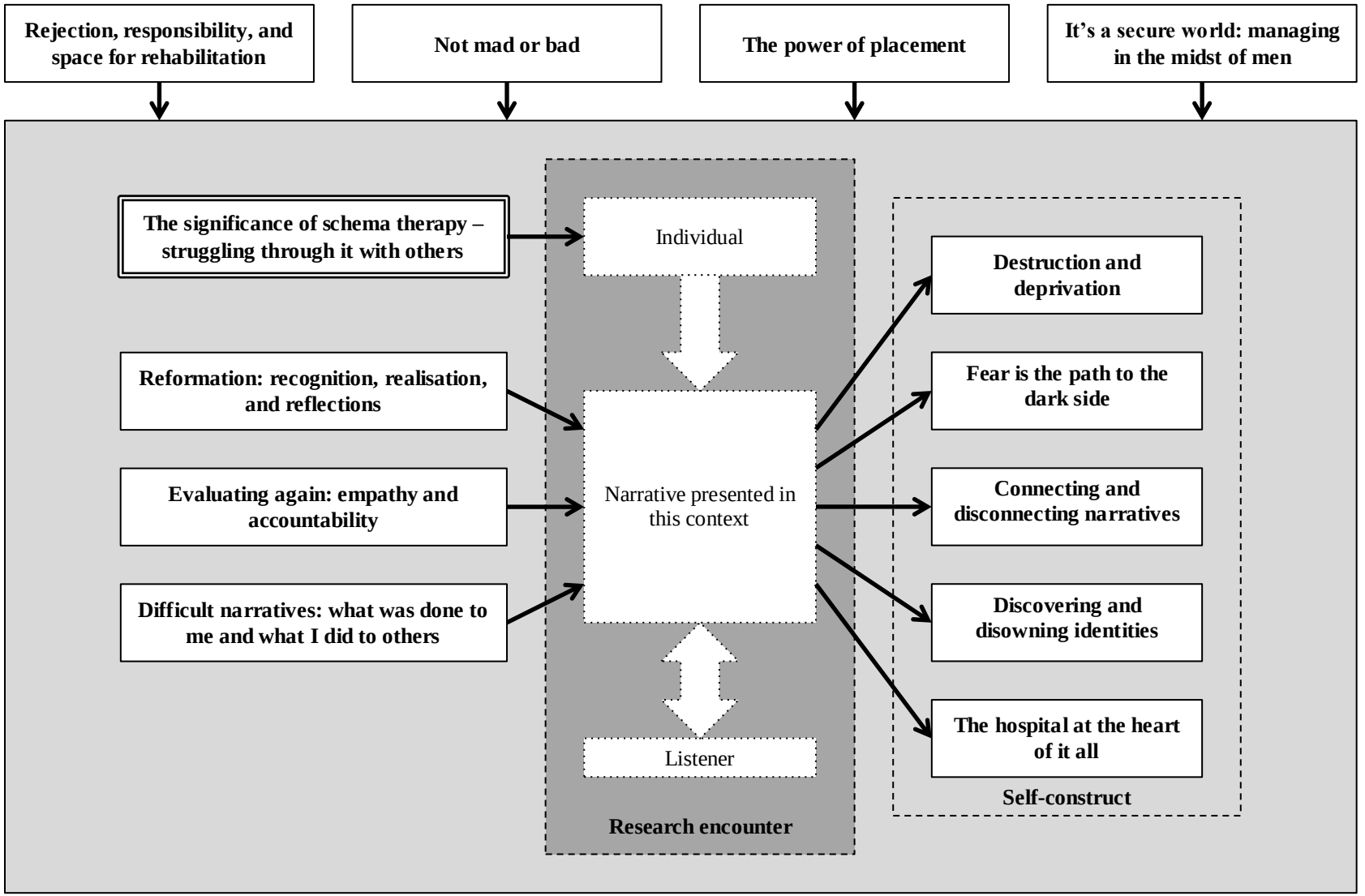


Figure 5. Clear boxes represent the results of narrative analysis and the shaded boxes represent immediate and wider contexts. The immediate context was the research encounter (darker shaded box) that comprised the presentation of a particular narrative by the individual. Analysis of this narrative allowed consideration of the impact of ST on the individual, the strategies and processes leading to the construction of the chosen narrative, and the self-construct that was presented to the researcher. All processes took place within the wider context of a secure setting (lighter shaded box), and analysis also highlighted how dominant discourses related to this context influenced these narratives.

Figure 6. Framework for Processes of Changes in Self-Constructs

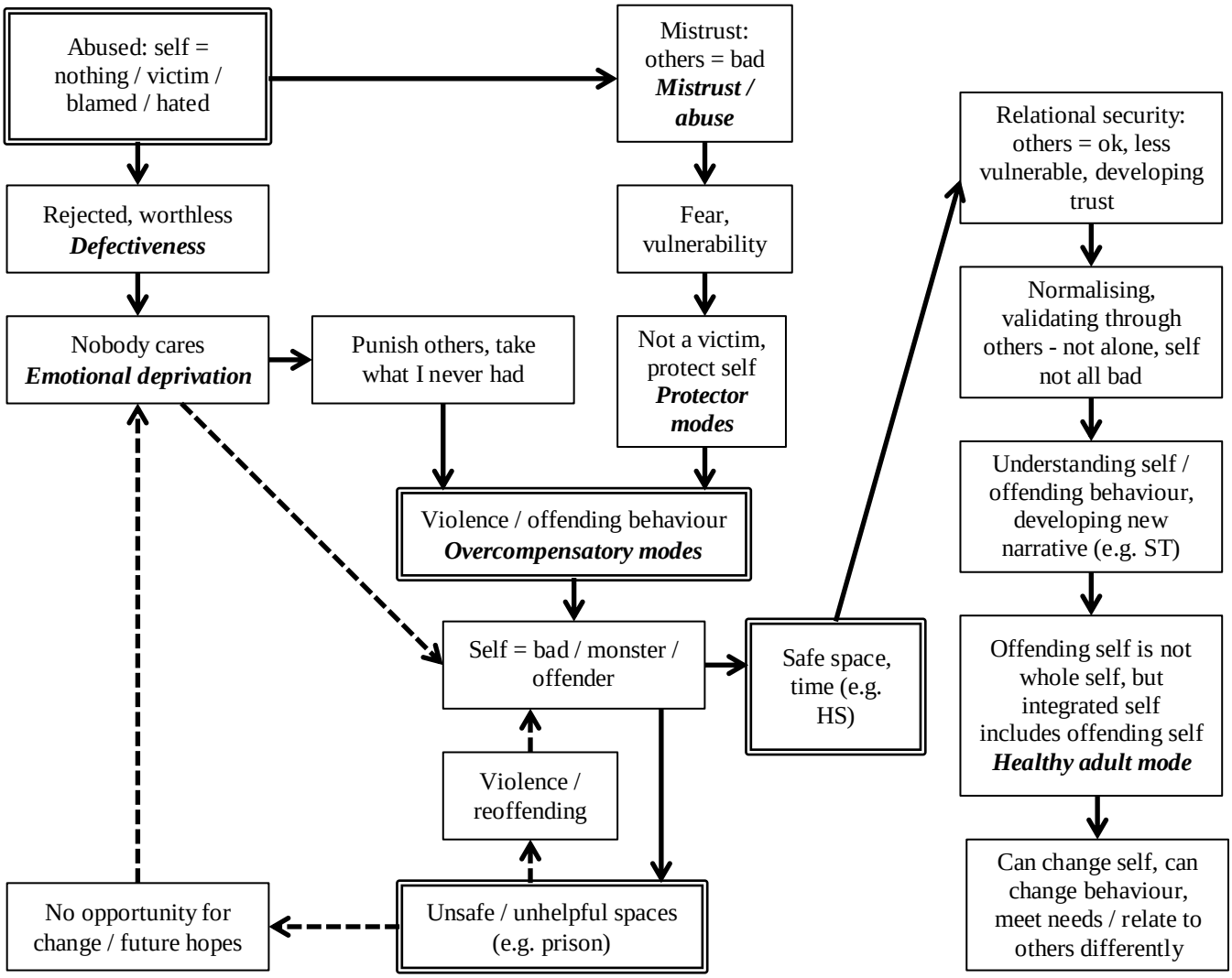


Figure 6. Double-outlined boxes represent critical turning points for changes; dashed arrows represent processes occurring in unsafe / unhelpful spaces; bold italicised text identifies schemas and modes mapping onto this process. This framework identifies the key experiences and turning points contributing to development and changes in self-constructs for individuals participating in this study.

Table 2

Findings Positioned in Relation to Previous Research

ST studies	ST suggests risk of reoffending is reduced through ameliorating maladaptive schema modes and strengthening healthy adult modes (Bernstein, Arntz, & de Vos, 2007; Bernstein et al., 2012; de Vos et al., 2014), congruent with the framework of change presented here as schema modes map onto the different selves individuals described as parts of self-constructs, with healthy adult modes corresponding to a more integrated self. This study did not directly explore the impact of ST so cannot be compared with quantitative studies (Bernstein & Arntz, 2009; Nentjes & Bernstein, 2011). However, narratives were analysed for congruence with therapeutic change, and many individuals presented narratives reflecting changes in self-constructs and schema modes leading to different relational experiences.
Maruna (2001)	Maruna (2001) found desisting individuals developed self-constructs where the offending self was not the real self. This dissonance initiated agency in changing behaviours previously attributed to uncontrollable factors, which they could now control (Maruna, 2001). However, this study argues individuals need to accept their experiences holistically into an integrated self to effect change. Disassociating from an offending self not considered part of the real self means offending behaviour is not fully integrated into narratives, but offender identities need to be reconciled with other selves to change (Adshead, 2011). Individuals in this study used ST as a vehicle for this integrative process, and such intensive interventions may not have been available to those in Maruna's (2001) study.
Presser (2008)	There are similarities between narratives in this study and those of Presser (2008). She found some individuals constructed "elastic" narratives, where the self had no agency in offending behaviours, and offending behaviours were attributed to broad causal mechanisms such as substance misuse or mental health difficulties (Presser, 2008). Some individuals in this study also constructed similar narratives, and struggled to reconcile offending selves with other selves. Presser (2008) found others presented "reform" narratives returning to the good / moral self they had always been (similar to those in Maruna's (2001) study) or "stability" narratives (the self had always been moral and was positioned as a victim of circumstances). A fully integrated narrative where multiplicities of self were reconciled was not presented in Presser's (2008) study and is therefore a new finding emerging here. It is possible that without the combination of context and intervention, namely relational security and ST, such change is difficult to achieve.
Ward and Marshall (2007)	Findings of this study lend support to the crucial role of narrative identity in forensic rehabilitation. Ward and Marshall (2007) conceptualised identity as dynamically constructed narratives emerging from individual's interactions with social contexts, reflecting accounts of individuals in this study who described how their self-constructs were shaped by relational experiences. Ward and Marshall (2007) link narrative identity to the GLM (Ward, 2002) and suggest effective forensic rehabilitation requires developing narratives linking offending behaviours to values and goals. Integrating offending behaviours into personal narratives means a continuous sense of self develops, with new narratives retaining values and primary goals of offending selves but incorporating prosocial means to fulfilling these (Ward & Marshall, 2007). If offending selves are not seen as real selves, thin narratives are constructed with fewer therapeutic targets for rehabilitation, as was the case for some individuals in this and previous studies [a]. The findings of this study suggest ST is an effective means of developing integrated narrative identities through reformulation of self-constructs.

[a] It should be noted that there may have been many factors determining whether individuals presented thin narratives, including quality / quantity of therapy, degree of previous psychological damage, etc. or interactions between these. Anxiety or triggering of mistrust / defectiveness schemas during interviews may also have flipped them into detached modes which could have reduced what they presented.

Appendix A: The Schema Model

An important point to note regarding the schema model is that it posits all individuals develop schemas and present with certain schema modes, and it is specifically when core emotional needs are unmet that schemas become maladaptive (Genderen, Rijkeboer, & Arntz, 2012; Young et al., 2003). EMS are functional in enabling the individual to cope with difficult relationships or environments, but become dysfunctional when they are triggered in situations that do not require the same response as when the schema was developed. Similarly, schema modes are present for all individuals but tend to be less integrated in those with interpersonal difficulties, leading to inflexible patterns of cognitions, emotional responses, and behaviour that dominate an individual's presentation (Genderen et al., 2012; Young et al., 2003).

Offending behaviours are conceptualised as extremes of behavioural strategies that an individual employs in an attempt to compensate for core unmet childhood needs and related schemas (Beckley, 2011a). This formulation helps to minimise defensiveness, shame, and guilt that can interfere with therapy and risk management (Tangney, Stuewig, & Martinez, 2014), as ST aims to engage directly with the (often violent) over-compensatory modes that individuals may have developed to cope with underlying feelings of vulnerability, humiliation, or abuse, as well as with the child modes that experience such emotions, and the protective modes that enable individuals to detach from them (Bernstein et al., 2012a).

ST for forensic populations is a non-pathologising framework, offering a common language for individuals and therapists to co-construct contextual narratives incorporating early psychological trauma, offending behaviours, and current psychological distress (Beckley, 2011a). Adjusting the focus away from diagnostic descriptions that limit professional perspectives to challenging behavioural manifestations of underlying needs and vulnerabilities (Beckley, 2010) enables clinicians of all disciplines to work empathically,

effectively, and safely in these settings (Beckley, 2011b; Gordon, Beckley, & Lowings, 2011). It is recommended individuals engage in ST prior to offence-focussed interventions (Beckley, 2010), as improved engagement and outcomes are reported when maladaptive behaviour patterns are framed within developmental contexts, with a focus on meeting core needs in prosocial ways as exemplified by the Good Lives Model (GLM) (Ward, 2002), rather than on manualised cognitive-behavioural relapse prevention (Sainsbury, 2010).

Appendix B: Choosing and Using Narrative Analysis

The process of telling one's story provides insights into how individuals make sense of experiences, including offending behaviour. A narrative approach therefore provided a more nuanced indication of whether participants had internalised new learning from therapy in comparison to qualitative approaches such as interpretive phenomenological analysis (IPA), which may have posed more direct questions relating to therapeutic experiences. Furthermore, unlike other qualitative methodologies, NA allows an individual's story to be considered as a whole, rather than being fragmented into codes across the dataset, facilitating holistic and contextual understandings of individuals and their experiences.

For this method, interviews would usually be minimally structured and open-ended in order to elicit participants' self-generated narratives, thereby giving priority to their perspectives and their processes of making sense of their experiences (Mishler, 1991). Possible drawbacks of this method include the difficulties in eliciting participants' narratives when the population is difficult to engage or the interview topic is sensitive or distressing; both these issues were potentially pertinent in this study.

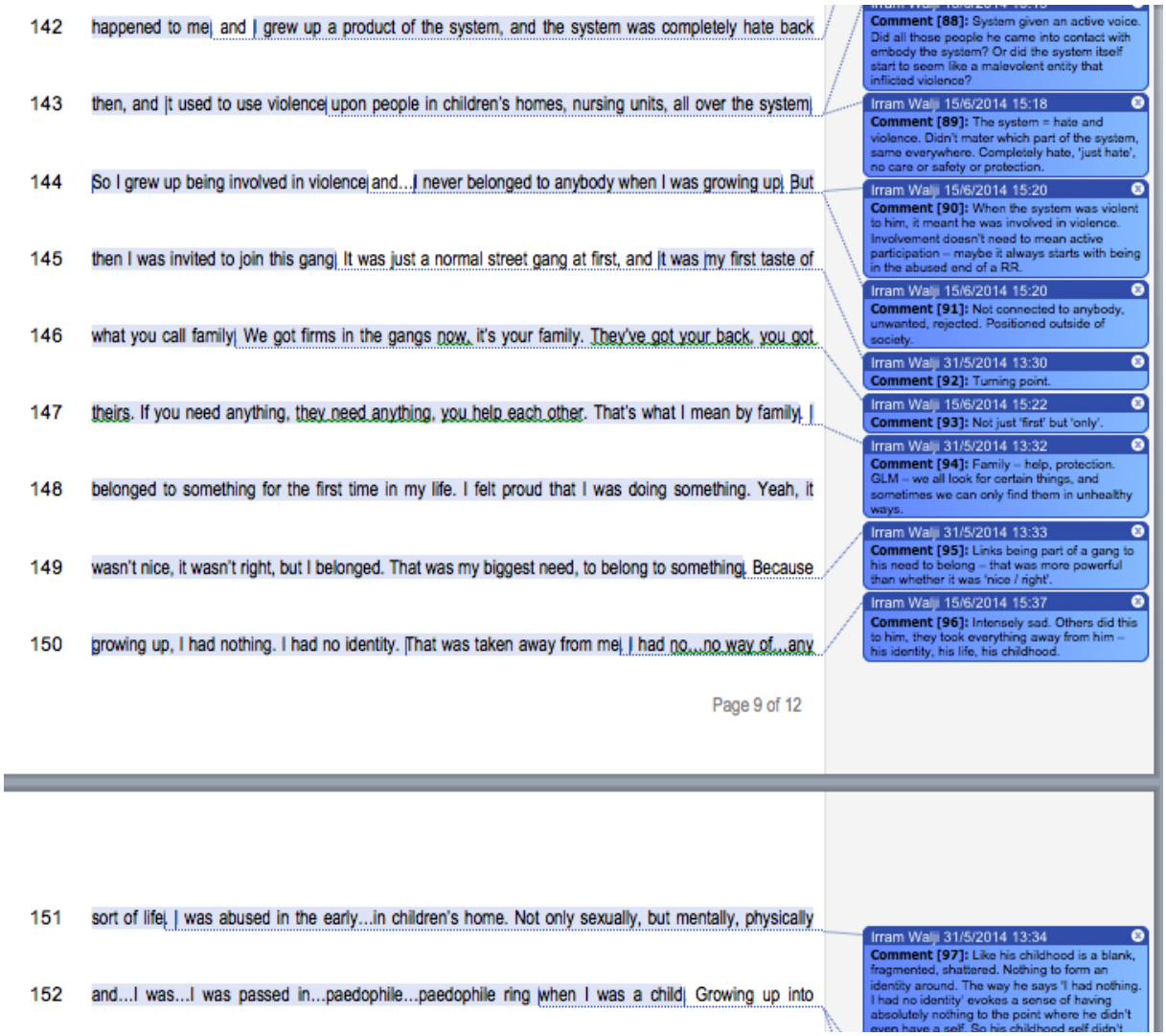
A narrative approach does offer a way of approaching the interview from a more person-centred and less 'expert' position; however, it was acknowledged that a balance needed to be achieved between allowing narratives to emerge naturally and eliciting the information required to answer the research question. The resulting interview was therefore still flexible and responsive to individual participants' responses and way of telling their story. It was anticipated participants might have been more willing to discuss their therapeutic experiences than aspects of their personal experiences, but the aim of this approach was to create space for participants to feel comfortable with sharing both types of narratives. The co-constructed understandings generated by such semi-structured interviews prioritised subjectivity because of the emphasis on each participant's unique process of sense-making and also ensured

participants' perspectives were privileged, rather than those of the researcher, which cannot be achieved to the same extent through rigidly structured interviews (Mishler, 1991).

Appendix C: Stages of Analysis

The process of analysis is explained further below, illustrated by examples of transcripts and tables. Steps 1-3 below present Danny's transcript as an example.

Step One: transcripts were read multiple times, adding analytic comments based on the NA framework developed for this study (Figure 2). A subsequent re-reading of a hard copy allowed further hand-written notes to be incorporated into the electronic document. Reading the document in different formats ensured familiarity with the content did not result in superficial readings, as written notes can facilitate a deeper level of processing (Mueller & Oppenheimer, 2014).



Step Two: notes were made on key ideas (highlighted) for each narrative, based on both the transcript text and the analytic comments. Starting line numbers of each narrative segment were also noted. Key ideas were labelled according to which part of the analytic framework they corresponded to, as indicated below:

What is the self-construct presented in this narrative?	How he accounts for himself / his experiences	1A
	Reflections - multiplicities & contradictions	1B
	How does he position himself in relation to similar others / society?	1C
How & why has this conceptualisation of the self been constructed & presented?	What was said / selected / revealed? what was unsaid / omitted / hidden? when key events were introduced	2A
	What purpose does this narrative serve? Motivation for telling this story? What is the plot being developed here?	2B
	What is the desired identity?	2C
	Are therapeutic discourses reflected in the narrative?	2D
What has shaped / influenced how the self-constructed has been presented here & now?	Context	3A
	Wider discourses	3B

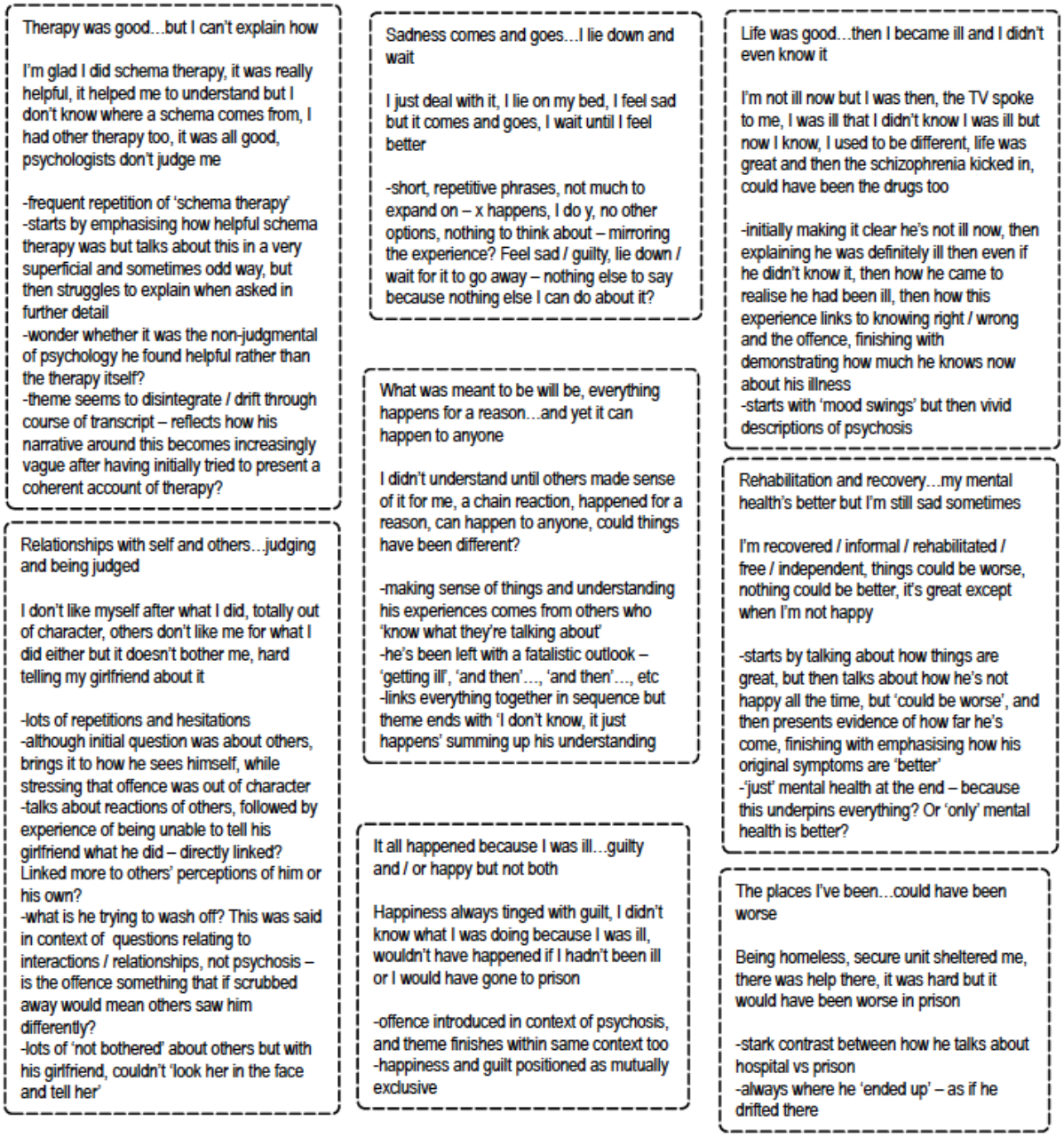
Step Three: key ideas were collated and tabulated for each narrative, ensuring line numbers of text were kept for subsequent reference to the raw data in Step Eight. The final column in the table allowed themes within these key ideas to emerge.

		Lines	Key ideas	Themes
What is the self construct presented in this narrative? *Burck Weatherhead*	How he accounts for himself / his experiences (1A)	1A (3)	whole story = prison and [redacted] lots of transitions between prison and [redacted]	Transitions between prison and [redacted] Bullying, fighting, drugs, weapons, violence, crime, hostage-taking, riots Failure in the system, brought up in the system Uprooted since 16, involved in gangs Cycle of prion and reoffending, more time in prison than outside Violent upbringing, sexual / physical / emotional abuse, paedophile ring
		1A, 1B, 3B (30)	used to be a bit of a knob – bullying, fighting, always had drugs and weapons differentiating between name and identity labelled as a failure in the system – eliciting hopelessness – failure of person or system? He'll always be the same – realistic expectations of change ad transformation or pathologising labels? Changing because I want to – retaining power, control, agency	
		1A, 1B (37)	change is hard uprooted since 16, no secure base involved in gangs since 16 more time spent n prison than outside – no difference between prison self and outside self? cycle of prison and reoffending – inevitable, unstoppable	
		1A, 1B, 2C (68)	involved in violence, crime, hostage-taking, riots – horrendous violent acts past always mentioned – space to add new chapters to his story?	
		1A, 1B, 1C (109)	old self would knock people out, tearing out throats, fighting, violence, using weapons new self more reflective – considering motivations of others – destroying others not my problem, their problem – not going to be pulled back any more	
		1A, 1C, 2A (141)	links made between violent upbringing and gang involvement initially minimising childhood abuse but then names it brought up in the system – same everywhere, no care / protection system given active voice – used hate and violence grew up involved in violence – never belonged to anybody, unwanted, rejected	
		1A, 2B (144)	turning point – invited to join gang first taste of family – got your back wasn't nice / right – but I belonged – biggest need was to belong – powerful need finding family, help, protection in other ways - GLM	
		1A, 1B, 1C (150)	I had nothing, no identity, taken away from me – no childhood self Abused in children's homes, passed into paedophile ring – sexually / mentally / physically abused Won't ever become a victim again Joined gang to belong, be protected – nothing else mattered	

Step Four, part one: themes for each narrative, based on groupings of key ideas, were transferred into an overall table. These themes were then further grouped together under titles (shown in uppercase). Information for each participant was colour-coded to ensure identification during subsequent steps.

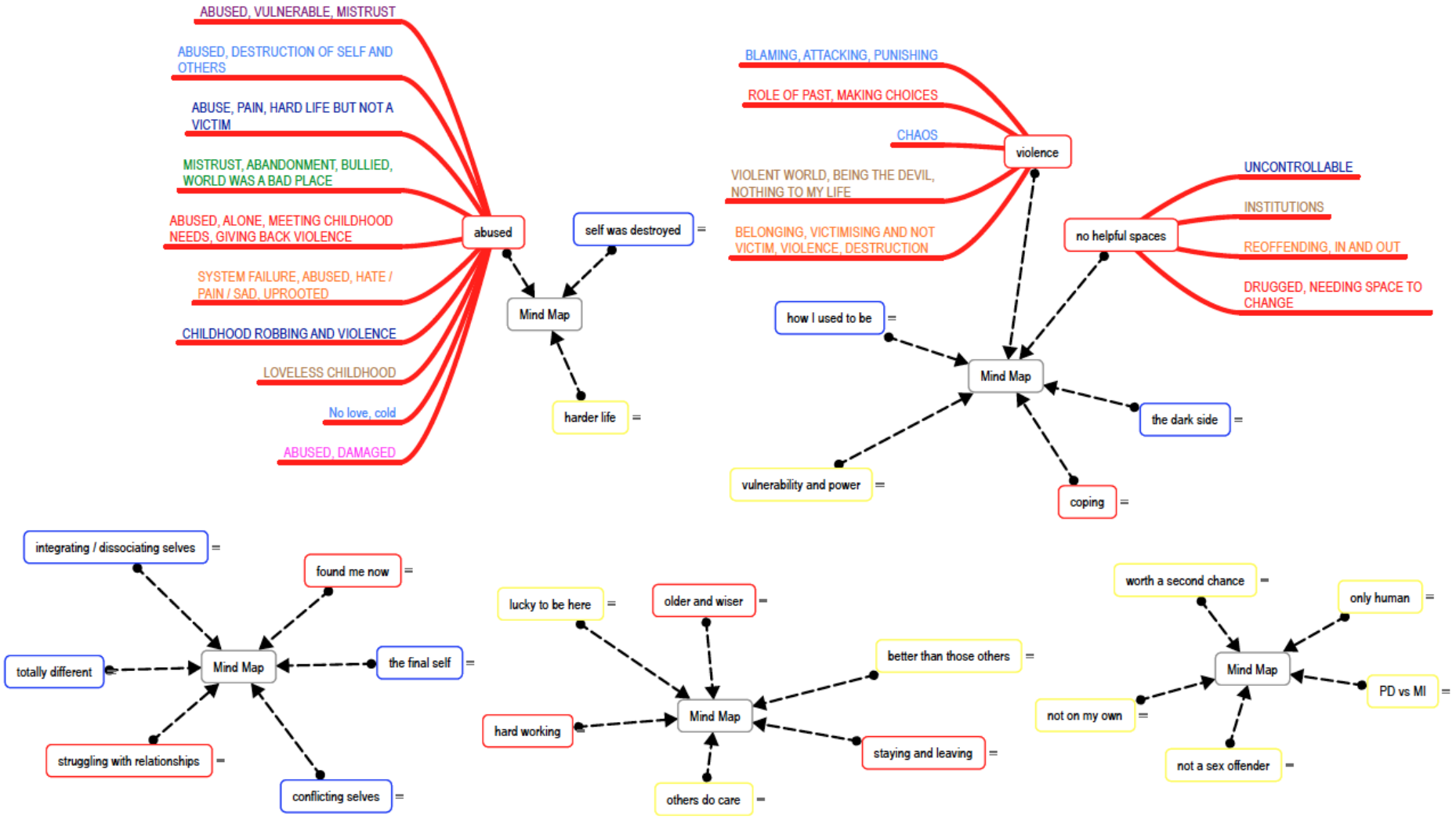
		Eddie	Danny	Andy	Ben	Carl	Dave	Matthew	Terry
What is the self construct presented in this narrative? Burck Weatherhead	How he accounts for himself / his experiences (1A)	INSTITUTIONS 20 years – 2 x HS Institutions since age 15 LOVELESS CHILDHOOD steps from childhood parents didn't love me, didn't know what love was VIOLENT WORLD, BEING THE DEVIL, NOTHING TO MY LIFE done some bad crimes violence before, not now violent world, nothing to my life, hurt others, tried killing myself, being the devil, listening to rock MISC got my life back, saved my life, got this far good fate and bad fate, can't change it	REOFFENDING, IN AND OUT Transitions between prison and [redacted] Cycle of prison and reoffending, more time in prison than outside BELONGING, VICTIMISING AND NOT VICTIM, VIOLENCE, DESTRUCTION Bullying, fighting, drugs, weapons, violence, crime, hostage-taking, riots Sabotaging, destroying Avoid being victimised again – better to hurt others than to be hurt Gang was family, belonging Never be a victim again, objectified / exploited by gang SYSTEM FAILURE, ABUSED, HATE / PAIN / SAD, UPROOTED Failure in the system, brought up in the system Violent upbringing, sexual / physical / emotional abuse, paedophile ring – no identity, had nothing Hate, pain, lonely, sad Uprooted since 16, involved in gangs MISC Lone person, don't like groups Can't take praise, embarrassing from men Found myself – Little Danny	ABUSED, DESTRUCTION OF SELF AND OTHERS Sexually abused by dad, psychologically destroyed Destruction – self, others, sabotage Being hurt, hurting self, hurting others Would have ended up killing self / others CHAOS Life was chaotic Confused violent mess, didn't understand myself BLAMING, ATTACKING, PUNISHING Disconnected, alone, nobody to help Blame, hate, anger – dad, self, society – hurt them / self No self-worth, self-respect Wanted to kill dad, blamed everyone Nasty bastard, hurting everybody MISC Prison routine = drugs Putting on a front, using drink and drugs No love, cold	ABUSE, PAIN, HARD LIFE BUT NOT A VICTIM Always pain, life's shit Childhood sexual abuse Had a hard life, not a victim, can't blame the past DRUGS, SELF INJURY, DISCLOSURE Links – past, self injury, drugs Impacts of disclosure Self injury I was crazy, fucked up, off-key UNCONTROLLABLE Couldn't handle me Power and control CHILDHOOD ROBBING AND VIOLENCE Loved robbing Violence, uncle made us fight other children MISC Immature but grown-up	DRUGGED, NEEDING SPACE TO CHANGE Drugged in prison for fighting, chemical; restraint, drug-abused by the system Sort myself out but can't do it in prison, need to come here ABUSED, ALONE, MEETING CHILDHOOD NEEDS, GIVING BACK VIOLENCE Dad didn't show feelings but aggressive, no boundaries Children grow wild if needs not met, inter-generational and systemic responsibility Moulded as a child by system, made me bitter and angry, horrific abuse by men, giving back the violence to others Self-dependent since 9, on streets at 11-12 – surviving alone, rough childhood ROLE OF PAST, MAKING CHOICES Past played role in personality but still my choice of how to behave Lashing out at others, didn't have skills, no choices, doing whatever it takes MISC Still struggle with relationships, would be happy to live alone Wanted my identity back, got my life back now	HELPFUL BUT TOO LONG Treatment has been beneficial Sentence was too long but won't reoffend now ABUSED, DAMAGED Physically abused, racist attacks – children turned into monsters Abuse caused PD, PD caused MI NOT A CRIMINAL, DIMINISHED RESPONSIBILITY, Diminished responsibility, hospital order Don't have big criminal record Index offence was moment of madness, had stopped medication, couldn't explain then or now, stabbed him MISC Hard work, experienced Coping by cutting off but need to talk about it here	WORKING HARD, SKILLED, ALWAYS LEARNING Doing lots of activities, working hard ST – learnt skills Always learning, good at making things, different types of skills, been in a lot of jobs Long time in prison, learnt a lot, always something to learn MISTRUST, ABANDONMENT, BULLIED, WORLD WAS A BAD PLACE Mum always busy, did what I wanted, got into trouble, secrets – dad died when 5, deprived of toys, stealing – mistrust, abandonment Stealing to meet unmet needs World was a bad place, sad child, bullied at school for speech difficulties, truanting, low confidence socially OTHERS DO BETTER Slow to learn, others do better Always been a worker, poorly paid, missed out FAMILY, FRIENDS Got on with family, spoiled my marriage by getting into trouble Did have friends MISC Sexual offences – nothing in my past, new and exciting, just happened, stopped but caught when police found	LEAVING HOME, STARTING AGAIN Living in [redacted], this is my home Moving on, missing people Starting all over again, everything will be different, adjusting, don't know anybody there Leaving work, gardens Make the next place home, stay there until I die ABUSED, VULNERABLE, MISTRUST Sexually abused, beaten up Being backwards Took 10 years to start trusting men, feeling vulnerable, mistrust MAKING CHANGES, WANT TO STAY, ACCEPTANCE / CHOICE Prison didn't change anything Coming here was the best thing, learnt so much, changed a lot Changed so much, so can't stay Would choose to stay here Need to accept changes Been here a long time, worked hard, need to rest now MISC Older and wiser

Step Four, part two: themes from George's story were identified.



Step Five: Grouped themes from across transcripts were collated together and grouped further. The mind-map below shows how similar themes were grouped for the first sub-part of the analytic framework (1A).

Step Six: the groups of themes identified in Step Five for each sub-section (1A, 1B…etc.) of the analytic framework were collated into a single mind-map for each section (1, 2, 3). The groups identified in Step Five were named, and then organised into further groups, as shown below for section 1. Some nodes of the mind-map have been unfolded to show how this mind-map connects to that in Step Five.



Step Seven: the groups from Step Six were transferred into the first columns of the three tables below, corresponding to the three sections of the analytic framework. Underlying concepts for each group were identified, and final themes were identified through several iterations of refining the concepts.

	What is the self-construct presented in this narrative?		
Themes identified across narratives	First iteration	Second iteration	Final iteration
Abused Self was destroyed Harder life	Abused, self destroyed, life always been more difficult for me	Damaged and destroyed, deprived and disadvantaged	Destruction and deprivation
Violence The dark side Vulnerability and power How I used to be No helpful spaces Coping	The dark side, navigating power and vulnerability (mistrust / fear), no containing / safe spaces	Mistrust / fear / unsafe spaces leading to the dark side	Fear is the path to the dark side
Worth a second chance Only human MI vs. PD Not on my own Not a sex offender	Deserving second chances, negotiating differences, like others but not like them, not on my own	Shared narratives, similarities and differences to peers / society	Connecting and disconnecting narratives
Integrating / dissociating selves Found me now The final self Conflicting selves Total different Struggling with relationships	Finding me, being different, splitting / conflicting / integrating selves, still have struggles	Finding me, owning and disowning identities, differences	Discovering and disowning identities
Older and wiser Better than those others Hard working Lucky to be here Others do care Staying and leaving	Growing up here, making the most of being here, people care here, staying / leaving	Hospital / others as a backdrop for experiencing self	The hospital at the heart of it all

How & why has this conceptualisation of the self been constructed & presented? (What strategies have been used to construct the narrative in this way? What psychological processes are at work here?)			
Themes identified across narratives	First iteration	Second iteration	Final iteration
Different now Different understandings / interactions Better / recovered / no more offending Better relationally Owning self Different to others – better now, worse before Repetitions Dichotomies Metaphors – physical spaces, travelling Turning points, alternative endings	Different / better person now, better relationships, owning self, done better than others	Differences relating to self and others, achievements	Reformation – recognition, realisation, and reflections
Not just another group Schemas in past ST – active, metaphors, tenses ST – metaphors, active Accessibility / motivations / expectations Recommended Therapeutic relationships, not alone Challenging, hard work Hard-working, controlling the demon Not a quick-fix	Active voices for ST, powerful / transformative / insight / understanding self, role of relationships, hard / challenging	ST as active, changed me, relationships, hard	The significance of schema therapy – struggling through it with others
Past regrets Victim empathy Not a bad person Did care about others The self Determining responsibility	Regrets, empathy, not bad, responsibility	Empathy for others, not being judged	Evaluating again – empathy and accountability
Talking about violence / chaos / lack of control How violent I was Index offence Fragmented sections Links to childhood Understanding offences / diagnoses / childhood	Fragmented narratives, childhood, violence, index offence narratives, understanding links	Difficult to talk about childhood / violence / index offence	Difficult narratives - what was done to me and what I did to others

What has shaped / influenced how the self-constructed has been presented here & now?			
Themes identified across narratives	First iteration	Second iteration	Final iteration
Research encounter (multiple) Couldn't / wouldn't talk to you before Story on demand	----------(discussed in Critical Appraisal) ----------		
Understanding / responsibility / blame Offending and identity Second chances, people / patients / monsters	Negotiating understanding / responsibility, offending identities, second chances, not monsters	Understanding and not judging, offending identities, second chances	Rejection, responsibility, and space for rehabilitation
PD / MI / recovery Expectations of MH / PD Hospital discourses	Reciprocal stigmas, mad / bad, recovery, learning hospital language	Recovered now, not mad or bad	Not mad or bad
Moving from prison System failures / power Prison discourses Resources / costs	Prison damaging / not helpful, traumatising / abusive systems, HS is expensive	Power of different places to help or harm, punishment or therapy	The power of placement
Living environment The good side of HS Secure / safe world Masculinity Relational context HS narratives, separation Time Timescales Changes over the years	A separate world, relational security, living with others but away from society, enacting masculinity in male environments, lengths of time	A secure world, being around men, time passing	It's a secure world – managing in the midst of men

Step Eight: referring to the line numbers recorded in Step Two, quotes from each narrative were collated for each theme in table form.

What is the self-construct presented in this narrative?		
Final iteration	*Themes identified across narratives*	*Quotes*
Destruction and deprivation	Abused	Sexually abused, beaten up - 78 Being backwards - 124 Took 10 years to start trusting men, feeling vulnerable, mistrust – 89, 100 Sexually abused by dad, psychologically destroyed - 80 Destruction – self, others, sabotage – 35, 50, 55, 98 Being hurt, hurting self, hurting others – 64, 100 Would have ended up killing self / others - 64 No love, cold - 82 Always pain, life's shit - 501 Childhood sexual abuse – 11, 52 Had a hard life, not a victim, can't blame the past – 233 Loved robbing - 233 Violence, uncle made us fight other children – 300 Mum always busy, did what I wanted, got into trouble, secrets – dad died when 5, deprived of toys, stealing – mistrust, abandonment - 16 Stealing to meet unmet needs - 56 World was a bad place, sad child, bullied at school for speech difficulties, truanting, low confidence socially – 40, 63, 72 Dad didn't show feelings but aggressive, no boundaries - 629 Children grow wild if needs not met, inter-generational and systemic responsibility - 610 Moulded as a child by system, made me bitter and angry, horrific abuse by men, giving back the violence to others - 268 Self-dependent since 9, on streets at 11-12 – surviving alone, rough childhood Failure in the system, brought up in the system - 141 Violent upbringing, sexual / physical / emotional abuse, paedophile ring – no identity, had nothing – 141, 150 Hate, pain, lonely, sad - 585 Uprooted since 16, involved in gangs – 37 Stems from childhood - 3 Parents didn't love me, didn't know what love was – 174 Physically abused, racist attacks – children turned into monsters – 134, 467 Abuse caused PD, PD caused MI – 159
	Self was destroyed	Self-destruction - 35 Self psychologically destroyed by dad - 80 Childhood self- had no identity, won't be victim again - 150

Appendix D: Individual Participant Summaries

NA research projects / theses often include summary stories of participants. These offer an overall sense of each participant through a summary of the individual's story constructed by the researcher. For the first participant in this study (George), a different version of a summary story was created, where his story was re-told by the researcher after considering what was being implicitly conveyed in the narrative and the wider discourses that may have shaped it. Re-telling George's story as a simple summary would have resulted in a thin, reductionist narrative mirroring the narrative he presented during the interview. It felt important to contextualise and explore why he might have presented the story he did, and consider how interactions during the research encounter could have influenced the story and self he preferred to present. The resulting re-told story is presented in this appendix.

However, re-telling George's story in this way evoked feelings of self-doubt, since it seemed the researcher's voice was being used to convey his story rather than his own words, despite ensuring interpretation and analysis was grounded in his narrative. A different method was therefore used for the other participants, and the summaries presented here have been developed based on Riessman's (1993, 2008) adaptation of Gee's (1991) structural analysis. While Gee (1991) restructured unbroken narrative segments into stanzas, Riessman (1993, 2008) adapted his method to produce poetic structures where interactions, non-lexical expressions, false starts and non-related text were excluded. This results in narratives that (despite being highly interpretative[19]) can convey an aspect of the story that may evade understanding if fragmented into themes.

During multiple reading and annotations of each transcripts, notes were kept on any threads within the narrative that seemed to stand out due to repetition, vivid use of imagery / metaphor, or significance to the overall story (Lieblich et al., 1998). These were often threads

[19] Complete transcripts have been kept to evidence the development of each summary from raw data.

that could not be conveyed through the final analysis since they pertained to an individual's unique story and experiences, and there would not be scope in the Findings section to present them. Text pertaining to this thread was then extracted from the transcript, and restructured into a more poetic form as a summary for the participant (Gee, 1991; Riessman, 1993, 2008). This meant summaries could be presented in individuals' own words, and felt more congruent with the researcher's aims of using NA to hear the voices and stories of those who are seldom offered such opportunities.

Andy:

Understanding my Dark Side

When I was about six…

my mum disappeared

we stayed and lived with my dad…

who's very abusive…and psychologically…

I was psychologically…destroyed, I think.

and I was suffering…

and suffered sexual abuse, psychological abuse, and…

at the hands of my dad

I used to blame myself.

I used to take overdoses, various suicide attempts, and it…got to a point,

I got sick of doing that, so what I started to do was…

blame everybody else…

Blaming everybody for…the life that I had…

I had no self-respect,

absolutely no self-respect at all,

and I didn't respect anybody else…

I was just going round and…hurting people…

I used to make weapons…

with the intent of using them…

ultimately, to use them on my dad.

I wanted to kill my dad basically…

There was something inside saying "no, get help, get help, get help",
but then this other side, this other part…
and saying "right, I'm going to become the, the most evil…person…that that I could possibly be, to be able to make him suffer".
So what I did is, I made, I made weapons.
I made a…I made like a glove…
it was in a film called Nightmare on Elm Street,
and it's like a, like a…blades on each finger.
I made one of those to…to attack my dad

I was going out hurting people on a regular basis.
I mean, I'd come home,
wake up in the morning,
the place would be a mess,
and my glove would be on the side…
with one of the blades bent, with blood on it…
Yeah, I just wanted to make him suffer,
but I blamed everybody else and…
that's why I'm here.

But what is, but what is good…eventually,
if anything good can come out…it is…
obviously being at HS's gave me insight, you know,

So much insight,

and so many bells are ringing

and so…made so much sense, you know…

A part of that was…part of that was schema therapy…

it just made sense, you know.

I won't say, I won't say it's helped,

because it's far more than a help.

It's changed my way of thinking in a sense,

that I've been able to…understand myself a lot more,

and…and by understanding myself…

given me that self-respect back...you know,

instead of blaming other people,

instead of blaming myself…

understanding,

and realising what a sh*t life I've had basically,

and what my problems were

I wouldn't be where I'm at now without…HS…

I just wouldn't be,

I wouldn't be where I am.

I wouldn't be at a point in my life…

because it's…just changed my life.

I think…turned me around…you know,

changed my way of thinking,

changed my way…

changed my way of thoughts about people,

thoughts about understanding myself and…yeah, yeah.

There is still…parts of me that used to go round hurting people.

Punishing people…for feeling that I wasn't helped…

blaming society for the life I had

a part that…that, that I decided to call…Dark Andy

I'd just change into that Dark Andy…

and just mindless…a mindless brute

But that person hasn't gone

It's there,

it's always going to be there…

because that was part,

that's part of me

but…I…I've moved on from that…

I can't say that "oh no, I'm not that person anymore"

that's sort of almost saying, almost like denying that…that part of me exists.

Yeah, it does, but I've dealt with it,

that part of me,

that is part of me that's been dealt with,

and it's been filed

and it's been put away.

Ben:

Who wants to be a Big Man in HS? There's Pain Underneath the Mask

I've always been violent, always…

I'm trying to get rid of it now,

but there's people on the ward now that I'd just love to smash.

But I just think "do you know what? Go to your room"

Or the way people talk to me some days…

I think "what the f*ck are you talking to?"

In jail I was…I was fighting all the time

F*ck that, I wouldn't let no-one talk to me like a d*ckhead, but here…

I'm trying to change

I'm trying to step away from it all.

I thought "forget about it. They're idiots. Who wants to be a big man in HS?"

Because, when I were younger, I were violent…

I was a violent person, yeah.

But now, I try and get a better life by having a laugh

So I have a laugh with people instead,

instead of being violent or…

I think I'm trying to…come across as someone different

I can't go around being violent no more…

I just…I don't want to be in here for the rest of my life

So I like this person now…

I like the way I cope with things now.

I think everyone has to wear a different mask for different places, innit?

In jail…you can't let your guard down in jail…

you can't be…who you are here

there's been a violent one…

a criminal one…

that's about it really…

violent one and a criminal one.

Don't know if self-harm is a mask?

Some of it, that was a mask…yeah.

This is the good me mask.

This is the mask I want to be

I feel as though…I've changed

I like it.

I like this…being happy

there's always pain underneath, in't there?

You're always thinking about things in life, aren't you…

like the, the abuse or…

there's always pain…

but it's how you…come across,

how you act…

how you treat people

there's always pain underneath…

but it's how you…how you come across to other people

That kind of…that kind of a mask.

I know, I know how it comes across…

I don't mean like that,

I don't mean pretending to be this person to just get out

Or where it's like…how I come across

Because that's a different…not mask,

but a different personality if you know what I mean.

But I like this personality.

I like being…having a laugh with people

Carl:

Finding my Identity - Being Me

I decided, one day…

you know, I were looking in the mirror at myself

and I couldn't…

all I saw was an angry Carl,

I didn't see an angry…anybody,

I just saw…I saw an angry person there

and I made a…I realised that I needed to sort myself out.

Plus I wanted my identity back.

I want to be me.

I don't want to be what other people wanted me to be.

I don't want to be like my dad.

My dad was a professional boxer and he had no…he had no skills,

how to deal with emotions…

he was quiet and shut off…

and I developed his personality

I didn't have my own identity.

I, I, I get it from my father and his personality and behaviour…

I wasn't myself.

You know, like when I come here…

they've…I…they've allowed me to be myself

But like I said, you know, I have my dad's personality.

and…I'm now glad that I've got away from that

and am now myself.

So I can be…

I can be who I want to be, you know what I mean?

Not be what other people want me to be.

And I'm now Carl Williams,

not somebody else

It's given me my life back…

like I said, I am…

I am me now, you know what I mean?

I'm not being what the system wants me to be.

I'm actually being Carl.

That's good, that.

I've got my identity back.

I've got my life back and I'm happy with that.

For once in my life, I'm me…

and that's a big buzz for me

Danny:

Belonging to Myself – Finding the Little Boy Inside

I come from very a violent upbringing

I grew up a product of the system,

and the system was completely hate back then,

and it used to use violence upon people in children's homes

So I grew up being involved in violence and…

I never belonged to anybody when I was growing up.

But then I was invited to join this gang.

It was my first taste of what you call family.

It's your family.

They've got your back, you got theirs.

That's what I mean by family.

I belonged to something for the first time in my life.

Yeah, it wasn't nice,

it wasn't right,

but I belonged.

That was my biggest need,

to belong to something.

Because growing up, I had nothing.

I had no identity.

That was taken away from me.

I had no…no way of…any sort of life.

I was abused in the early…in children's home.

Not only sexually, but mentally, physically

and…I was…I was passed in…paedophile…paedophile ring when I was a child.

Growing up into adulthood,

I thought to myself, "I won't ever become a victim again".

So I joined this street gang,

purely to have somebody who I could belong to.

Growing up, even though most of these people weren't good friends

and I never would be part of them,

I was prepared to overlook that

because I felt I belonged.

To join the gang when I was sixteen for me

was to have…to belong to something.

I belong to myself now, not nobody else

it was hard,

hard for anybody because…it's…

you have to change everything you believe in.

It's not easy,

it doesn't take…it doesn't happen overnight.

There's a lot of hard work involved in it

I think you find it hard when you come from, like,

cultures that are gangs and roughy-toughy

some stuff as a geezer,

you don't talk about between other geezers.

It's not, it's not the thing to do.

You don't sit there and tell your mates, "ah…bit sad this, that…"

You just…you just don't do it.

I'm too much of a man, to, to, to be pampered and given compliments of how you're doing really well.

Course I'm not doing really well or I wouldn't be doing it.

But it's nice to hear sometimes

I've changed massively, massively.

I feel really good for changing,

I feel really good and positive.

I found something in life I care about now

and that's myself, because I never used to.

I used to self-harm,

I used to try and take overdoses,

I used to…I used to have no care about myself whatsoever

and I would have no quibbles or anything about hurting people.

I didn't like myself.

I used to say to people "you can do whatever you want to me because it won't bother me one bit".

You can't hate, hurt me or hate me more than I hate myself.

I hated myself so much,

I didn't care if I lived or died

because I have nothing,

I have nobody to care for,

I have nobody to understand…

it's a lonely, sad place to be in.

But now, I'm happier,

I found…

I found what I needed to find,

I found myself

and it's like, it's like this little boy just being surrounded…

the Big Bully Danny protects the Little Danny behind all of this,

and he closes them all off so nobody can get in.

Now I've sent him away,

and I'm opening up,

and I'm letting people in

Dave:

I Was Mad, Not Bad

I wouldn't say 'serious personality disorder'

I don't want to be classed as a psychopath

I didn't want to be classed as a PD,

When I go to an RSU,

I'll be going to a mental health ward.

I won't be going to a PD ward

Most of us moving on from this side will go to PD…

the dual diagnosis,

most of them go to PD…

but in my case,

because my mental health's more predominant than my PD…

I mean everyone's got PD traits,

it's just to what degree you've got them and stuff.

Some people worse than others.

My mental health is more predominant…

my index offence was more mental health,

there was no PD

Either we're mad or bad.

And I was mad.

Not bad.

And some people will be mad and bad

I'd rather be neither,

neither bad nor mad

That is a lot of the way that a lot people see us

I would say that the mad and bad thing just relates to either…

when you come in here, you're processed as either…

life sentence or hospital order…

one's mad,

one's bad.

Even the courts do, so it's, you know…

and in some cases, where some people have been bad

and they try and get mad,

because they prefer mad to bad, you know, it just…

I mean, that's one thing I can say for myself.

I've never been…

from day one of being in here,

I've never been, like, confused over my index offence.

I've always, like, give…

it was like a moment's madness

Eddie:

A Tale of Two Selves – Taking the Devil to Church

I've been a very violent person in the past and…

as I've got older, I've calmed down, but…

I was still violent when I come to this hospital,

and I did schema, and something just clicked…

and…

I don't want to be violent –

well, I don't want to be violent anymore.

I try not to be violent,

and I want to live that way

I was always brought up with violence around me.

And I lived a violent life,

and I didn't know why I was being violent,

just knew that I was violent

I always got told that I was wrong,

and my mum used to tell them,

tell everyone that I was the devil and…

saying I were a violent thug

I even had the devil tattooed on my arm

but…at one time, I thought I was the devil but now…

I've started going to church again.

I went to church yesterday

and I've give a lot of thought to prayers.

I've changed my life

From being like…

evil and violent

to being good…

well, I hope I'm good.

I tried killing myself in jail

I thought "well…I can't live outside and I can't live inside…

maybe my mum was right,

maybe I am the devil

and I should be in hell",

so I tried killing myself…

and…I nearly died…

I don't listen to a lot of rock music now

Because I used to associate rock music with the devil,

and I associated the devil with my mother…

and the rock music…used to drive me crazy at times because…the things that I've done

It's just fate

I think that the world just keeps turning and…

you can't change…

it's just fate…

And…you're here one day,

you could be dead the next.

You've got to live your life…as best you can while you're here

I've had fifty odd year of violence and…

now I've no violence in my life,

and that's like fate.

That's good fate because…

I never thought I'd change from being violent, whereas…

that's come along in my life where it's just by fate that it's happened.

But I think everything happens in your life has got a lot to do with fate.

You either get a good fate

or bad fate

I knew what happened in your life were fate, and…

whatever happens, happens.

You couldn't change it.

Who we are is who we are

Matthew:

Learning to Survive

Ever since I've been a child

I was very slow in learning

I tend to be independent…independent, yeah.

I do things a lot myself

but that is one of the skills what I learnt over the years

I've been in quite a lot of jobs

I learnt a lot in skills-wise

The schema course has brought a lot out

in how people behave and stuff like that,

so I learnt a lot.

It was good and I learnt a lot about myself

But of course, I can't remember the big words and all that

I found prison all right.

It…it was just the length obviously,

it's a long time to spend in jail.

But I learnt a lot.

I'd done the…a course in prison, the offending course.

It learnt me a lot

All the skills that what I learnt in the coursework and stuff like that,

I think that I've got the skill to keep out of trouble too.

Been a long time being locked up

and I have learnt a lot while I've been here,

it's been good, it's been good…

There's always something to learn.

Say you learn until your death.

There's always something what you can learn,

you're learning all the time, yeah.

I keep learning and yeah, try to take it.

I find it hard sometimes to…if people give me too much information, or too much in one go,

it…I cannot take it in.

Well, I do take it but, like,

maybe not well as other people probably do.

It takes a while for it to click sometimes, and when it does click, well, I'm…I understand,

but if you told me to take this tape to bits and put it back together again,

I can do that with my eyes closed.

It's funny, it…

I got skills,

I got good skills in one way where I can do things,

but other ways it's…

I always find it difficult,

I'm not an emotional person though,

that's the only trouble

I don't show my emotions so much,

and that's what they keep on about it.

I don't show my emotions.

I think they get…they see it…

I don't think they see it in me,

I don't think…they do see it

but I don't think they realise I can cope all right.

You know, I mean I can cope

I coped all right.

I came out ok where a lot of people gone downhill,

a survivor,

a survivor.

I can cope myself and do things myself.

I don't have to, like, go and pester somebody else to do it for me.

So is that a good thing

or is that a bad thing?

These are saying it's a bad thing

because they got to go and ask people for help

But if you can do it yourself within a short time,

why go and worry about somebody else to get them to do it?

That's a hard one, innit?

I tend to like to be independent.

I can do it myself,

I don't need anybody else.

I think, yeah, they want people to help you.

independent…

been doing it for years, you know,

I always been the one what done it myself

and I get to know myself how to do things.

Terry:

Missing my Home

I've been in HS just over forty years

I'm just, I'm just waiting now to…

to get the ok to move on to another, less secure, a unit

I feel that I'm ready now, really for moving on.

I'm a bit nervous about it, but…

it's a, it's a new thing for me,

moving on from here to somewhere else.

I'm not so keen in moving on in a sense

because this is my home,

and moving from…to somewhere else,

I feel is a bit, you know, a bit scary…

and you know, going to somewhere where I don't really know anybody,

and, you know, it's starting again.

I've got to go back, go, move on

it's like a new, you know, a new home you know,

for me it is anyway,

as it's been my home for so many years.

Moving on…to somewhere else

I've got to try and…adjust myself to that, which is…

might be a bit hard for me, you know,

I shall miss being here, put it that way.

I want to stay where I am.

I suppose I'm looking forward to it in another way

I'm quite chuffed with myself

that I've actually proved to myself, you know,

that I'm moving on

Being in here for so long.

when my gatekeeper come up and said

"well, we think, you know, I'm thinking that, you know, you don't need to be here, you should be moved on, you know".

my old heart was going a lot quicker

and I was…course I was getting a bit panicky.

And I think, well, do I really want to go?

Because people are starting to tell me that "oh, we're going to miss you"

and that makes me feel…

mostly already home.

I'd stay here to be honest

because I know everybody, yeah,

and I've got good relationships you know, with some of the staff.

It's…so different to where I'm going,

I think "can I adjust to that sort of, sort of that move?"

And yeah, it's going to be, it's going to be hard.

This is my home.

I class it as my home.

The first one I went to,

there's no fence or anything around there

a bit scary when you got a big wall around me here

I was glad to be back,

back to my home.

Back here and…

so it has been scary.

And where I'm going to

it's got a big fence around it as well,

I've felt secure here.

a big fence and that,

I felt that I was secure,

that I was in

I didn't want to go out of it.

It's accepting what, you know,

changes and that, you know,

that has come, you know,

you can't be doing, you know,

nothing about it so just go along with it, you know,

go along with the flow

They've got that fence down there

so I'll be living in that fence

where I feel I'll be safer…moving on.

I've never been out on my own, you know…

for over forty years I should think,

and, and, it'll probably be frightening to go out on your own

I've got so used to having a wall around me,

that's what's changed me from wanting to go out on my own

because I spent so many…you know, so long here…

There's no…problems of me running off or whatever

because I wouldn't,

because I can't,

all the years I've been here,

I've never even thought about running off,

it doesn't really matter where I am as part of society,

I feel what I've, what I've done is wrong in the first place,

and I don't deserve to be back out there in society after what I've done.

I'm locked away from the outside world

I shall be going…

I'll just stay there…

until I die.

I've got to make that opportunity to make that the next place another home

that will be my home.

George's Story

During the interview, George provided an account of experiencing mental health difficulties, committing his index offence (manslaughter due to diminished responsibility), being arrested and detained in two medium secure hospitals for seven years, before moving to a rehabilitation hospital just under two years ago. George mentions several different settings throughout the interview, including his home, 'the streets', two MS units, prison, his flat in the rehabilitation hospital, and his girlfriend's residence. However, he does not see any multiplicity of selves in these various contexts, stating they had not changed the way he thought about or experienced himself. Nonetheless, there have been some challenges to his sense of self when experiences have contradicted his conceptualisation of…, such as his index offence: "I wasn't a violent guy at all. Totally out of character, totally out of character". To reconcile these different selves, George presents a self-construct that enables him to maintain his desired identity, whilst accounting for behaviours incongruent with this ideal self.

The narrative he constructs for this purpose is one that reflects the wider discourses within the services and systems he has been in. George's story centres on his diagnosis of paranoid schizophrenia, and this is the keystone he uses to connect and understand his experiences. After being arrested and charged for his offence, George was detained under the MHA (he reports he was experiencing psychosis during this period) rather than being processed through the criminal justice system and receiving a custodial sentence. This shapes his understanding of his offending behaviour as a product of 'mental illness', and he becomes subject to the dichotomies inherent within forensic mental health systems of 'mad / bad' and 'moral / deviant'. Navigating through forensic mental health services requires engagement with the

dominant narratives within those systems. Detention under the MHA and hierarchies within multidisciplinary teams of mental health professionals mean a diagnostic discourse has greater power in these settings and is frequently privileged over other narratives. This enhances the legitimacy of this discourse and therefore grants it more control over determining the assessment and management of risk and care for individuals in these settings. Such individuals therefore need to accept and subscribe to the discursive reality of the institution in order to move through a system that decrees they are 'ill' upon admission and 'well' upon discharge.

In George's case, the narrative offered to him was one of paranoid schizophrenia, where he committed the index offence when psychotic. While this is a thin, reductionist version of a (probably) much more complex and nuanced story, it is likely to have been appealing in its implicit offer of hope and redemption. By framing his offence within symptoms of an illness, George could work towards "recovery" by complying with "treatment" offered to him. This also allowed him to position his previous self on the desired pole of the "moral / deviant" dichotomy through aligning himself with the "mad" position rather than the "bad" one. He is not a "bad" person if his illness caused his offence: "it happened because I was mentally ill, so there's the link there". Indeed, George first mentions his index offence during a description of psychotic experiences: "that's why I ended up inside, because I listened to what the TV was saying". He emphasises this link further by stressing that his illness meant he was unable to distinguish 'right' from 'wrong':

> the simple reason being, when I first came in, I didn't think I'd done anything wrong. But now in hindsight, with time to deal with my illness and different things and this and that, and now I know it was

wrong. But at the time, I wasn't really that bothered because I didn't think I'd done anything wrong

George describes being so "ill" that he was not even aware he was "ill", thereby distancing himself further from his offence through his diagnosis:

George my parents, well my mum and my sister were [___?] saying like, you're ill, you need to go to hospital, and stuff like that. But when I was on the outside, even though I was hearing the TV speaking to me, I didn't think I was ill.

IW What did you think?

George I can't [___?] what I thought, I just, I just didn't think I was ill. And they're saying 'you're ill', I'm saying 'I'm not ill at all'

He also uses his detention in secure hospitals rather than in prison as evidence that he did not offend deliberately, and deserves care rather than punishment:

people don't go out deliberately and do stupid things like that so they can get, I mean, but if like, some people do do it and end up in prison because they're not mentally ill, know what I mean, but I'm mentally ill.

Although he spent a week in prison at one point, he quickly tells me he was in the hospital wing with others who were "mentally ill". George is unable or unwilling to mention any reasons why individuals might commit offences when they are not mentally unwell, maybe because this is an issue that feels unsafe to think about as it contradicts his personal narrative.

In his response above, George refers to his offence as a "stupid thing", which may initially seem as if he is minimising it. However, it is notable that throughout the interview, he refers to it as the "offence" without ever mentioning what it was. I am

not sure whether he assumed I was already aware of it, and if so, how he thought I perceived him and whether I judged him; this might have been an additional impetus for him to present a self that was "well" and therefore "good". Alternatively, George's repeated use of "the offence" as a descriptor, may mirror language used by professionals in the services he has been in who may have referred to it in this manner. Such language may be used to convey a degree of objectivity or professionalism, or to minimise distress elicited through frequent or ongoing mention of violent acts. However, it can also serve to sanitise and reduce the offence, distancing oneself from hearing about or mentioning a violent act, which may inhibit processing of any trauma or other emotions triggered by it. George may be utilising the phrase for similar purposes as professionals, or it may be a strategy to minimise the inclusion of it within his narrative and therefore his identity. His index offence can therefore almost become a separate entity, situated externally to him: "I couldn't get any leave at the MS because my index offence was just up the road". He also states that the offence is part of his past, and was such a disparate experience that he has almost dismissed it and is unable to connect with it: "the old stuff, it's not fresh in the mind so I can't really identify with it". It seems his thoughts and feelings related to the psychosis and his offence are like an infectious contaminant that needed to be cleansed or washed away:

George	I used to have, like, five baths a day trying to get rid of the stuff out of my head, like if I scrub my face like trying to get rid of the stuff that was going on in my head.
IW	When was that?
George	That was when I was in…the MS, when I was upstairs on the…acute ward.

IW And would that help?

George Yeah. But like then it would come back, and I'd have to jump back in the bath again.

By adopting the illness narrative as his preferred story and hence "mentally ill" as part of his identity, George is compelled to demonstrate that he is no longer ill in order to present a self that is "good" and congruent with a desistance or reform narrative. He does this by reminding me frequently that he is not ill now, for example: "like I've said like, I'm not ill any more. I just get sad from time to time". When he slips into talking in the present tense when referring to being ill, he is quick to correct himself: "Because I'm ill. 'Cause I'm ill basically was why, you know…just, you know, I'm just… well, I'm not poorly now but I was poorly then". Although George is adamant that he needed care in hospital rather than punishment in prison, his descriptions of his feelings towards himself are not congruent with the narrative of an essentially "good" self:

> I feel terrible like, and even now, it's still hard because like, it's like…its like I can't feel, because of what I've done yeah, I can't feel real pleasure in my life because when I do feel happy, I feel guilty at the same time. Like, almost like I'm not supposed to be happy like, I need to be sad all the time or something.

By aligning himself with a script that reduces the offence to a symptom of an illness, he may have lost the opportunity to fully acknowledge the impact of his behaviour and process any shame or remorse associated with it. He is able to admit to guilt, as it seems guilt is 'acceptable' and indeed required for rehabilitation. Guilt and innocence is part of the discourse in forensic systems, and denying guilt may be equated to lacking insight into mental health difficulties or minimising offending behaviours,

therefore George freely acknowledges feelings of guilt. However, he may feel that connecting with feelings of shame or remorse would imply he had knowingly committed an action he knew was wrong, and this creates dissonance with a narrative that stresses he was not in control of his behaviour. Feelings of remorse may therefore trigger negative emotions incongruent with his desire / expectation of happiness, but services may not have offered him therapeutic spaces or opportunities to explore this conflict fully.

George does not offer a narrative in uninterrupted story form; rather, this is elicited through frequent and ongoing questions, prompts, and follow-up statements. His narrative is therefore embedded in, and a product of, the dialogue that was co-constructed between us; this seems to reflect other narratives he has developed around significant personal experiences where others have provided a framework for him to attach his story to. He displays a similar passivity in the interview, waiting for me to ask him questions before offering any information, and frequently mirroring the words and phrases I use. For example, when he talks about his paranoia and his unusual auditory and gustatory perceptions, and I ask him how he 'made sense' of those experiences, he replies:

> I didn't make sense of it. It's not till you go inside and you, you see people who, who deal with this issue, sort of thing, every day of their lives 'cause that's their job. I didn't know anything till I came inside.

The "knowledge" that was shared with him forms the basis of psychiatric care and dominant discourses within forensic mental health settings, and it seems this constituted a narrative that subjugated any other he might have constructed prior to engaging with services. This further reinforced his sense of powerlessness, helplessness, and passivity by highlighting how his lack of "knowledge" had

contributed to his mental health difficulties and index offence; his 'recovery' was therefore dependent on this "knowledge" being imparted to him by others. When he experiences difficulties now such as mood swings, guilty feelings, or low mood, he is passive in his coping strategies and simply waits for them to pass.

I also noticed that when I ask George a question leading on from or referring to something he has just mentioned, he frequently still wants me to remind him what I'm asking about. It is unclear whether this is due to cognitive issues (e.g. attention, concentration, working memory, processing speed) that may be inherent or affected by medication or mood, or George's attempts to keep the conversations as closed as possible and limited to those questions he feels safe answering. A significant omission from George's story is any mention of earlier life experiences. He closes down these conversations as soon as I start them, leaving a space in the transcript that is almost defined by what is unsaid. There is no reference to any experience before 1999 when he first became unwell, except for one occasion when he mentions himself as a child:

George	Because my mum said I was a right pain in the arse when I was a child.
IW	Right. What do you think?
George	I probably was.
IW	Do you remember?
George	Yeah.

He then declines to discuss this any further by waiting silently until I ask him another question. George does not actively refuse to answer any of my questions; indeed, he attempts to answer them all, even the ones he does not have answers for such as how therapy might have been helpful to him. When George does not want to or cannot talk about an issue, he adopts a passive position with his silence and waits for me to move

the conversation elsewhere. Passivity is a theme that runs throughout George's story. He uses a passive voice in relation to himself when describing his experiences, and conveys the message that things 'happened' to him and he was swept along by events. In contrast, the schizophrenia is given an active voice, as is the TV that commanded him to do things, and the illicit drugs that might have induced his psychosis. His external locus of control leads him to construct a narrative that emphasises his lack of agency and autonomy throughout his experiences but especially during his psychosis, further reinforcing a preferred self-construct that presents him as a good or moral individual who would not have actively committed a violent offence if he had not become unwell.

During the interview, I was hoping to hear that services had created a therapeutic space for George to understand his index offence with reference to his life experiences. I frequently use terms such as "understanding" and "make sense of" in an attempt to elicit the responses I was looking for, and as the interview progresses and such responses are not forthcoming, my questions become more direct, repetitive, and more closed reflecting my need to find this. However, George's account of this process describes a path from being "ill" to becoming "well" that did not seem to have explored any such aspects. Consequently, another facet of George's understanding is that the illness was something that happened to him, that it was a random occurrence disconnected with any previous experiences, and he was simply a passive recipient without any control over what happened to him: "Could happen to anyone, couldn't it? Could happen to anyone at any time. There's no specific reason for it." He seems unaware of any risk factors associated with developing psychosis, and I was uncertain whether this was due to limited comprehension / retention of a more detailed narrative, or whether he had only been provided with the version he

was recounting. It is possible that psychotherapeutic formulations are subjugated by more medical discourses, which negate some of the legitimacy of any other narratives that cannot be understood or incorporated within the dominant framework, as illustrated by George's dismissal of my suggestion that understanding early experiences could be helpful:

IW Were there sort of earlier experiences when you were a child or when you were a teenager or…that schema therapy helped you to understand?

George Not really, no. I wasn't really ill, you know.

In my hope of discovering some form of meaning-making process he has not mentioned, I eventually resort to summarising a list of his experiences towards the end of the interview, and then asking him explicitly if he connects them in the form of a story:

George Yeah, yeah, yeah. It's like, yeah, you're right, it's like a story, yeah.

IW And do all the bits of the story sort of…fit together?

George Yeah, just, it's like a link, yeah, it's like a chain. Like links of a chain.

IW Are there any links that maybe…seem a bit odd or don't seem to fit?

George No. No.

George is emphatic in his response and agrees with me, using the metaphor of 'links of a chain' to reinforce this. However, the interview as a whole indicates the only way in which he links any of his experiences together is through the illness narrative, and it does not seem any other framework for constructing a coherent story of these events

has been offered to him. His use of 'links' implies a series of separate incidents occurring one after another, as well as a sense of inevitability where one 'link' follows another in a sequential manner. When I enquire further (495) about any disparate links, such as committing an offence that he reports is 'out of character' for him, he changes the metaphor to 'chain reaction':

IW …so I was just wondering if maybe…how you might see those links, like…do those links seem as continuous as other links?

George It's just like, it's sort of the same really. It's just like a chain reaction.

IW What do you mean, chain reaction?

George Just the way things went like, you know, obviously getting ill and losing my flat, and then getting ill and doing what I did and then ending up in MS and then ending up in MS-2, then ending up in [rehabilitation hospital] – it's just all a big thing.

He dismisses the idea of separate links and it seems his experiences of psychosis and the offence may merge together into an indescribable or unmentionable 'thing' that happened to him, rather than a series of lived experiences where he was an active agent. A 'chain reaction' can also convey more of an inevitable sense of destruction than 'links of a chain', thus implying a catastrophic conclusion to events. This may be how George perceives the experiences that he mentions, and there is a recurrence of the passive voice in narrating where he 'ended up' without any control or choice over his destiny. Both meanings are accentuated by his subsequent comparison of mental health difficulties to a serious accident or illness:

> Why does, why do people get knocked over on the road and killed every day, you know? You know, why do people get cancer, you know what I mean? It's just one of them innit, you know, why, I don't know, it just happens.

George seems to believe in a script where he was pre-destined to become unwell and commit his offence: "I think things happen for a reason, and this happened for a reason. I don't know what the reason was but I think it, you know, I think everything…you know, what was meant to be was meant to be". This external locus of control frees him from searching for any multiplicity of meanings when considering why and how these experiences might have occurred. However, if he has already been provided with a legitimate discourse from services that accounts for and explains these experiences, he may not feel the need to look for other answers. This fatalistic outlook may arise from the underlying construction of the illness narrative that posits schizophrenia as arising from a biological vulnerability over which George had no control and which was always destined to strike him down. Life is therefore starkly divided into 'before' and 'after': "life was great before. Well, no…not…not great. I've been ill since 2000, so '99 or 2000 yeah, but before that, like it, life was good and that before I became ill. Then I became ill, life became an absolute nightmare". Similarly, his low moods and feelings of guilt become an inevitable consequence of his index offence, which in turn was something that 'happened' in his life, rather than being actively committed by him.

This may also reflect the implicit perspectives of professionals and / or services that do not or can not invest time or resources to discovering and exploring individual stories, but instead often overlay them with a dominant narrative that does not require an understanding of personal meanings and experiences. The goal of "treatment" is

then limited to a reduction of an individual's presenting symptomology, which in turn is defined by privileged diagnostic discourses and an improvement in currently observable / measurable symptoms and risk factors. George may not have been encouraged to consider alternative perspectives and is therefore unlikely to have encountered any multiplicity of meaning, and this may impact on his view of how his risk factors for psychosis or offending may fluctuate in the future; it is possible George sees these as stable rather than dynamic, and by considering himself "recovered", he may not be aware of potential difficulties that may arise if his emotional, relational, or situational experiences become unstable. While this may inspire hope of a future where these issues need not be considered, it may conversely impact negatively on his hope / motivation for the future if he has needed to incorporate a permanent biological defect or vulnerability into his narrative identity. It may also contribute to a reluctance to seek help or engage with services in the future, and reduce awareness and acknowledgment of early signs of mental health difficulties, which has negative implications for managing risk and providing care before an individual reaches crisis point or re-offends.

At times, George does use phrases implying choice, agency, or autonomy that apparently contradict the themes of inevitability and passivity, for example: "when I came in and I was getting myself better". However, it is obvious George would have had no choice in being detained or in being compelled to receive "treatment". Nevertheless, George presents himself as compliant and motivated to engage with services, and using language implying choice fits with the preferred self he chooses to construct here. Similarly, it seems clear that schema therapy has not contributed to the process of meaning-making for George, and yet he still engages with a script of therapy being helpful. His descriptions of schema therapy are superficial and use

clinical terms incorrectly at times, and it seems as if he had remembered key phrases for the purpose of telling a preferred story about his engagement with therapy:

> if I was in a certain mood, like before I did schema therapy, I wouldn't know what it was about, but like with schema therapy, there's like different schemas, in't there, like compliant surrender, punitive parent … Through doing schema therapy, when I weren't feeling too good, I could understand what mode I was in, and how to deal with it better.

George seems to be very keen throughout to provide positive feedback about any therapy he had engaged in. At several points in the interview, we return to his experiences of therapy and whether he thinks it was helpful, and George is emphatic in his responses: "Yeah, definitely was, therapy was really useful, yeah. Like I said, it helped to understand what schema I was in". However, he is unable to answer my questions about possible childhood origins of schemas, and when I try and explore how this therapy was useful and specifically what it helped him to understand, he struggles to articulate this:

> I just didn't know how to…I didn't really understand what was going with me. Like I knew I was ill but I didn't know, like what kind of mode I was in. But with this schema therapy, I could identify how feelings, the mode of the schema therapy.

Similarly, he provides a very thin description of a substance misuse group he had attended, but is more focussed on trying to tell me what the group was called than how he experienced it: "Can't remember the name of the group…yeah, I have had other therapy but I can't remember the name of the group now. It was group therapy, it was. I can't remember the name of the group it was though".

George is likely to have narrated a similar account to multiple audiences since he committed his index offence and was detained in a secure hospital, and many of these narrations would have been in clinical contexts where his insight, engagement, and progress were being evaluated (e.g. ward rounds, CPAs, MHRTs). To move forwards within these services, he would have needed to offer a particular story that his audience wanted to hear. In the context of his diagnosis and his index offence, this narrative would be likely to include aspects such as knowledge of his diagnosis, a willingness to engage with therapy, compliance with medication, acknowledgement of his index offence, and 'good' conduct. References to groups he has engaged in and the helpfulness of therapy are also part of this story, although it is clear that thin descriptions have sufficed to convince previous audiences. Nevertheless, such a narrative would have served him well in those contexts, and would be self-reinforcing in that George would be deemed 'well' by the same institution that had evaluated him as 'ill'.

I am mindful that George may have been unsure what my role was and the degree of confidentiality around the interview. He had agreed to participate in the study with minimal awareness of its aim, and although I had spent some time before starting the interview going through the study details with him, he did not seem very concerned with reading any of the information himself, for example, he would have signed the consent form without looking over it if I had not insisted on reading it to him. I wondered if George's motivations for participating included disseminating his redemption and "recovery" script, and this also raised concerns for me about whether he was aware that the interview would not be shared with any professionals involved in his care, especially since it seems that the story he told me was one which might have echoed previous accounts provided to professionals and those in positions of

power. Alternatively, a lack of clarity over my role may have prompted him to construct this particular narrative; staff had mistakenly signed me in and greeted me as 'Dr IW', and our meeting took place in an interview room within a forensic mental health service setting where he usually attends outpatient appointments. These factors may have recreated an encounter similar to contexts where George had learnt a specific story that his audience expected to hear, and his previous experiences of providing them with that narrative had been positively reinforcing.

He therefore uses the interview as an opportunity to emphasise these aspects of his story. When he is describing the rehabilitation hospital, he emphasises the freedoms he enjoys with regard to no longer being detained under the MHA and positions himself favourably relative to others in similar contexts through such descriptions:

> I've got my own kitchen, my own bathroom, and you know, it's just there. But all the others, they've all got rooms, I've got a flat and it's great. I can cook at like, if I wanted, at two in the morning for instance, or make a brew anytime I want, or…so it's great.

George therefore has a great deal to lose if he does not engage with the narrative he expects others want to hear from him. While he is unable to envisage how life may have been better for him given the theme of inevitability that runs through his story, he is adamant that life could be worse; for example, he could be in prison or in an acute ward in the medium secure unit. However, this is incongruent with his earlier statements of being in hospital rather than prison because his offence was only due to a mental illness, but maybe he implicitly recognises the power of services to determine which lens his behaviour is viewed through and how others perceive him.

George may also be more willing to internalise the narrative provided by professionals if services have offered one of the few opportunities for him to experience a secure base. George describes chaotic and unstable experiences for the 5-6 years prior to committing his index offence including being homeless, and his descriptions of secure hospitals convey a sense of shelter and safety:

George At least I had somewhere to stay, warm and dry, and I was, you know, and they fed me. I know it was like a medium secure, but it was still better than being on the streets.

IW Were there any other ways it was better?

George No. Just the part…basically, it was better because I had something to eat and a bed to lie in. And that's what was, you know, but it was better than the streets.

IW And in other ways, it must've been hard.

George In other ways, yeah. In other ways it was, yeah. It's like you know, it's the toss of a coin. It was hard, but it was ok as well if you know what I mean.

It is unusual to hear a MS hospital being described in this manner; indeed earlier, George refers to his admission as a "bonus". The phrases he uses to construct this part of his story imply a degree of helplessness and needing to be taken care of, as well as gratitude towards those who "fed him" and provided somewhere for him to stay. Deprivation of his liberty and restriction of his freedoms in this context may almost be equated to feeling contained and safe, and this may be why he uses the metaphor of "the toss of a coin" to communicate an alternative perspective of how this hospital admission was experienced by him.

A central character in George's story is his girlfriend. One of the few times George talks about his feelings is when he is describing telling his girlfriend about his offence. He states he felt "scared and nervous" and was unable to "look her in the face and tell her", so his social worker helped him with this disclosure:

> we were discussing it [___?] and er, different ways with which we can go around it, and I decided the best way for me personally is that she had the word from sort of, herself, rather than…because I didn't want to go there, look her in the face and tell her that, and put her in a position where she felt guilty or she might have to stay with me because I was there at the time. I thought if Susan tells her and I'm not in the picture, it's easier for her to make a decision.

This is from the longest extract in the interview where George speaks unprompted, and it is evident that this relationship is very important to him as he becomes more animated and expresses greater emotion here than at any other point. He displays some ability to mentalise and carefully considers how his disclosure may impact on her and on their relationship, but it is notable that this is an important part of his story that he felt unable to tell her himself. His repeated use of 'look her in the face' implies underlying feelings of shame and a fear of being held in a dismissive or rejecting gaze, and suggests he has struggled to reconcile the offence with his narrative identity - he may be unable to disclose it to others without fear of being rejected or judged if he is still rejecting and judging himself, hence his feelings of guilt and sadness:

George I'm not a big fan of meself anyway, do you know what I mean? So like…

IW What, what does that mean?

George Just I'm not that keen on myself after what's happened…you

know, I don't really like myself.

George uses three different phrases here, with increasing intensity of meaning, to communicate that he has a negative perception of himself since the offence. His self-formulation of his offending behaviour is so thin that there is no scope for connecting or making sense of this experience within the context of his life story, therefore he is unable to have compassion for himself and assumes others will not do so either. While this may have its origins in the roles others have played in relation to him, George is now enacting a judging / rejecting role toward himself.

The relationship with his girlfriend may be more precious to George if his other relational experiences have not been positive. He mentions family members briefly but it is to say that they recognised he was experiencing mental health difficulties before he did, and that they would not allow him to stay at home after a certain point because of his behaviour. Other characters in his story are largely divided into two categories – those who engage with him and those who do not. I ask George at several points in the interview about his relationships with others in the settings where has been, and how he thinks they perceive him but he portrays himself as unconcerned with the views of others:

George Still the same, yeah. I talk to people. They don't talk to me, that's fine. But I talk to people anyway.

IW Have you always been like that?

George Yeah. I'm not bothered if somebody doesn't like me. I don't have to like them, you know.

IW So has that always been, like even from school, and stuff?

George Yeah, yeah. I mean it's the same, there's people in your life you can't stand and they can't stand you but, you know, I'm not really bothered.

IW Are there times when it does bother you?

George It doesn't bother me at all. I might be just with my friends I've got, I don't need…if I make new friends, fair play, that's good, but you know, people don't want to talk to me, I'm not really bothered neither.

However, it is clear he is careful to present himself in a particular way to avoid negative reactions from others:

George Because if people know what I did, they'll give me all the grief.

IW What grief?

George They'll just, you know, just make life difficult for me.

IW What kind of things have people done to make life difficult?

George Just by not speaking to me and spreading rumours round about this and that, so everyone turns their back on me and that – spreading rumours and then everybody'll turn their back on me and I won't have nobody to talk to.

The number of times George insists he does not care how others perceive him indicates this is an issue he is likely to have spent considerable time reflecting on, and suggests he may feel more strongly about this then he admits, despite insisting he does not care. This may arise from a desire to be seen as strong and not vulnerable, possibly stemming from alignment with societal / cultural scripts around gender roles, and / or early experiences. Most of George's relationships seem to be based on a

dismissive / avoidant attachment style where he anticipates rejection, and therefore remains guarded to ameliorate any distress he may feel when others reject him because they do not see the self he wants them to see. George says little about his therapeutic relationships but does mention a particular interaction with his psychologist:

> It was hard, yeah, it was, it was hard that, at the beginning. But then you get used to going there and talking about it and…and like, like Lisa said, she went "with psychologists", she said, "I'm not here to judge you", do you know what I mean, so that was, you know, that was ok.

It is reassuring to hear of at least one safe space where George was able to feel heard without being judged, although one would hope to hear multiple mentions of such encounters during his seven years within secure services. However, I wonder how it could be possible to avoid overwhelming feelings of judgement when detained under a hospital order in a secure mental health setting. Previously mundane activities such as going for a walk alone must be approved by multiple others including the Ministry of Justice, inherently conveying the implicit judgments of society as a whole, as well as those in proximity to him and those with apparent authority over him.

In summary, George's story conveys his struggles to reconcile his offending behaviour with his desired identity, and how prevailing discourses within services have shaped the narrative he constructs in order to keep hold of this preferred self. While he seems to have achieved this, his story has been restricted to those experiences privileged and legitimised by previous audiences. George is subsequently left with a thin, fragmented, and reductionist narrative rather than a rich understanding and enhanced awareness of his experiences and risk factors.

Appendix E: Epistemology

The researcher positions herself within a social constructionist framework, considering "knowledge" as a social enterprise constructed through the medium of language (Polkinghorne, 1988). "Knowledge" therefore consists of interpretations and narratives validated through societal discourse, where some interpretations inevitably become privileged and more powerful in the relational construction of "reality" (Foucault, 1976). However, there can be no "reality" that is not socially constructed through linguistic means, therefore "reality" is dynamically defined within a multiplicity of relational contexts rather than being an objective "truth", although this is often overlooked within privileged discourses (Polkinghorne, 1988).

Consequently, individuals' personal narratives are socially constructed by themselves and others, dependent on context and discourses available within those contexts (Presser, 2009). Narratives cannot be conceptualised as reflecting "reality" since "reality" is a social and relational representation constructed within a particular context, therefore individuals' narratives convey information about how they make sense of their "reality" and implicitly communicate discourses and contexts shaping meaning-making processes (Emerson & Frosh, 2004). Veracity is of little pragmatic relevance within this framework (Presser, 2009), as personal narratives are not considered records of events since there can be no *de facto* representation of "reality" (Polkinghorne, 1988). For clinicians and researchers, the value of forensic narratives lies not in their utility for obtaining authentic experiential records, but in identifying how individuals construct multiplicities of selves in social and relational contexts and the wider discourses influencing this (Presser, 2010).

Appendix F: Supporting Material for Findings

This section presents additional quotes and material related to the findings to demonstrate the nuances of different individuals' narratives, and lend support to the final themes reported.

Section One: Self-Constructs Presented in the Narratives

Destruction and deprivation
I had nothing. I had no identity. That was taken away from me. I had no…no way of…any sort of life. I was abused in the early…in children's home. Not only sexually, but mentally, physically and…I was…I was passed in…paedophile…paedophile ring when I was a child (Danny).
Fear is the path to the dark side
Ben would "wear three coats in summer and make myself look big, so everyone wouldn't touch me", and Carl tried to "keep them at a distance. That way, they can't hurt you and you can't hurt them".
"I was so…insecure and…scared of people and society, that I carried a weapon" (Andy).
Isolation and disconnection felt during abusive experiences led Andy to blame myself. I used to take overdoses, various suicide attempts, and it…got to a point, I got sick of doing that, so what I started to do was…blame everybody else […] I was attacking people on a daily basis. Blaming everybody for…the life that I had.
Eddie developed a violent self-construct partly because "my mum used to tell them, tell everyone that I was the devil and…saying I were a violent thug […] I even had the devil tattooed on my arm".
Violent behaviours could also be driven by revenge:

I wanted to kill my dad basically […] there was something inside saying "no, get help, get help, get help", but then this other side, this other part…and saying "right, I'm going to become the, the most evil…person…that that I could possibly be, to be able to make him suffer". […] I made a glove, so it was in a film called Nightmare on Elm Street, and it's like a, like a…blades on each finger. I made one of those to…to attack my dad (Andy).
For Danny, prison had been ineffective: "I've spent more time in prison than I do on the outside. I go outside for a few months, year or two, back in with the same crowd, ended up doing something, get sent down, start the whole process over".
Most individuals made attempts to block distressing feelings during this period of their lives through a "detached protector, angry protector" (Dave) mode to self-soothe or numb emotions; Andy, Ben, Danny, George, and Eddie used drugs or alcohol, while Ben was a "self-harmer".
Connecting and disconnecting narratives
"I've had mates that've killed theirselves…because they had similar kind of lives…and they're dead now…and…that could've been me" (Eddie).
The exception to individuals feeling they deserved second chances was Terry, who thought he did not "deserve to be back out there in society after what I've done".
Those with violent (not sexual) offending histories said: "I don't like anyone that's in for like…a naughty offence, to do with kids or women" (Ben).
Discovering and disowning identities
Andy described how I'd just change into that Dark Andy…and just mindless…a mindless brute […] that person hasn't gone […] It's there, it's always going to be

there…because that was part, that's part of me but…I…I've moved on from that… yeah. I can't say that "oh no, I'm not that person anymore" because that part…that's sort of almost saying, almost like denying that…that part of me exists.
Dave was critical toward his previous self, often referring to himself in the third person as if that self had been completely removed from his identity.
Eddie used a sharp dichotomy in his narrative to illustrate that "at one time, I thought I was the devil but now…I've started going to church again".
Carl felt "it's given me my life back…like I said, I am…I am me now, you know what I mean? I'm not being what the system wants me to be. I'm actually being Carl. That's good, that. I've got my identity back".
The hospital at the heart of it all
Individuals valued therapeutic and occupational opportunities offering new experiences to incorporate into narratives. They were critical of others perceived to be "sitting on the ward all day, head down, they're not doing things and them are the ones what I'm on about, the ones what don't think to push themselves to get better" (Matthew), although they also acknowledged "some people come here, you know, and they can't survive, you know, that's because they're not ready for change" (Carl).

Section Two: Strategies and Processes for Constructing and Presenting Self-Constructs

Reformation: recognition, realisation, and reflections
Danny said he had taken "giant steps in the right directions" despite obstacles to changing, which felt like two steps backwards but then one step, you take forward. It seems like an endless…an endless road that you're going to go down constantly

when people are down…get half way down, and someone pulls you back to the beginning, and you have to start all over again.
Differences in interactions with peers and family members were also frequently mentioned as evidence of change. Andy attributed these different relational experiences to "understanding myself and then to…respect myself", repeating the words "understanding" and "respect" in relation to himself and others frequently throughout his narrative. Ben described himself as "cheeky […] I say what I'm thinking. I'm always having a laugh, up for a laugh", and these qualities enabled him to hold power differently and "try and get a better life by having a laugh…do you know what I mean? So I have a laugh with people instead, instead of being violent".
Ben initially described behavioural strategies for avoiding reoffending, saying "I want to stay away from the things that f*cked me up", but then also explained how he was managing to react differently to previous triggers:
I thought "what the f*ck's he just swore at me like that?" I had to take myself away and go to my room and listen to some music for a bit. I thought "forget about it. They're idiots. Who wants to be a big man in HS?"
If I had insight into my mental illness, I wouldn't be sitting here now. It's because I didn't have insight into my mental illness […] it's a classic mistake you find in psychiatric services where a patient stops taking medication because they think they didn't need it, but you need it all the time. It's important because you have no insight into mental illness, that's what I had, no insight at the time (Dave).
Danny's self-construct was holistic:
Gangs have always been my life. It's what made me the person I am today. This may sound a bit strange but I wouldn't change anything to

do that…I wouldn't want to change any part of my life. Every part of my life so far has been…in here and care and everything with that…and I become a stronger and stronger person. […] I belong to myself now, not nobody else.
Evaluating again: empathy and accountability
Dave was "deeply sorry for what I've done", but while saying "I didn't blame anyone. I just took the blame myself for what had happened…my name but…I didn't, like, hide behind mental illness", he also felt "resentment for the fact that they hadn't done anything with us in the community, which I should have this treatment in the community".
The significance of schema therapy – struggling through it with others
Ben used a variety of vision-related metaphors saying ST had helped him see things more clearly and picture things, whereas Andy said "it's almost as though…I've wrote a short, a short…a few pages about myself and, and…there's a bell ringing, you know…this is what's been happening".
I found what I needed to find, I found myself and it's like, it's like this little boy just being surrounded…this is a schema term, like you have the Big Bully Danny protects the Little Danny behind all of this, and he closes them all off so nobody can get in. Now I've sent him away, and I'm opening up, and I'm letting people in (Danny).
Emotions were given agency and active voices by many individuals so they became entities in the narrative, and individuals felt equipped with strategies to "battle with them" (Ben).
ST discourses were sometimes difficult to grasp, as Matthew said "I probably have half a dozen more schemas, but I cannot say them because it's…it would be nice if they made it more simpler to understand", echoed by Danny who explained

not all the lads here are the brightest bunch in the toolbox, and we find things hard to understand unless you tell us in our terms. If you use big long words and…meanings we don't understand, we will say "yes, I understand" when we don't understand, because we don't want to look stupid. Danny also had suggestions for increased flexibility with modules and a more interesting introduction to the ST group to improve motivation and engagement. In contrast, Eddie refused to say anything about ST was unhelpful.
ST was "the worst one, it's one of the most difficult courses out the lot" (Carl). Dave felt vulnerable in the group when describing childhood experiences, and Danny found it difficult to discuss emotions with other men. Danny and Ben both struggled with hearing about others' sexual offences against children.
Carl moved from a position of "you have to paddle your own canoe" to "we've all been in the same boat and put trust in each other".
Consistency and trust in therapeutic relationships also applied to staff outside the therapeutic programme: my named nurse is spot on, man. I've told her everything, she knows some right f*cking naughty things about me…not naughty, do you know what I mean? I've cried in front of her and everything. I've never done in that front of anyone, do you know what I mean? So I trust her, and I've had the same named nurse for…four and a half years now (Ben).
Ben, Danny, and Carl all mentioned they had originally thought "I've done groups in jail…and I think "yeah alright…yeah, yeah, yeah…do these groups"... To me, people do groups just to get out…do you know what I mean? And I just think…I thought

they were all bullsh*t" (Ben).
Expectations for ST were high before starting it, but individuals quickly realised that it was not "a miracle cure" (Danny), and developed realistic goals: Schema can't solve all my problems for me. All the schema does is just give you an insight into what my problems are and how I go about dealing with them from day-to-day, do you know what I mean? They give me the tools to cope with that. And that's where your DBT comes in (Carl).
Difficult narratives: what was done to me and what I did to others
Ben and Dave named their index offences at the beginning whereas Carl and Matthew mentioned it two thirds of the way through without naming it. Andy and Danny did not explicitly name their offences but presented descriptions of offending behaviours. Eddie also did this albeit in a much briefer manner. Terry and George never mentioned their index offences. Andy and Dave offered detailed descriptions of offences, and Matthew and Danny gave partial descriptions whereas Ben, Carl, and Terry presented no details. Danny was the only person who never used a passive voice when referring to offending behaviour, and Andy also mostly used an active voice. However, Matthew's description was very passive and removed agency from himself, and Dave's narrative similarly referred to his offence as an accidental occurrence. Matthew and Terry only described acquisitive offences, and George and Dave emphasised they had not been violent prior to their index offences.
I've hurt three or four women and…I showed [___?]. It's just because of the way I was brought up in a violent world and…I've hurt, I've hurt men as well, and I've stabbed, and I've shot, and I've done all sorts (Eddie).
So then I started self-harming. The very first time I ever self-harmed…I self-harmed

all night…[…]…I took 52 paracetamols, cut my arms, and got in bed. Thought "f*ck it, I'm dead", do you know what I mean? […] I were self-harming and putting…sticking things through my feet and…oh, I were doing everything (Ben).
I've had fifty-odd year of violence and…now I've no violence in my life, and that's like fate. That's good fate because…it came along and I didn't have anything come along in my life. I never thought I'd change from being violent, whereas…that's come along in my life where it's just by fate that it's happened (Eddie).
I was going out hurting people on a regular basis. I mean, I'd come home, wake up in the morning, the place would be a mess, and my glove would be on the side…with one of the blades bent, with blood on it (Andy).
"I think the abuse that's caused…psychological and mental abuse, and the physical abuse at the children's homes that's caused them problems…caused the PD, and the PD obviously caused the mental illness" (Dave).

Section Three: Influences on Constructing and Presenting Self-Constructs

It's a secure world: managing in the midst of men
This place is mad, plus you're listened to 24 / 7 […] They invade, they invade you, […] they're sat on top of you with visits. I'm not saying I want to talk about criminal things and that, but…my family has got f*ck all to do with this place. I'm here, that's me innit? […] you can't have owt personal…do you know what I mean? There's no private (Ben).
I started to talk to men a bit more freely and that, and only recently that I've started to…I've had a male key nurse, now doctors, and that…I feel alright, and, and relaxed, you know, chatting to them and that, than what I used to do. Many years ago, I wouldn't, it was quite bad (Terry).

If people call me "what a monster", whatever, you know what I mean? That's fine…I never saw myself as a human being when I come here […] I didn't see myself as a man because what I done was not, was not the nature of the man. I think…I think I was a monster, you know. I saw myself as a monster who didn't care about other people and who I hurt (Carl).
Andy, Eddie, Carl, and Danny all said the hospital had "saved my life basically. It's like you said earlier on… you know, what would you be doing if you hadn't, sort of…not been here. I'd be dead" (Andy).
Danny, Dave, and Matthew reframed their long sentences in a different way, as did Carl: my getting a life sentence, it's probably the best thing that's happened to me. Because if I'd have been doing something like ten years or twelve years, I'd have gone back out on the street, doing exactly what I've been doing, being the same person, not changing, being violent again.
Time could have a confusing effect on individuals' sense of self when their environment remained unchanging and they had nothing to measure their developing self against: if you come away at a certain age, it's like time stops…I am, I feel the age I am when I come away…it's a mind f*ck, do you know what I mean? And I don't feel any older, right, I still feel inside as though I'm 21. But I'm not, I'm 35 (Ben).
The power of placement
Increasing levels of security seemed to be a common strategy for addressing difficulties, although this was internalised as evidence for individuals to believe they

were uncontainable:

> they couldn't handle me in the end…because I…I was just crazy, I was just off-key. So this this was at a Cat B jail, so because of my behaviour…they moved me to a Cat A jail, which is dispersal…for like…that'll sort out…they put me on constant watch down there, and then they put me on the wing […] And then I come here (Ben).

Ben tried to hold on to agency and control in a disempowering system by refusing to let others have power over him: "I said "I'm not arsed, so there's nothing you can do to me", do you know what I mean? And they realised that. Because once they lose that, once they lose control over you, yeah…that's when they don't like you".

Not mad or bad

Dave's narrative contained frequent repetition of "insight", whereas Eddie presented aspects of a desistance / reform narrative, and Carl acknowledged "it's about respecting the system" rather than "pushing boundaries".

Rejection, responsibility and space for rehabilitation

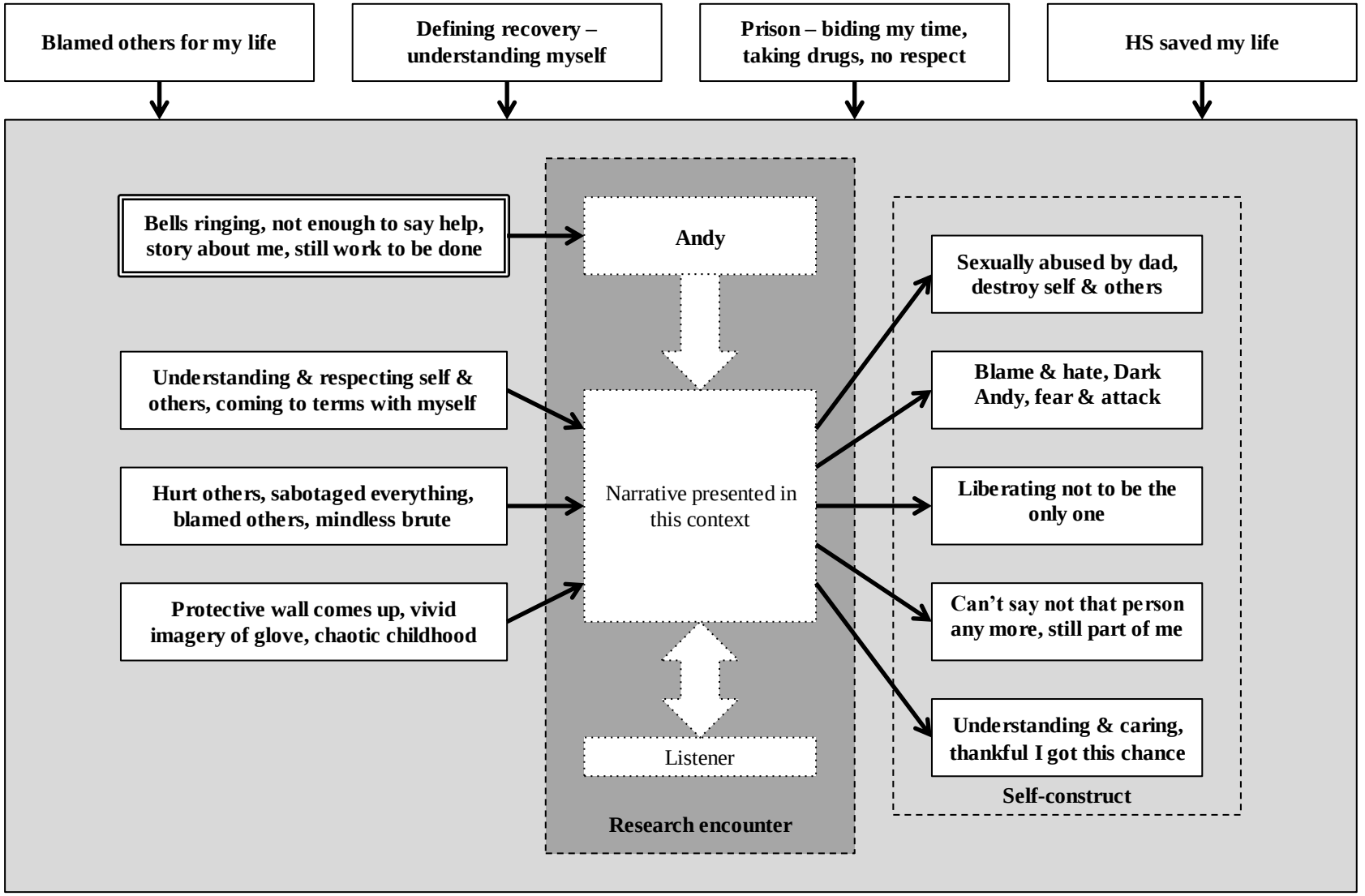
In prison, you get preconceived ideas about people. These are the bad people, these are the good people […] "I'm better than him or I don't…sexually assault kids and stuff like that. I'm a better person […]" no-one's better than nobody. I'm not any better than him, or just because he's got a sexual offence and I've got an offence for violence doesn't mean that I'm better than him (Dave).

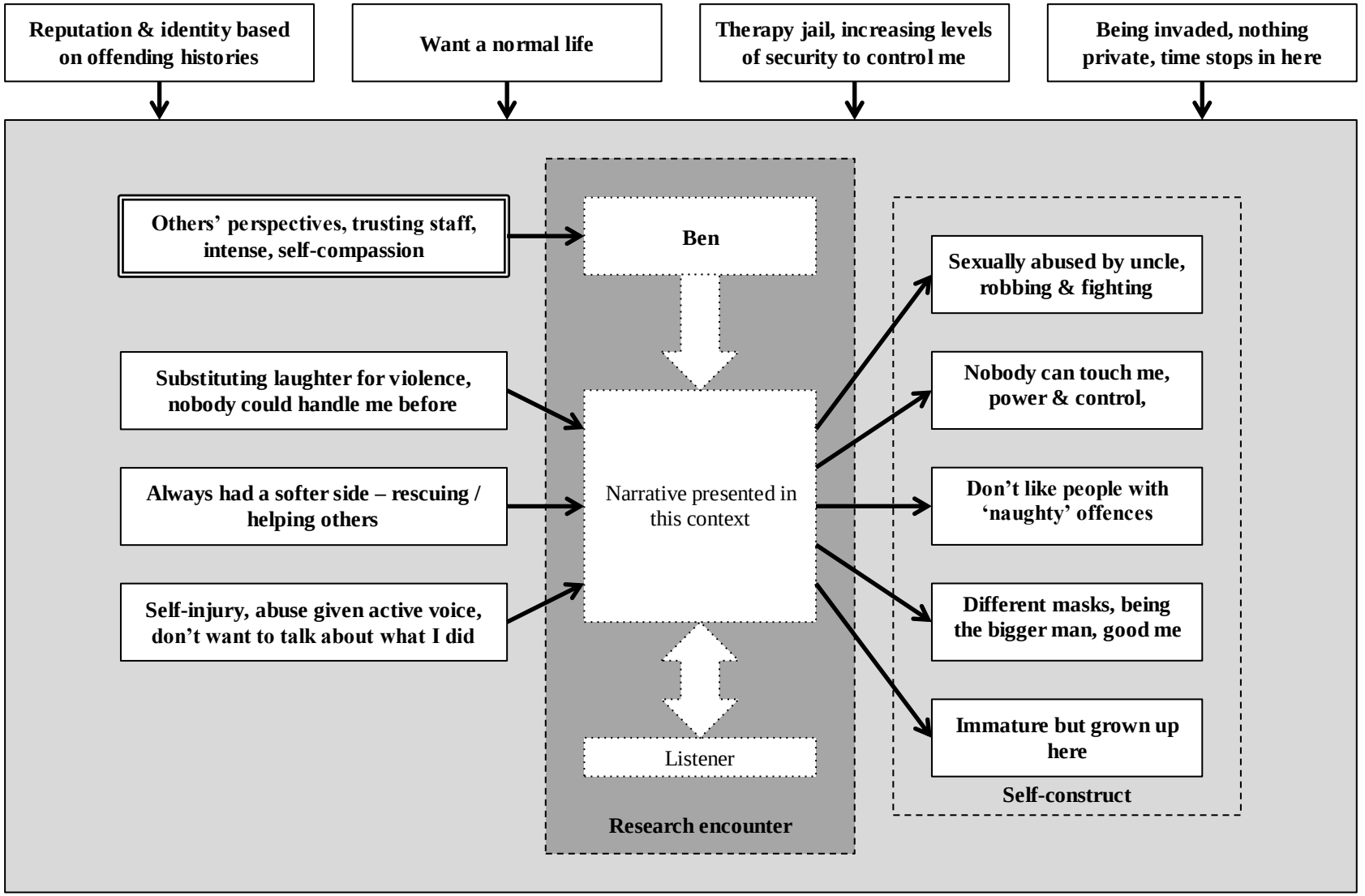
Ben seemed to define identity through offending history, and realised his own index offence was perceived very differently in different contexts:

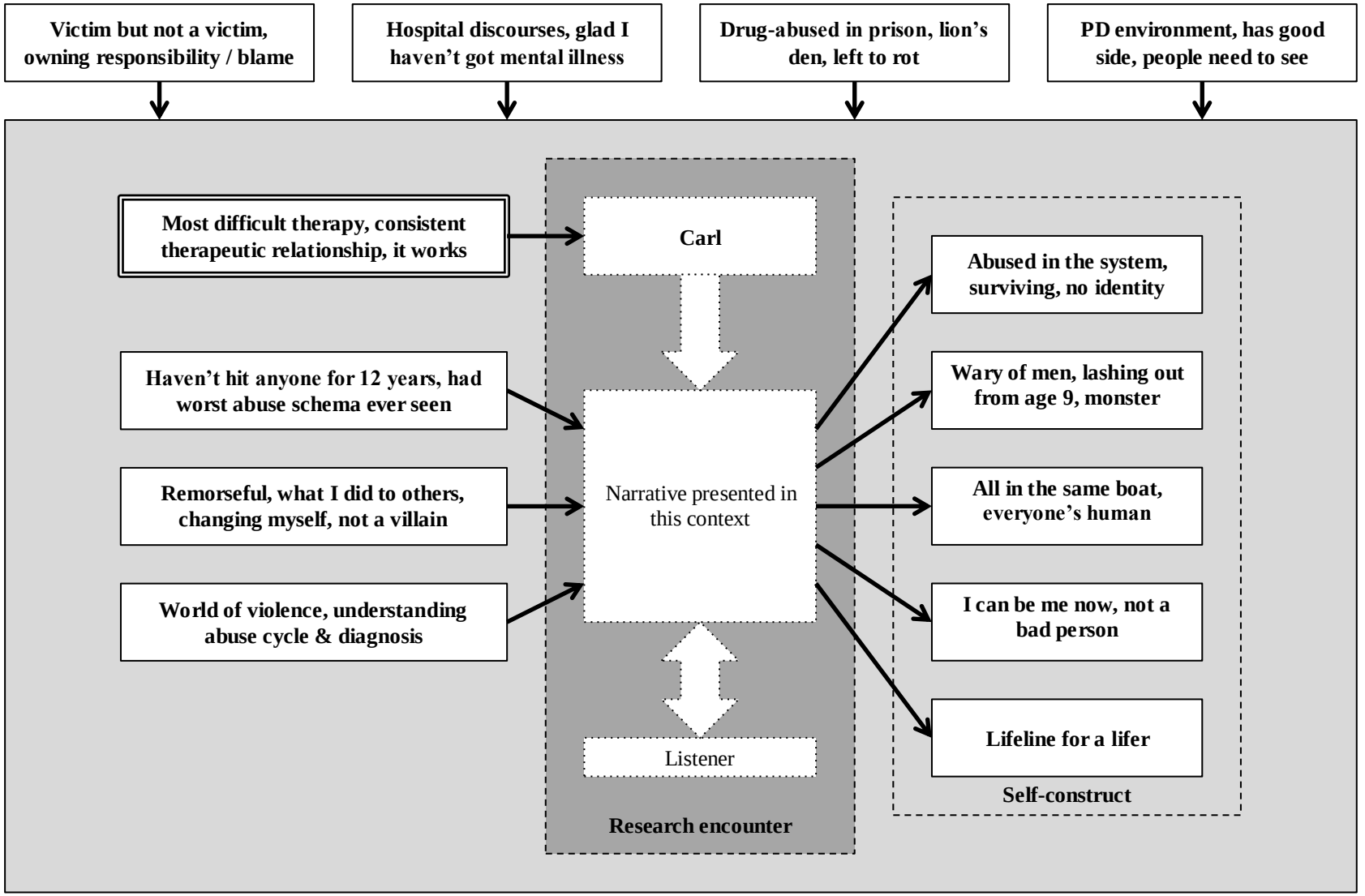
> we killed a security guard on an armed robbery, yeah? In jail, that's not a bad offence…my nephew's still up there living off my reputation…for what we did, do you know what I mean?

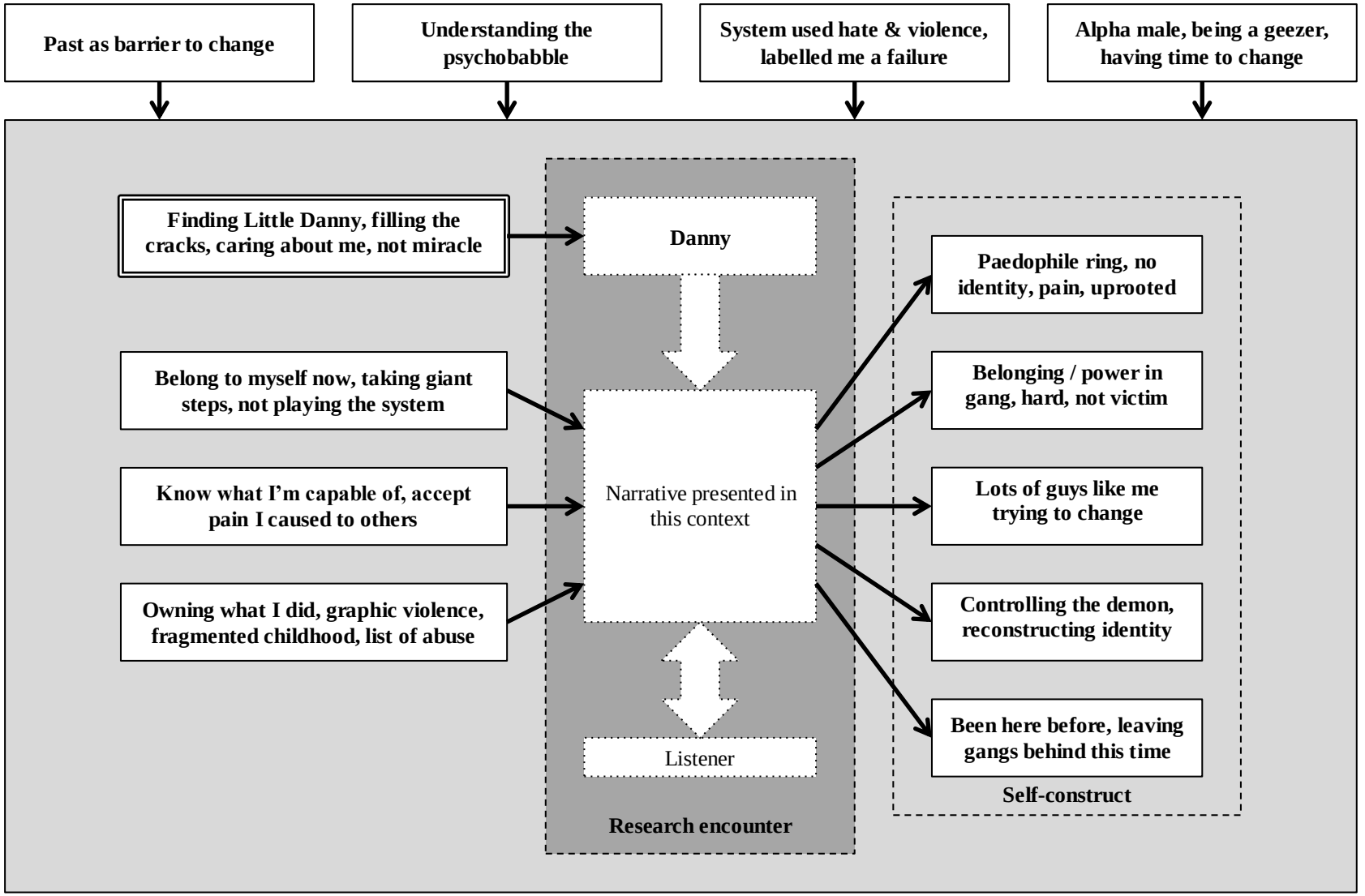
So…people…I don't like telling people what I'm in for, because people think that I'm bigging myself up.
No matter how hard I try…well, my past always comes up and it always will do. You know, this is the sad part because what I have done is going to tarnish me for the rest of my life. And as I say, I think about…because no matter how much work or progress I am…it's going be in someone's back of mind, "is this a game, is he just playing the system again?" (Danny).
They do have an old saying that a leopard never changes its spots. I don't agree with that. I think people do change if they're given the right help and support. Not just kicked out into the street and expected…well, they just expect them to survive. It don't work (Carl).
Society's failing people big time out there. […] when Margaret Thatcher was in power…you know, the biggest thing that I ever agreed with her was…she said to me…one day she said on telly, "that's not a society, that's a native of individual people who don't care about nobody but themselves" (Carl).

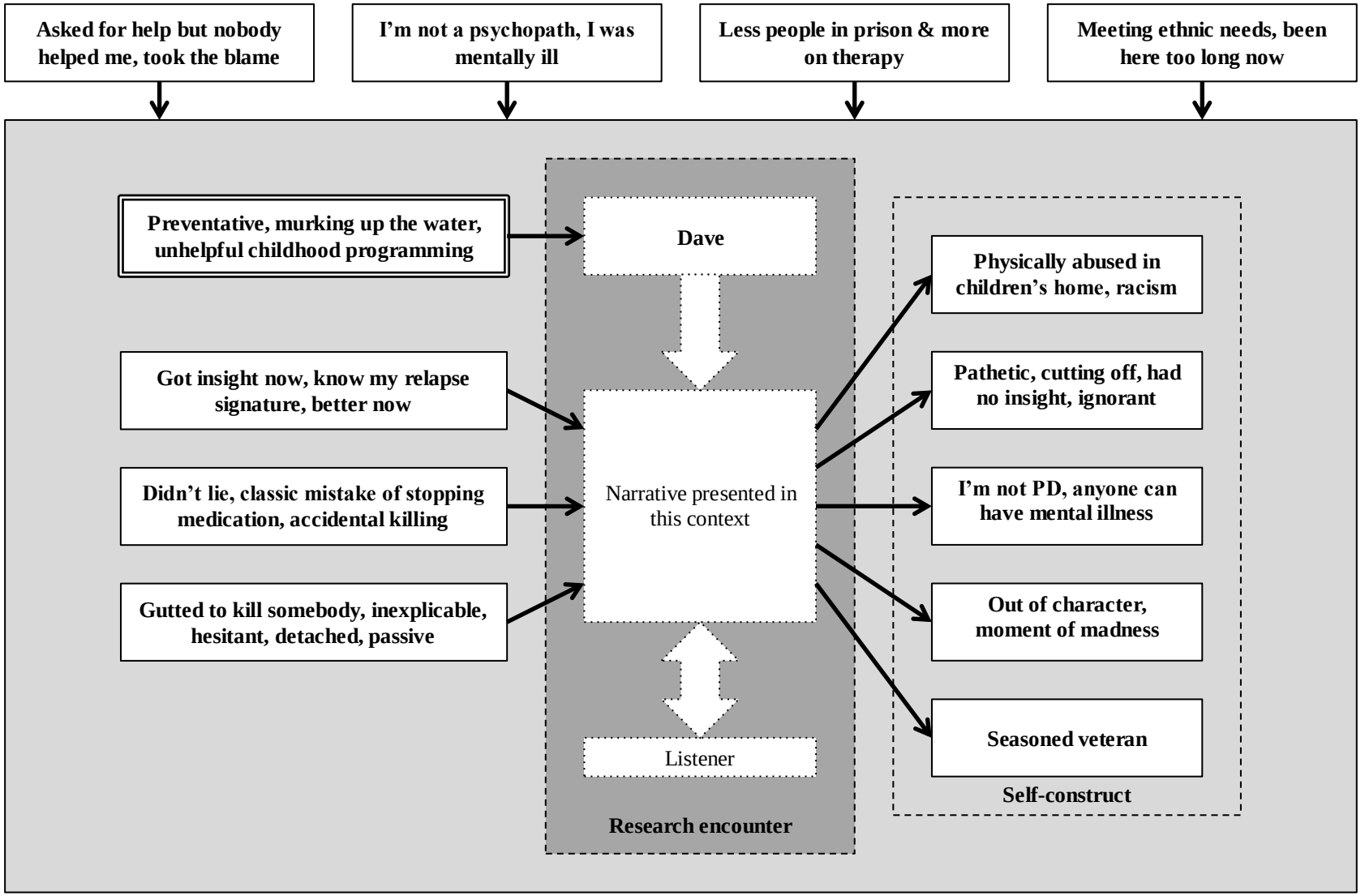
Appendix G: Individual Narrative Maps

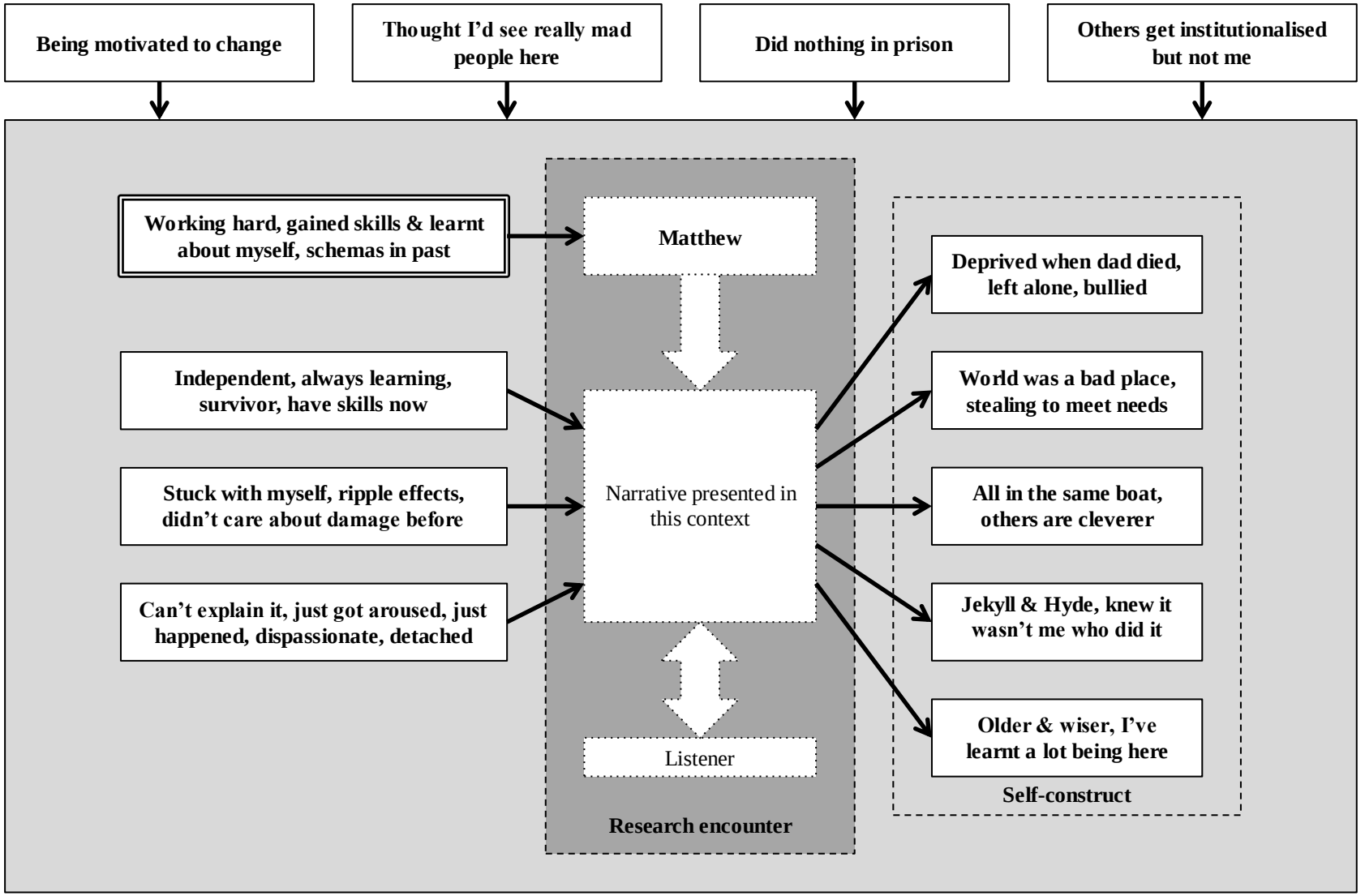


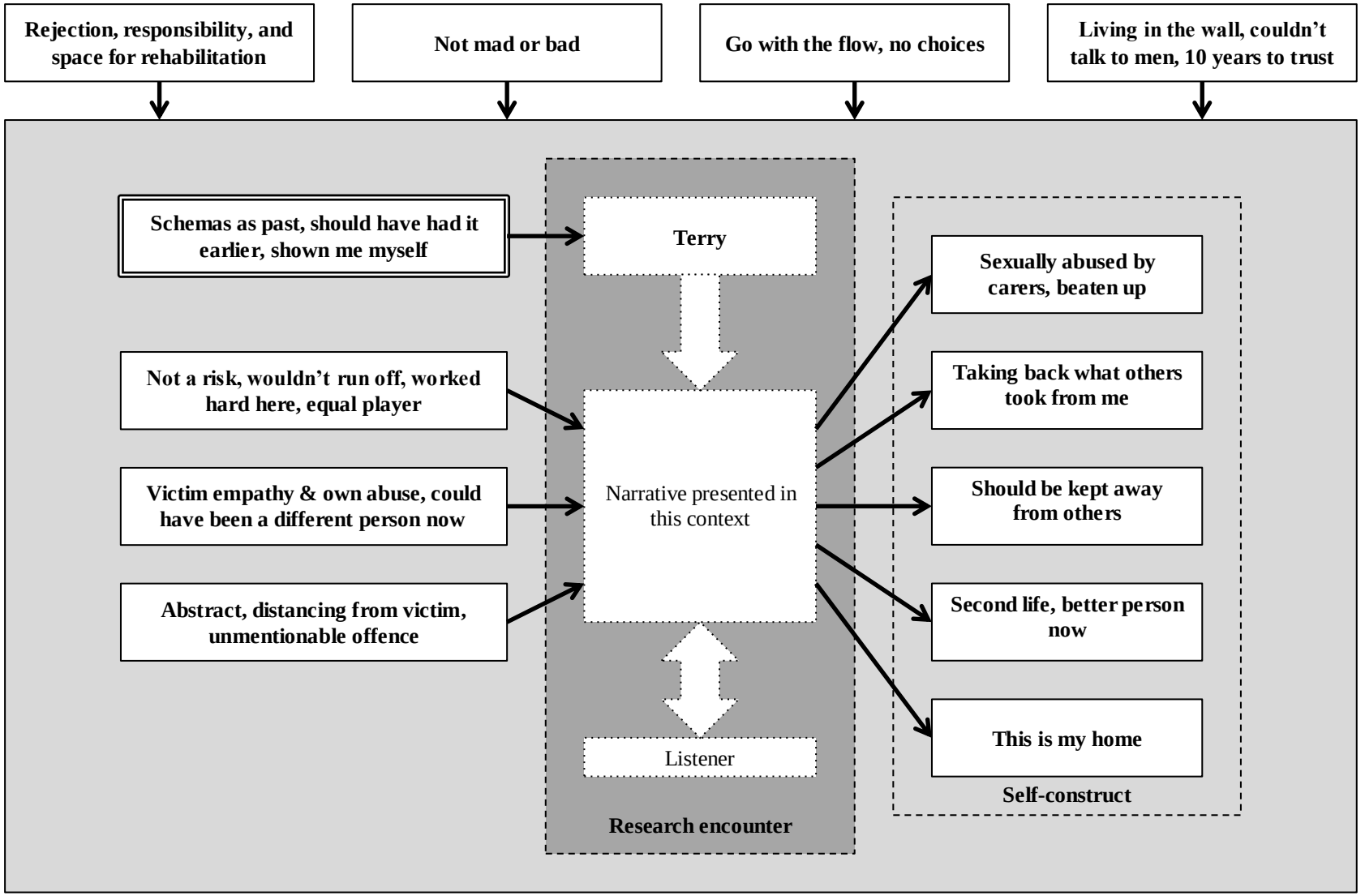

Reputation & identity based on offending histories
Want a normal life
Therapy jail, increasing levels of security to control me
Being invaded, nothing private, time stops in here
Others' perspectives, trusting staff, intense, self-compassion
Substituting laughter for violence, nobody could handle me before
Always had a softer side – rescuing / helping others
Self-injury, abuse given active voice, don't want to talk about what I did
Ben
Narrative presented in this context
Listener
Research encounter
Sexually abused by uncle, robbing & fighting
Nobody can touch me, power & control,
Don't like people with 'naughty' offences
Different masks, being the bigger man, good me
Immature but grown up here
Self-construct

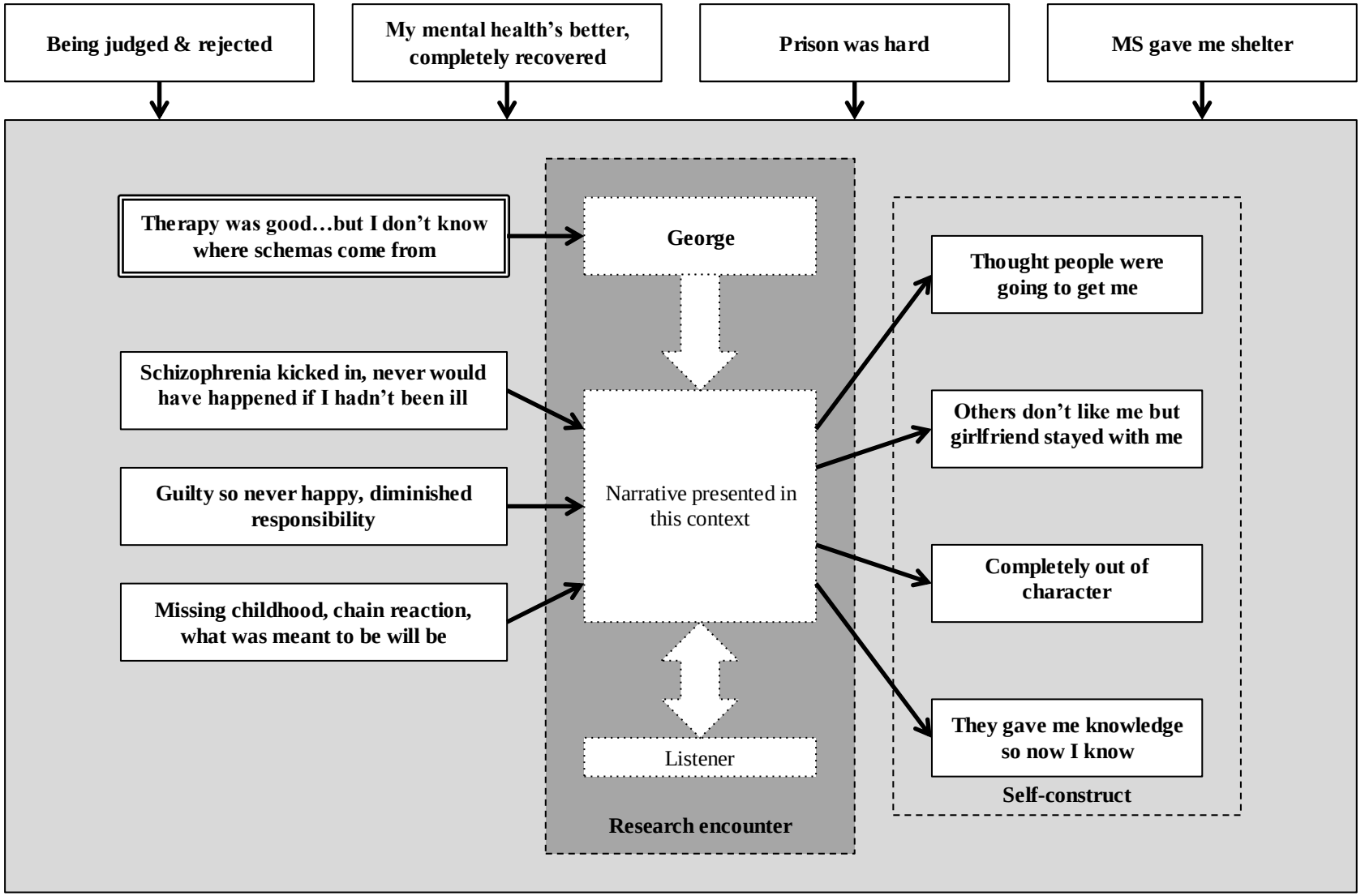

Victim but not a victim, owning responsibility / blame
Hospital discourses, glad I haven't got mental illness
Drug-abused in prison, lion's den, left to rot
PD environment, has good side, people need to see
Most difficult therapy, consistent therapeutic relationship, it works
Carl
Haven't hit anyone for 12 years, had worst abuse schema ever seen
Remorseful, what I did to others, changing myself, not a villain
Narrative presented in this context
World of violence, understanding abuse cycle & diagnosis
Listener
Research encounter
Abused in the system, surviving, no identity
Wary of men, lashing out from age 9, monster
All in the same boat, everyone's human
I can be me now, not a bad person
Lifeline for a lifer
Self-construct


Past as barrier to change
Understanding the psychobabble
System used hate & violence, labelled me a failure
Alpha male, being a geezer, having time to change
Finding Little Danny, filling the cracks, caring about me, not miracle
Belong to myself now, taking giant steps, not playing the system
Know what I'm capable of, accept pain I caused to others
Owning what I did, graphic violence, fragmented childhood, list of abuse
Danny
Narrative presented in this context
Listener
Research encounter
Paedophile ring, no identity, pain, uprooted
Belonging / power in gang, hard, not victim
Lots of guys like me trying to change
Controlling the demon, reconstructing identity
Been here before, leaving gangs behind this time
Self-construct


Asked for help but nobody helped me, took the blame
I'm not a psychopath, I was mentally ill
Less people in prison & more on therapy
Meeting ethnic needs, been here too long now
Preventative, murking up the water, unhelpful childhood programming
Got insight now, know my relapse signature, better now
Didn't lie, classic mistake of stopping medication, accidental killing
Gutted to kill somebody, inexplicable, hesitant, detached, passive
Dave
Narrative presented in this context
Listener
Research encounter
Physically abused in children's home, racism
Pathetic, cutting off, had no insight, ignorant
I'm not PD, anyone can have mental illness
Out of character, moment of madness
Seasoned veteran
Self-construct


Being motivated to change
Thought I'd see really mad people here
Did nothing in prison
Others get institutionalised but not me
Working hard, gained skills & learnt about myself, schemas in past
Independent, always learning, survivor, have skills now
Stuck with myself, ripple effects, didn't care about damage before
Can't explain it, just got aroused, just happened, dispassionate, detached
Matthew
Narrative presented in this context
Listener
Research encounter
Deprived when dad died, left alone, bullied
World was a bad place, stealing to meet needs
All in the same boat, others are cleverer
Jekyll & Hyde, knew it wasn't me who did it
Older & wiser, I've learnt a lot being here
Self-construct


Rejection, responsibility, and space for rehabilitation
Not mad or bad
Go with the flow, no choices
Living in the wall, couldn't talk to men, 10 years to trust
Schemas as past, should have had it earlier, shown me myself
Not a risk, wouldn't run off, worked hard here, equal player
Victim empathy & own abuse, could have been a different person now
Abstract, distancing from victim, unmentionable offence
Terry
Narrative presented in this context
Listener
Research encounter
Sexually abused by carers, beaten up
Taking back what others took from me
Should be kept away from others
Second life, better person now
This is my home
Self-construct


Being judged & rejected
My mental health's better, completely recovered
Prison was hard
MS gave me shelter
Therapy was good…but I don't know where schemas come from
Schizophrenia kicked in, never would have happened if I hadn't been ill
Guilty so never happy, diminished responsibility
Missing childhood, chain reaction, what was meant to be will be
George
Narrative presented in this context
Listener
Research encounter
Thought people were going to get me
Others don't like me but girlfriend stayed with me
Completely out of character
They gave me knowledge so now I know
Self-construct

Appendix H: Author Guidelines for International Journal of Forensic Mental Health

International Journal of Forensic Mental Health

Routledge OPEN SELECT | peer review integrity

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Book: Millman, M. (1980). *Such a pretty face.* New York: W.W. Norton.
Contribution to a Book: Hartley, J.T., & Walsh, D.A. (1980). Contemporary issues in adult development of learning. In I.W. Poon (ed.). *Ageing jin the 1980s* (pp. 239-252). Washington, DC: American Psychological Association.

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- Submitted as separate files, not embedded in text files

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Section Three: Critical Appraisal

Reflections on the Relational Aspects of Qualitative Research in Forensic Contexts

Word count: 4000

Irram Walji

Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

Reflections on the Relational Aspects of Qualitative Research in Forensic Contexts

Violent offending is an essentially relational process (Pollock & Stowell-Smith, 2006), and throughout the thesis process, I repeatedly returned to the central concept that the ways in which individuals relate to others reflects their own relational contexts. Research itself is also a relational process since it is not conducted in a vacuum but is shaped by our relationships with participants and data, supervisors and colleagues, and situated within wider societal discourses (Riessman, 2008). The reflective notes I made whilst completing the literature review and the empirical study also happened to focus largely on relational themes, but traditional forms of academic writing for publication leave little space for these aspects within reflexivity or discussion sections. This critical appraisal presents and explores those reflections in greater detail[1].

Structuring this paper around relational themes is also more congruent with a narrative focus, which urges researchers to consider their roles in the co-construction of narratives and analytic processes (Emerson & Frosh, 2004). Moreover, researchers exploring forensic narratives are especially encouraged to tell their own story as well as those of their participants' (Farrant, 2014; Presser, 2005). This paper therefore explores my relational experiences during the thesis process and considers how these may have impacted on different parts of the research. The paper outlines my interactions with participants in the empirical study, how I related to written and spoken data, the use of supervision as a safe relational space, and the impact of this research on my clinical work and therapeutic

[1] Although the critical appraisal often resembles an expanded discussion section of the empirical paper, it can also serve as a space to discuss and reflect on process issues arising during the thesis as a whole; this is more pertinent to qualitative studies and a particular aspect may be chosen to focus upon.

relationships. Relationships with wider systems and discourses will not be explored here as these have been discussed in the literature review and empirical study, albeit indirectly.

Interactions with Participants

Narrative interviews are considered a co-construction where the story presented develops as a result of interactions between the participant and the researcher (Randall, Prior, & Skarborn, 2006). Interactions in my interviews were also shaped by power dynamics pertaining to the encounter itself and inherent in the wider context of forensic settings (Presser, 2005). For example, everything in high secure settings (HS) is video-recorded in case a serious incident occurs, and I wondered how confidential interviews could feel for individuals when they knew this. I was always offered interview rooms in busy corridors so staff could ensure proximity in case their intervention was required, but this meant interviews were punctuated by background noises of slamming doors and voices in communal areas. Interruptions occurred at least once during most of the interviews as staff checked whether there were any problems, or if I wanted a drink. I was apologetic on each occasion but the interruptions and lack of privacy seemed to be unacknowledged by my participants, and they would continue with their narratives of often extremely personal experiences as if nothing had happened. At times, it seemed as if they did not consider these narratives or that space as private, and I wondered whether being in HS meant little felt personal any more despite the hospital being described as "home". Maybe they had told their story so many times to so many people that it no longer felt owned by them (Adshead, 2012). These frequent interruptions seemed to convey staff might feel the same way.

Staff also interrupted at times to check I was wearing a personal alarm. As soon as interviews were completed, I was asked to wait in the ward office for my supervisor so nursing staff could be aware of where I was at all times. At one point, I was locked in the office (in full view of the ward) as most staff were off the ward and they felt this would be

safest for me. While I understood the need for risk management, I also felt this implicitly conveyed a sense of fear and set up a dynamic for interviews where it was possible participants might have thought I felt unsafe with them (Presser, 2005). I did not actually feel unsafe, and tried to convey this by conducting the interviews in a relaxed and informal way, but nearly all individuals mentioned their previous violent presentations meant they would not have been able to participate in interviews with me prior to the therapeutic gains they had made, and I wondered whether these were efforts to reassure me that they were now safe to be with. Gender may also have influenced this, and they may not have made such comments to a male researcher (Presser, 2005). Alternatively, this could have been an attempt to re-establish power through enacting masculinity by reminding me that I was in a room with somebody who was more physically powerful than me (Sollund, 2008).

There were several occurrences that highlighted how participants perceived power dynamics during the interviews. Individuals seemed to assume I had certain expectations of them and they needed to fulfil these, for example, many of them brought flashcards or formulations from ST and read them out during the interview, evidencing the therapeutic work they had done, and some said they hoped the interview had been helpful in providing what I needed. One individual was apologetic for not being able to say things in "the right way", and another was overwhelmingly positive about ST, refusing to mention any difficulties or challenges in the group. I was assured by one individual of the veracity of his narrative by him explaining it was the same offence account he had presented in court, and another asked me not to judge him based on the story he had shared. Such dynamics were openly named by one individual, who also explained he was not using strong language as he respected women who were in authoritative roles.

These experiences initially led me to believe that I held too much power during the interviews, and I attempted to resolve this by allowing participants to guide the interviews

and decide how much they wanted to share (Mishler, 1991). I was also aware these were individuals who had been through mental health and criminal justice systems multiple times, as well as engaging in extensive therapy, and I wanted to create a different space where they could decide what to share with me rather than presenting the narrative that they thought was expected of them (Emerson & Frosh, 2004). In doing so, I realised that the power dynamic was not as imbalanced as I had assumed since I was completely reliant on individuals to share their stories in a way that would be useful to my study therefore they actually held the power (Enosh & Buchbinder, 2005). Despite the power derived from my professional role and the restrictions inherent in the context, they had the power to resist (Foucault, 1976).

Nevertheless, individuals approached the interview within the context of their own relational frames (Enosh & Buchbinder, 2005), exemplified by one participant where power and control were pervasive themes throughout his story; unlike any of the others, he swore throughout the interview as he described how he had always been perceived as uncontrollable by others. He frequently used phrases such as "do you know what I mean?" to draw me into his narrative (Blagden & Pemberton, 2010), as well as giving voices to many of the other characters in his story and turning it into a performance (Farrant, 2014). I found myself laughing at many points during the interview, and it was only afterwards that I realised how he had used humour to prevent me from either judging him during descriptions of violence, or seeing him as a victim when he talked about his childhood.

Relating to the Data

While completing the literature review and empirical paper, I was wary of imposing a professional or academic voice onto personal stories and offence accounts, as I wanted to analyse and discuss the narratives based on an understanding of the processes underlying their construction (Emerson & Frosh, 2004). In trying to achieve this, I immersed myself in the data as fully as possible. I found with both papers that the nature of the content of these

narratives meant this was an extremely difficult and distressing process at times. I could have completed both papers without engaging with the data to this degree but I felt this would be incongruent with my reasons for doing these studies, and I valued the "connected knowing"[2] that came from reflecting on my emotions and experiences of relating to the narratives I read and heard (Gilgun, 2008). Moreover, Jewkes (2012) suggests that the emotional distress experienced during such work can actually be considered an indicator of authentic, trustworthy, and ethically sound research.

Spoken stories. Narratives frequently contained accounts of childhood abuse, self-injurious behaviours, and violent or sexual offences. Some individuals briefly referred to such experiences whereas others gave much fuller descriptions. In qualitative interviews, the researcher is the instrument through which data is collected and analysed, and empathically connecting with individuals' narratives is central to these processes (Rager, 2005b). My professional background meant I was also using my clinical skills of empathically engaging with others and developing rapport to relate to my participants (Coles & Mudaly, 2010). The content of interviews with this population can be extremely distressing to hear and frequently causes secondary traumatisation in researchers (Blagden & Pemberton, 2010; Coles & Mudaly, 2010; Gilgun, 2008; Roberts, 2011; Sollund, 2008). The intense processes involved in qualitative research from interviewing through to completion of presenting findings meant I remained connected to these stories for a considerable length of time (Woodby, Williams, Wittich, & Burgio, 2011).

I listened to narratives of self-injury that felt physically painful to me, and accounts of childhood abuse that left me in tears afterwards. I heard descriptions of violent and sexual offending that sometimes shocked me due to the passive tone in which they were described, and at other times left me with graphic images of victims. However, I also witnessed

[2] Gilgun (2008) describes this as a process where the reflexive use of self and emotional connection is a strategy for furthering a deeper understanding.

individuals becoming tearful when they told me about powerful moments during therapy (Lalor, Begley, & Devane, 2006), and was often struck by the incongruence of their vulnerability with the dominant "monster" narratives society holds about them (Waldram, 2007). These distressing emotional experiences did not just occur during the interviewing phase; I lived with these stories throughout the ongoing processes of re-listening to recordings, correcting transcripts, reading and re-reading transcripts, spending months making detailed analytic comments, and then finally writing up the results of the analysis using quotes from interviews (Coles & Mudaly, 2010).

There was one individual in particular whose story stayed with me. He was initially anxious about participating but was willing to try. He relaxed soon after the interview started, and reflected insightfully on his developing understanding of himself and his experiences. He described a horrific childhood of being sexually abused by his father, and his subsequent hate and rage directed at himself, his father, and society who had neglected him. He mentioned he was experiencing traumatic flashbacks at some points, and his account of offending behaviours was vivid and so powerful that I thought he might have dissociated in one instance. He was open and courageous about sharing his story, and I was moved that he chose to do so despite it evidently being challenging for him. I felt so touched by it that unlike the other narratives where I had listened to recordings for a group of them, then corrected all those transcripts before starting analysis on each, I decided to complete these steps in a continuous process for him which meant I spent a few days completely absorbed in his story. I started to feel inhabited by this individual as other researchers have described (Jewkes, 2012), and this was followed by an extremely vivid and distressing dream where I had replaced him in his abusive life experiences. Intrusive memories of this affected me for some time afterwards and I was unable to return to his transcript for a while, although this may have been beneficial in preventing me from engaging with it in a superficial way

(Coles & Mudaly, 2010). This also gave me space to come to a position of "connected knowing" where I could reflect on how individuals who have lived through such experiences endure these feelings, and what it might feel like to disclose or discuss these issues (Gilgun, 2008).

Power over others' stories: abusing the data? Although power dynamics during interviews fluctuated between the participants and myself, this relationship shifted during the analysis and writing stages as the researcher then has power over presenting findings (Enosh & Buchbinder, 2005). I chose narrative analysis partly because I felt some other qualitative methodologies prioritised data over participants so personal narratives became fragmented in the search for themes, and I wanted my research to privilege individuals' meaning-making processes. However, I was aware the highly subjective nature of analysis in qualitative research meant it was inevitable the analysis would reflect my interpretation of their narratives as much as it would offer a framework for presenting their stories, although this evoked guilt and self-doubt (Woodby et al., 2011). In retelling their stories and considering the psychological processes underpinning the construction of their narratives, I initially felt I was "stealing" their stories (Farrant, 2014) and having power over the data in this way felt almost abusive when I was presenting the self-constructs of individuals who had experienced a lifetime of disempowerment.

Similarly, I realised the language I used reflected my relationship with the individuals who were the focus of the research and would also shape readers' perceptions of them. For example, I do not describe people as "offenders" as this is incongruent with my position of wanting to understand an individual's whole story rather than reducing them to a label. I discovered there were no alternatives that I was comfortable using, and I wondered whether this reflected a social, academic, and clinical desire to designate such individuals as "others" (Farrant, 2014), facilitating an increased distance and disconnection to them while

disregarding the damaging experiences that contribute to destructive self-constructs and behaviours (Schultz, 2005).

Reading written accounts: being abused by the data? I had assumed that despite the potentially distressing topic of my literature review, analysing written offence accounts would be a manageable albeit difficult endeavour. I had clinical experience of exploring individuals' sexual offences with them in therapeutic contexts, and I anticipated that reading offence accounts divorced of this context meant I would not relate as empathically to the content therefore it would not be as distressing. I was very wrong – the absence of a clinical context meant I had no therapeutic tasks to shield me from emotion (Coles & Mudaly, 2010), and I found myself defenceless against the words I read and re-read through the intensive analytic process. I felt submerged in vast amounts of details from a large number of people regarding their experiences of having sexually abused children.

This was very different to therapy when a single story emerged gradually with an attached context, and where I could understand how and why sexual offending had become part of an individual's narrative. In contrast, reading multiple offence accounts was an unrelenting series of largely context-less stories, and as I progressed with analysis, I felt saturated with graphic, explicit details of how children had been sexually abused, often by primary caregivers. Moreover, I was working with individuals clinically at the time who had been sexually abused as children and / or had sexually abused children themselves, so I felt surrounded by horrific narratives until it seemed as if child sexual abuse was happening all around me. I found this more distressing than my experiences of interviews in the empirical study, as those participants presented a whole narrative and there was never the level of detail that these accounts included.

There is an assumption that secondary data does not have the same emotional impact as interpersonal encounters, but Jackson, Backett-Milburn, and Newall (2013) argue that

narratives are not passive but have affective agency in mediating a relationship between the researcher and the participant. The power of the narratives I was connecting with meant I was vicariously witnessing children being sexually abused again and again (Gilgun, 2008), and I frequently felt tearful and upset. When reading the accounts, I could not help imagining the events described and seeing the abuse, and these images became quite intrusive (Jackson et al., 2013).

I felt trapped in a project that seemed never-ending and consequently, I felt helpless without any control or power over how these narratives were affecting me. I could only passively experience my emotions, as attempts to block them were unsuccessful due to their invasiveness, even when I was not working. I started to become numb at times, and could not watch or read anything that even indirectly related to others suffering as it felt overwhelming. I was reluctant to share how I was feeling with anyone because I did not want to offload traumatising details onto others, and I also felt ashamed I was not more resilient and that it was my own fault for not anticipating how distressing this was going to be; this left me feeling very isolated (Roberts, 2011). When I discussed how I was feeling with my thesis supervisor, he remarked that my narrative resonated with others he had heard from individuals who had been abused, and I realised that through these offence accounts, I was relating to and identifying with sexually abused children (Gilgun, 2008). Indeed, when I completed the literature review, I felt as if I'd escaped from an abusive situation.

I found I related to the data differently throughout this process. At times, I felt completely immersed in it, but at other points, it was almost like I was trying to read the data without getting too close to it as this muted some of the emotional intensity of the words. However, I was concerned this could result in a superficial or distorted analysis (Jackson et al., 2013) so I tried to keep myself fully engaged with it. Despite this, there were still times when I felt disconnected from the data, and I worried this meant I was becoming desensitised

to descriptions of child sexual abuse, before realising this was a reflexive attempt at self-care through numbing distress (Jackson et al., 2013). Using supervision to explore my emotional reactions, and personal reflection subsequently, helped to frame my experiences as "connected knowing" and leave me with a deeper understanding of child sexual abuse that is helpful in both clinical and research contexts (Gilgun, 2008).

The Supervisory Relationship

Although peer support is part of my self-care, I found it was not as helpful during the experiences described above. Comments from peers about my choice of research topics implied I was too empathic towards individuals who had harmed others, leaving me feeling judged and marginalised, much like the populations I was focussing upon (Farrant, 2014). I found I was becoming defensive in justifying my choices to others, both verbally and when drafting the rationale for these studies, and started to avoid discussing my research in detail. I also became concerned with what these completed studies would convey about me and whether others might interpret the quotes I had chosen to use or the conclusions I had come to as arising from a condoning or voyeuristic perspective (Farrant, 2014).

During the most emotionally difficult periods, and indeed throughout the whole thesis, I found supervision invaluable for processing these issues. While thesis supervision can often focus solely on practical or academic aspects of research (Johnson & Clarke, 2003), there is a growing awareness that research involving potentially distressing subjects, including secondary data analysis (Jackson et al., 2013), can have a harmful impact on the researcher (Rager, 2005a) and this needs to be addressed in the same way potential harm to participants is considered by ethics committees (Dickson-Swift, James, Kippen, & Liamputtong, 2008).

I had given little thought to this before my supervisor mentioned it and suggested this might be an issue we needed to be aware of during my thesis. Despite this, I initially felt I

was inflicting a traumatic experience on him through my choice of projects, as supervisors can also experience distress when encountering this material via supervisees (Lalor et al., 2006), and I was aware this could lead to some refusing to continue supervising such research (Schultz, 2005). However, being able to explore these experiences within a safe supervisory relationship helped me to process and connect with what I was feeling, and having space to create my own narrative around this research has been central in helping me think about creating spaces in interviews and reports for others' stories to emerge (Jackson et al., 2013; Roberts, 2011).

The process of doing research in forensic settings can be a lonely and isolating journey with many personal and emotional difficulties, but is also fraught with logistical, methodological, and ethical challenges (Roberts, 2011). I encountered frequent obstacles such as finding field supervisors and locating / recruiting individuals who fit the inclusion criteria. There were several points at which I might have had to restart my thesis, and containing relational experiences in supervision were prompts for me to reflect on how I related to the uncertainty inherent within forensic systems, and whether I could hold this differently in future.

Therapeutic Relationships

I completed my literature review whilst I was on a forensic learning difficulties placement, and my interviews for the empirical paper while on placement in a high secure hospital. Doing these placements during this time also meant I was surrounded by narratives of individuals being hurt and hurting others, regardless of whether I was on placement or at home, and it became increasingly difficult not to ruminate over clinical issues while at home. I also found the research had a significant impact on my clinical work at both placements; for example, I became more aware of issues in high secure settings regarding prison transfers and personality disorder diagnoses that I might have otherwise remained unaware of.

At times, it was difficult to hold in mind perspectives of both those who had abused and those who had been abused, as it could feel as if I was almost betraying abused individuals I was working with on placement while continuing to focus on and understand those who had committed such abuse when I returned home.

Simultaneously, I found myself more sensitised to reading or hearing about historical childhood sexual abuse, and empathy in clinical contexts could feel almost painful when the images and narratives embedded in my mind were triggered directly or indirectly. I initially reflected on whether this meant I was a better or worse clinician than I had been previously, before realising that I was just different but I valued being able to hold empathy and compassion for individuals who have been in both abused and abusing roles. Paradoxically, this can be easier than having self-compassion for being able to do that, as the reactions of colleagues can make it feel like this should not be possible if one truly feels empathy for victims of abuse (Waldram, 2007). I realised this mirrored a societal "victim-offender" dichotomy (Welldon & van Velsen, 2007), and found this was also reflected in my empirical study findings where individuals struggled to hold both roles within their self-constructs.

Conclusions

While my therapeutic roles initially led me towards the research topics I chose, my role as a researcher has also influenced my sense of who I am as a therapist. The narratives shared with me during research interviews reaffirmed my beliefs in the importance of relational contexts and the value of understanding an individual's story holistically. The relationships between my different roles in different contexts have been shaped by the other relational aspects described above, and I feel that working in forensic settings means this connection is valuable in facilitating a more nuanced perspective than either a research or therapeutic role alone. I hope to continue in both roles as this creates more space to consider

how research and clinical work can lead to better outcomes and best practice for forensic populations.

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Section Four: Ethics Documents

Narratives of Individuals With Violent Offending Histories After Schema Therapy

Word count: 4634

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Research Protocol

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Doctorate in Clinical Psychology

Thesis Research Protocol (V 6 07.10.2013)

Title:	The impact of schema therapy on narratives of individuals in secure settings	
Applicant:	[redacted]	(Trainee Clinical Psychologist, Lancaster University)
Academic supervisor:	Dr[redacted]	(Lecturer in Health Research & Clinical Tutor, Lancaster University)
Field supervisor:	Dr[redacted]	(Highly Specialist Clinical Psychologist, [redacted])
Field supervisor:	Dr[redacted]	(Consultant Clinical & Forensic Psychologist, [redacted])

Introduction

Schema therapy has been shown to be an effective psychotherapeutic intervention for individuals who present with chronic psychological distress related to interpersonal difficulties (Giesen-Bloo et al., 2006). Such individuals are often given a diagnosis of 'personality disorder', and most other therapies are often unsuccessful or have only limited effects due to issues in developing and maintaining therapeutic relationships, and the complex and chronic nature of the presenting difficulties (Young, Klosko, & Weishar, 2003). However, a recent systematic review demonstrated that with such client groups, schema therapy shows clinically effective outcomes with medium to large effect sizes (Masley, Gillanders, Simpson, & Taylor, 2012).

Forensic populations have a high prevalence of individuals with such interpersonal difficulties; a systematic review of prison population surveys found that 65% had a diagnosis of personality disorder (Fazel & Danesh, 2002). Two thirds of offenders with personality difficulties are likely to reoffend within two years of returning to the community after leaving secure hospitals, and they are seven times more likely than those with diagnoses of mental health difficulties to be convicted of a serious offence (Jamieson & Taylor, 2004). This high rate of recidivism highlights the importance of considering what works with these individuals, and also indicates that a closer examination of the therapeutic interventions these individuals engage in is warranted.

Increasingly, schema therapy is being implemented in forensic settings in countries such as Britain, The Netherlands, Canada, and the United States (Bernstein, Arntz, & Vos, 2007). The interpersonal difficulties of forensic populations obviously vary significantly in degree, complexity, and presentation from those individuals for whom schema therapy was developed, and there are also important differences in aspects of the therapeutic context. However, adaptations to the original theoretical model

have been proposed, which allow the integration of schema therapy into forensic settings with the aim of meeting the needs of this challenging client group (Bernstein et al., 2007).

The original schema model by Young et al. (2003) proposes that adverse or abusive early experience, which mean that a child's core emotional needs are unmet, result in the development of early maladaptive schemas (Young et al., 2003). These are pervasive and self-defeating patterns of powerful emotions and cognitions regarding the individual's self-construct and their relationships with others; they are developed in childhood or adolescence as a way of understanding and coping with toxic experiences, but continue to be perpetuated through adulthood even when the individual's immediate relationships and environment have changed, thereby causing significant distress and dysfunction (Young et al., 2003). Eighteen different early maladaptive schemas have been identified by Young et al. (2003), such as abandonment, mistrust / abuse, defectiveness, emotional deprivation, entitlement, etc., and studies have shown that they are linked to personality traits and emotional distress (Nordahl, Holthe, & Haugum, 2005; Nordahl & Nysaeter, 2005). However, Young et al. (2003) found that those individuals with the most severe and complex difficulties, often resulting from extremely traumatic and abusive early experiences, were unable to benefit fully from schema therapy since they seemed to have a large number of different schemas; moreover, they presented with rapidly shifting emotional states which seemed disconnected and un-integrated (Young et al., 2003). They therefore developed the concept of schema modes for working therapeutically with these individuals. A schema mode is a characteristic grouping of schemas or coping responses that become activated in response to specific triggers, and manifests as distressing emotions or maladaptive behaviours (Young et al., 2003). An individual may present with a number of different modes (e.g. vulnerable child, angry child, detached protector, punitive parent, etc.), and these may be dissociated from each other to different degrees so the individual may appear to shift rapidly from one to another (Young et al., 2003).

Bernstein et al.'s (2007) adaptation of the schema model for forensic populations suggests that schema mode work is the preferred therapeutic intervention, and they propose four additional schema modes commonly observed in these individuals: angry protector, conning and manipulative mode, predator mode, and over-controller mode (Bernstein et al., 2007). The aim of therapy remains essentially the same, that is, to identify, increase awareness, and moderate or eliminate the maladaptive schema modes an individual has, and to strengthen their healthy adult mode to enable them meet their emotional needs in a more adaptive manner (Young et al., 2003). Moreover, in forensic populations, it is hoped that ameliorating schema modes would also impact on an individual's risk of violence and recidivism (Bernstein et al., 2007).

However, the only completed study identified during this review, focussing on outcomes of schema therapy with forensic populations did not find a statistically significant treatment effect for schema therapy when compared to treatment as usual (Tarrier et al., 2010). This was a randomised control trial conducted at a high security hospital, and there were significant methodological and design issues that may have impacted on the results, including therapist competence, feasibility and ethical issues of limiting the treatment provided to the control group, attrition and discharge of participants, and a lack of power and sufficiently large samples (Tarrier et al., 2010). Although significant clinical improvements were found in the schema therapy group, confounding factors meant these could not be conclusively attributed to the effects of the therapy. A study (currently ongoing) exploring the impact of schema

therapy for individuals in high security hospitals in The Netherlands has reported encouraging pilot data in the form of reliable improvements in assessment scores for risk and symptomology (Bernstein & Arntz, 2009). Another study (also ongoing) is monitoring changes in affective capacity of individuals with psychopathic traits to determine whether schema therapy is effective in producing changes in emotional functioning (Nentjes & Bernstein, 2011). There have been no other studies identified as exploring the impact of schema therapy in forensic populations.

All the studies mentioned previously (Bernstein & Arntz, 2009; Giesen-Bloo et al., 2006; Nordahl et al., 2005; Nordahl & Nysaeter, 2005; Tarrier et al., 2010), as well as the studies included in the recent systematic review (Masley et al., 2012), have used quantitative methodologies to measure the outcomes and effectiveness of therapy. There is insufficient research on individuals' actual experiences of engaging in schema therapy, and only one qualitative study to date could be identified in this area (ten Napel-Schutz, Abma, Bamelis, & Arntz, 2011). Although this study only explored one aspect of schema therapy (experiential imagery re-scripting exercises), the use of qualitative methods enabled a new perspective on this process to be discovered, resulting in valuable insights and the proposal of clinical practice guidelines for improving the therapeutic experience, thus promoting future responsivity and engagement. The authors conclude that clients' experiences and perspectives are an important factor in gaining further understanding and enriched insights to enhance the implementation of schema therapy (ten Napel-Schutz et al., 2011), and these cannot be achieved through just quantitative methodologies and outcome measures.

Positive outcomes are paramount with forensic populations, and prioritising qualitative methods in exploring their therapeutic experiences would be valuable in informing future clinical practice and effective risk management. Furthermore, eliciting the personal stories of individuals engaging in therapy provides an opportunity to hear the voices of a population that is often disempowered, and returns the focus of research to those who are most directly involved in and affected by the services provided. This is especially applicable to individuals in secure settings, as they often experience the greatest power imbalances and the fewest opportunities to express their perspectives. Using qualitative methodologies to explore these perspectives would enable these voices and stories to be heard to a greater degree, thereby facilitating a richer understanding of their therapeutic experiences.

There is an increased focus on the use of narrative approaches with forensic client groups, in assessment and therapy contexts, as well as recommendations for future research (Adshead, 2012; Canter & Youngs, 2012; Green, South, & Smith, 2006; Presser, 2009; Ward & Marshall, 2007). Narratives can be useful in informing clinicians' perspectives of offenders' self-constructs and identities, as well as providing an insight into their goals and motivations, attachments and relationships, and therapeutic experiences. The use of narrative identity as a concept in assessment and intervention with violent offenders has been linked to the Good Lives Model (Ward, 2002) and also seems to have utility in risk management and relapse prevention strategies (Ward & Marshall, 2007). Understanding how individuals perceive themselves in relation to others and in the context of their settings is an important part of the engagement, assessment, and formulation process, and can be a factor in improving the effectiveness of assessments and interventions by making them more responsive to individual needs and risks (Adshead, 2012; Ward & Marshall, 2007).

Rationale

Using a narrative approach to explore the experiences and stories of offenders who have engaged in schema therapy would provide a timely and much-needed insight into the experiences, effectiveness, and outcome of this therapy from the service user's perspective. Focussing this research on individuals in secure settings would highlight stories that are seldom heard (Bartlett & Canvin, 2003) but which are important for the further development of best practice of schema therapy with forensic populations. Furthermore, eliciting individuals' stories would enable clinicians to evaluate whether offenders' narratives have incorporated the concepts from schema therapy when describing offending behaviour, and the degree to which they have engaged with schema mode work in the way they describe their sense of self.

The aims of this research are therefore to explore individuals' experiences of schema therapy and how this fits with their understanding of their offending behavior and risk, and to consider if therapy has impacted on the way they perceive themselves and their relationships with others, and their previous experiences.

A core element of narrative analysis is the uncovering of participants' self-constructs, exploring the factors that have shaped their views, and how the topic under question has impacted on this process (Weatherhead, 2011). This method would therefore be an appropriate approach for exploring this topic, as the process of schema therapy is essentially one of reformulating individuals' self-constructs (Young et al., 2003). Using narrative analysis would also allow an exploration of how the different contexts which offenders experience have influenced their self-constructs and their meaning-making processes regarding their previous experiences and behaviours, as this method allows the participant to present their story in the way they prefer (Emerson & Frosh, 2004). Moreover, narrative analysis is a useful approach for research where only a small number of individuals are likely to fit the criteria, as each participant's narrative can be explored in depth (Weatherhead, 2011).

Research question

What are the personal narratives of individuals with a history of violent offending, following engagement in schema therapy?

Secondary aims include exploring individuals' narratives of engaging in schema therapy and how they feel the schema model may or may not apply to them, whether they have found the model helpful in understanding their previous offending behaviours and risk, and if their therapeutic experiences have impacted on their self-constructs and ways of relating to others.

Method

Participants

Participants will comprise of 5-10 individuals with a history of violent offending recruited from [redacted] and [redacted]

Inclusion criteria:

- Previously convicted of violent offence(s)
- Has engaged in schema therapy on 1:1 and/or group basis for a minimum of 12 months

Exclusion criteria:

- Recent serious incident (depending on type of incident and length of time prior to interview – risk assessment conducted by clinical staff on site)
- Participants will not be excluded based on when they completed therapy

Design

This will be a qualitative study with a sample size of five to ten participants. Individuals who meet the inclusion criteria comprise a small and hard to reach population, and the scarcity of qualitative research with such individuals means there is a high value to hearing their stories. Furthermore, qualitative research does not require large numbers of participants, as the aim is to elicit rich and detailed individual accounts for the purpose of developing a deeper understanding of a particular phenomenon in a specific cohort of individuals, rather than producing generalisable findings as in quantitative methodologies. However, it is hoped that findings will have utility and clinical implications for best practice.

Narrative analysis will be conducted on transcriptions of interview recordings. For this methodology, interviews would usually be minimally structured and open-ended in order to elicit participants' self-generated narratives, thereby giving priority to their perspectives and their processes of making sense of their experiences. Eliciting narrative accounts would allow a focus on exploring whether individuals' stories reflect an understanding congruent with the schema therapy they have engaged in. The process of telling one's personal story is a reflection of, and provides insight into, the way an individual makes sense of their experiences and behaviours, including offending behaviour. Since schema therapy aims to promote changes in individuals' understanding of themselves, a narrative approach would therefore provide a more appropriate indication of whether participants have internalised new learning from therapy in comparison to other qualitative approaches such as interpretive phenomenological analysis (IPA), which may pose more direct questions relating to therapeutic experiences. Analysis of narratives from such interviews would therefore produce different findings from analysis of responses using IPA or other qualitative methodologies. Furthermore, unlike other approaches, narrative analysis also allows an individual's story to be considered as a whole, rather than being fragmented into codes across the whole dataset. This allows the researcher to gain a more holistic understanding of an individual and their experiences.

Potential drawbacks of this method include the difficulties in eliciting participants' narratives when the population is difficult to engage or the interview topic is sensitive or distressing; both these issues may be pertinent in this study. A narrative approach does offer a way of approaching the interview from a more person-centred and less 'expert' position; however, it is acknowledged that a balance will need to be achieved between allowing narratives to emerge naturally and eliciting the information required to answer the research question. The interview guide will therefore be semi-structured rather than open-ended, with reflexive conversational prompts to be used as needed to facilitate responses, as well as specific prompt questions to cover areas not addressed spontaneously by participants. The resulting interview will therefore still be flexible and responsive to individual participants' responses and way of telling their story. It is possible participants may be more willing to discuss their therapeutic experiences than aspects of their personal experiences, but it is hoped this interview approach will create space for participants to feel comfortable with sharing both types of narratives.

This design has been informed by previous qualitative research conducted with individuals who have histories of sexually harmful behaviours, utilising the above approach to semi-structured interviews and then using narrative analysis (Emerson & Frosh, 2004). The co-constructed understandings generated by such semi-structured interviews prioritise subjectivity because of the emphasis on each participant's unique process of sense-making and also ensure participants' perspectives are privileged, rather than those of the researcher, which cannot be achieved to the same extent through rigidly structured interviews (Mishler, 1991).

Materials

See Appendix A for the semi-structured interview format. The questions and prompts included are a guide for the interview process only, and form the basis of the interview focus. Where necessary, the wording, order, and format of the questions will be adapted according to each individual participant's abilities and interactions.

Procedure

A phased recruitment strategy will be used, where the first stage of recruitment is aimed to recruit enough participants for the study:

1. Preliminary discussions with the field supervisor to identify potential participants
2. Initial visit to the site for the purposes of introductions, outlining study, and distributing information sheets (see Appendices B-C and E-F).
3. Follow-up visit to the site after one week to answer any questions, ascertain interest and arrange dates/times for interviews.
4. Interviews to be conducted at the site – dates / times to be arranged in collaboration with participants, field supervisor, and ward staff.
5. Interviews will be conducted individually, audio-recorded, and transcribed.

If insufficient numbers of participants come forward, the second stage of the recruitment strategy will be implemented and the options below carried out as required:

1. The recruitment process identified above will be repeated one month later.
2. The inclusion criteria will be modified to include individuals who have engaged in schema therapy on 1:1 and / or group basis for a minimum of six to nine months (instead of twelve months); this will increase the pool of potential participants.
3. Another site may be added to further increase the pool of potential participants and thereby facilitate recruitment; in this case, additional research governance approval will be sought from the Research and Development (R&D) Department at the relevant NHS Trust.

Recruitment approaches can only take place when the researcher is on site therefore potential participants will also be offered study information, the opportunity to enquire about the study, and discuss participation on the occasions when the researcher visits the site to conduct interviews. This approach will potentially maximise recruitment and participation.

In addition to the detailed participant information sheets, potential participants will also be given a summary information sheet providing an overview of pertinent information (see Appendices B and E). At the point of interview, the information sheet will be reviewed and a further opportunity will be provided to ask any questions, following which the consent form will be signed (see Appendices D and G).

Participants will have the option of retracting consent up to a week after the date of the interview; after this point, transcription will have been completed and analysis may have started making it difficult to identify and remove a specific participant's contributions from the complete dataset.

Up to three interviews may be conducted with each participant, depending on the amount of data obtained and the number of individuals willing to participate, to ensure sufficient depth of analysis. This possibility will be made clear to potential participants in the information sheets and consent forms. If further interviews are required, the researcher will revisit the site, contact participants, and arrange interviews as appropriate. Interviews may therefore take approximately 1-2 hours in total, with each interview lasting approximately 45 minutes-1 hour, and breaks will be offered in line with participants' needs to ensure their comfort.

The recruitment and data collection process will be reviewed in supervision on a monthly basis. Reflections on reflexivity and audit trails to evidence the data collection and analysis will be provided in the final report. Supervision will also be accessed as appropriate to minimise potential researcher bias by discussing and reviewing the analytic process with the academic supervisor.

Data storage – [redacted]

The audio recorder cannot be encrypted but interview recordings will be transferred to a secure medium such as a password-protected and encrypted computer within two hours of completing each interview; until this point, the recorder will be stored securely in a locked case. Interview recordings will be immediately deleted from the audio recorder once transfer to a secure medium takes place.

Interview recordings will be encrypted and stored securely on a password-protected and encrypted computer, and will then be transcribed verbatim by the researcher, and anonymised by assigning pseudonyms to names and places. Only the researcher and academic supervisor will have access to the data, and only the researcher will be aware of which participant each pseudonym corresponds to. Audio files will be securely deleted from the computer once analysis is completed. The computer will be remotely connected to the university's secure server enabling electronic data to be stored on an encrypted password-protected drive. This can also be accessed off-site using a secure VPN connection.

All electronic data and hard copies will be encrypted and kept securely on a password-protected server and a locked filing cabinet at Lancaster University for a period of five years following completion of the study and any associated publications, after which they will be destroyed. If publication is achieved, data will be retained for a further five years post-publication.

Data storage – [redacted]

Audio recording equipment provided by the hospital will be used, and the equipment will remain on site at all times. Transcription will take place on site therefore no recordings will be removed from the site at any time. Audio files will be securely deleted once analysis is completed. Transcripts will be anonymised by assigning pseudonyms to names and places. Only the researcher and academic supervisor will have access to this data, and only the researcher will be aware of which participant each pseudonym corresponds to.

All electronic data and hard copies will be encrypted and kept securely on a password-protected server and a locked filing cabinet at Lancaster University and [redacted] for a period of five years following completion of the study and any associated publications, after which they will be destroyed. If publication is achieved, data will be retained for a further five years post-publication.

Proposed analysis

The methodology used will be narrative analysis whereby transcripts will be analysed with a view to identifying the boundaries of narrative segments; content and underlying themes of these segments will be noted, followed by the identification of thematic and linguistic connections (Weatherhead, 2011).

Practical issues

It is anticipated that there will be travel costs incurred through visiting the sites for interviews, as well as other costs associated with recruitment and interviews, e.g. photocopying, printing, etc. The university will cover these costs. The university will also provide a mobile phone as a point of contact during the research.

Rooms for conducting interviews will need to be arranged at the site. Appropriate personnel at the locations will be contacted to make these arrangements during the recruitment process.

A digital recorder and foot pedal, loaned from the university, will be used to record and transcribe the interviews at [redacted] Transcription at [redacted] will be completed by administration staff from the psychology department who have previous experience of transcribing research interviews. This will be funded by the university and the researcher (some transcription costs may also be covered by the chief investigator, depending on total cost of transcription which will be determined by number / length of interviews).

Ethical issues

The research protocol will be submitted for approval by the Liverpool East Research Ethics Committee. R&D approval will also be sought from the relevant NHS Trust(s).

Risk / distress

All interviews will remain confidential unless any concern of risk to the participants themselves or to others is highlighted. If this should occur, it will be discussed with the research supervisors who would take appropriate action to manage the risk. This may include notifying other professionals at the site.

If participants have any concerns about the study or wish to raise any issues, they will be advised to speak to ward staff or the field supervisor, who can communicate these concerns to the researcher or the academic supervisor. Alternatively, participants can contact the academic supervisor at the university directly; contact details are provided on the participant information sheet.

It is possible that participation in this study could elicit negative emotions, as the interviews will involve discussion of experiences participants could potentially find distressing. In the event that this occurs, participants would be advised to speak to the field supervisor and other appropriate staff such as their primary nurse (or other nursing staff) as required following the interview. The researcher may also offer to pause or terminate the interview if a participant becomes distressed, and all participants will be offered the opportunity of debriefing to minimise any lasting impact. Potential participants will be made aware of this in advance through the information sheets. The researcher is a trainee clinical psychologist and therefore has skills and training enabling her to conduct the interviews in a sensitive and appropriate manner.

Sollund (2008) suggests that there can also be an emotional impact on the researcher in these contexts, depending on the content and interactional processes of the interviews. If this should occur, the researcher will access supervision and support as required. Regular supervision will also ensure that the process of reflecting on the interviews and the data collected does not negatively impact on the researcher in a way that could affect the analysis and interpretation (Roberts, 2011).

The researcher will conduct all interviews in line with Trust / service policies relating to risk management at each site. The researcher will have already completed breakaway training through the DClinPsy course, and will also ensure she is aware of site-specific aspects of risk management prior to recruitment processes. All interviews will take place on site and according to any Trust / service guidelines governing such processes.

Capacity

Individual capacity to consent and participate will not be assessed prior to recruitment, as the Mental Capacity Act (2005) states individuals should be presumed to have capacity unless indicated otherwise (Department for Constitutional Affairs, 2007), and detention under the Mental Health Act (1983) is insufficient indication to warrant assessment of capacity (Brown, 2003). Furthermore, if individuals did not have capacity to consent and participate in research, it would be unlikely they would be engaging with schema therapy.

It will therefore be assumed that participants have capacity to consent and participate, unless it becomes apparent to the researcher during the interview that this is not the case. In such a situation, the researcher will take appropriate action in line with the guidelines of the Mental Capacity Act (2005).

Confidentiality / anonymity

The field supervisor will be aware of who is participating due to processes around risk assessment and logistics of recruitment in secure settings. Moreover, the field supervisor is, or has been, involved in the care / treatment of potential participants. However, the field supervisor will not have access to interview recordings or transcripts and will only see the data at a later point in the analysis when findings have suitably anonymised, so she will be unable to identify individual contributions from specific participants. Use of pseudonyms throughout transcription and analysis will serve to further maintain anonymity. The field supervisor will not be directly involved in recruitment approaches to potential participants, thereby allowing individuals to make decisions on whether or not to participate without undue influence (Bartlett & Canvin, 2003). Recruitment of participants from [redacted] will also require the researcher to obtain approval letters (see Appendix H) from their Responsible Clinicians (RCs); however, RCs will not have any further direct involvement with the research project or have access to any data from interviews.

The academic supervisor will have access to all recordings from [redacted] and transcripts from both sites for the purposes of supervision, for example, listening to and providing feedback on interview technique. The academic supervisor is not involved with the care / treatment of potential participants in any way.

Potential participants will be made aware of the above in advance through the information sheets. It will be made explicit that participation will have no impact on care/treatment, and their individual contributions will not be identifiable after analysis has been completed, so the field supervisor will be unable to ascertain what individual participants have said in their interviews. Any concerns participants may have about this aspect of the study will be discussed during the recruitment approaches and prior to obtaining consent.

Timescale

Recruitment will start once ethical approval has been obtained. It is estimated that interviews will be conducted during October-December 2013. The final project report will be completed by May 2014, and findings will be disseminated following this. Study outcomes will be prepared for publication in a suitable journal, and may also be summarised and presented in relevant professional forums. Participants will be offered the opportunity to obtain feedback on the findings once the study has been completed if they indicate an interest in the outcomes when asked at interview.

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List of Appendices

Appendix A: Interview Guide

LANCASTER UNIVERSITY
DIVISION OF HEALTH RESEARCH
Doctorate in Clinical Psychology

Interview Guide (V 3 11.07.2013)

The questions and prompts included are a guide for the interview process only, and form the basis of the interview focus. Where necessary, the wording, order, and format of the questions will be adapted according to each individual participant's abilities and interactions.

1. **Introduction:**
   a. Outline aim of study, review information sheet if needed
   b. Process of interview (length, recording)
   c. Any questions or concerns
   d. Request consent
2. **Context:**
   a. Brief introduction
   b. Previous engagement in therapy – different settings / types of therapy
3. **Engagement in therapy:**
   a. Duration, type (1:1 and / or group)
   b. Preconceptions of therapy
   c. Reasons for engagement, motivations, goals
   d. Factors that impact on engagement
4. **Experience of therapy:**
   a. Positive / helpful experiences
   b. Difficult / unhelpful experiences
   c. Any differences between 1:1 and group therapy
   d. Any changes in engagement / motivation during course of therapy
   e. (If previous therapeutic experience – any differences)
5. **Learning points:**
   a. Progress towards achievement of initial goals
   b. Any changes while here
   c. Changes expected after leaving here
   d. Impact of therapy on understanding of offending behaviour / risk
6. **Broader impact of therapy:**
   a. Understanding of early / previous experiences
   b. Understanding of self and relationships with others
7. **Final reflections / comments**
8. **Debriefing:**
   a. What was it like to take part in this interview?
   b. Did you find it different from other times when you've talked about similar issues?
   c. Were there some parts that were more difficult to talk about or remember? Was there anything that upset you to think or talk about?
   d. Is there anything you're worried about now that we've finished?
   e. Are there any questions you would like to ask me, or any comments you would like to make?
   f. Review relevant information from information sheet if needed
9. **Offer summary report of findings**

Appendix B: Summary Participant Information Sheet

Summary Information for Participants – [redacted] (V 2 11.07.2013)

Have you engaged in schema therapy for at least 12 months?

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Doctorate in Clinical Psychology

Please consider taking part in this research project...

My name is [redacted] and I am a Trainee Clinical Psychologist. I would like to invite you to take part in my project: '<u>The impact of schema therapy on narratives of individuals in secure settings</u>'.

- ***What is the study about?***

This research is looking at people's experiences of schema therapy in secure settings, and how this fits with the way they make sense of their life stories and their understanding of themselves.

- ***Why have I been approached?***

We are approaching individuals who have engaged in schema therapy for at least twelve months in 1:1 sessions and/or in a group, while in a secure setting.

What will I have to do if I take part?

If you decide you would like to take part, please let me know when I return next week. We can then arrange an interview at a date and time convenient to you; this will take place on site. You might be asked to take part in more than one interview. Interview will be on a 1:1 basis and will be audio-recorded.

- ***What will happen to the results?***

All data will be anonymised so you cannot be identified individually. The results will be written up in the form of a thesis research project. Findings may also be published in a journal.

<u>Thank you for taking the time to read this.</u>

I will be coming back next week.
If you would like to take part in the study or want to know more, please let me know then.

Appendix C: Full Participant Information

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The impact of schema therapy on narratives of individuals in secure settings

Participant Information Sheet – [redacted] ***(V 4 26.09.2013)***

My name is [redacted] and I am conducting this research as a Trainee Clinical Psychologist. I am studying at the Doctorate of Clinical Psychology programme at Lancaster University.

What is the study about?

The purpose of this study is to explore people's experiences of schema therapy in secure settings, and how this fits with the way they make sense of their life stories and their understanding of themselves. By doing this research with individuals in secure settings, we hope to highlight stories that are seldom heard but which are important for the further development of best practice of schema therapy with forensic populations.

Secure settings are hospitals / clinics / wards where individuals are required to stay for a certain period of time so they can receive help for difficulties with behaviours that may harm themselves or others, and / or mental health issues.

Why have I been approached?

You have been approached because the study requires information from individuals who have engaged in schema therapy for at least twelve months, whether in 1:1 sessions or in a group, while in a secure setting. Therapy can have been on an outpatient or inpatient basis.

Do I have to take part?

No. It is up to you to decide to join the study. We will describe the study and go through the information sheet. If you agree to take part, we will then ask you to sign a consent form. Yu are free to withdraw at any time without giving a reason. This would not affect the standard of care you receive.

What will I be asked to do if I take part?

If you decide you would like to take part, please let me know when I return next week. You can also express your interest to nursing or ward staff. We can then make arrangements for an interview at a date and time convenient to you; this will take place on site.

If you are not currently staying at [redacted] we can try to arrange the interview to fit with when you are next here if you prefer not to make an extra trip. Travel expenses up to £10.00 will be paid if you bring a receipt / ticket with you.

At the point of interview, we will review the information sheet to provide an opportunity for you to ask any questions you might have. I will then ask you to sign a consent form before starting the interview. The interview will be on a 1:1 basis and will be audio-recorded using a digital recorder.

It is possible that I may ask you to take part in more than one interview. If this is the case, I will discuss this with you. Taking part in one interview does not mean you have to take part in any further interviews. Interviews will last 1-2 hours in total (approximately 1 hour at a time), with breaks in between as needed.

If you decide you no longer wish to take part in the study after your interview, you can inform the nursing or ward staff who will communicate this to Dr [redacted] She will let me know and I will ensure any information obtained/recorded from you will be deleted / destroyed. You may withdraw from the study up to a week after your interview; at this point; data analysis may be underway and it will be difficult to identify your individual data to remove it.

Will my data be confidential?

The information you provide is confidential. My academic supervisor for this project is Dr [redacted] from Lancaster University and will not be known to you. However, my field supervisor (Dr [redacted] will be known to you as she is, or has been, involved in your care, and this means she will know if you choose to take part in this study. Whether you choose to participate or not, it will not have any impact on the care and therapy you receive. If you do choose to participate, what you say will not have any impact on your care.

Part of the purpose of the project is to explore your experiences of therapy and whether you think it has been helpful. Nevertheless, we understand you may feel uncomfortable about speaking freely and might not wish the field supervisor to know what you have said. For this reason, the field supervisor will not have access to the interview recordings or transcripts; they will only see the data once it has been anonymised and analysed. At that point, your contribution will not be identifiable as yours, so while the field supervisor will be aware that you have participated, she will not be able to identify any of the comments as yours.

Furthermore, the data collected for this study will be stored securely to ensure it is only accessed by the researchers involved in the study as appropriate:

- Audio recordings will be stored securely on a password-protected laptop. Only the researcher and the academic supervisor involved in the project will listen to them.
- The typed version of your interview will be made anonymous by removing any identifying information including your name, so you will not be identifiable from the transcript. Pseudonyms will be used where appropriate. Only the researcher and the academic supervisor involved in the project will read them.
- All computer files will be encrypted (that is, no-one other than the researchers will be able to access them) and the computer itself password protected.
- Anonymised direct quotations from your interview may be used in the reports or publications from the study, but your name will not be attached to them.

- The university will keep all electronic data and hard copies for a period of five years following completion of the study and any associated publications, after which they will be destroyed.

The only exceptions to confidentiality are if what is said in the interview makes me think that you, or someone else, is at significant risk of harm, or if what is said in the interview amounts to new offence-related information. In these cases, I will have to break confidentiality and speak to my supervisors. If possible, I will tell you if I have to do this.

I will also be checking with the care team before the interview to make sure it has been arranged at a time that will be best for you. If there have been recent stressful events or incidents for you, the care team might let me know and suggest that we rearrange the interview.

What will happen to the results?

The results will be summarised and reported in the form of a thesis research paper and presentation to fulfil part of the requirements for the Doctorate in Clinical Psychology. This will be completed by May 2014. Findings may also be submitted for publication in an academic or professional journal.

A summary report of the findings will be available upon request. If you are interested in finding out more, please let me know after your interview.

Are there any risks?

The interviews may involve discussion of experiences you could find distressing. In the event that this occurs, you would be advised to speak to appropriate staff as required. This may be your schema therapist, your primary nurse, or other nursing staff. If you become distressed, you have the option of pausing or terminating the interview. All participants will also be offered an opportunity to discuss any negative feelings after the interview.

Are there any benefits to taking part?

Although you may find participation interesting, there are no direct benefits in taking part. However, the interview will provide you with an opportunity to share your story. Your experiences can be valuable in further developing schema therapy programmes in secure settings.

Who has reviewed the project?

This study has been reviewed and approved by the Liverpool East Research Ethics Committee.

Where can I obtain further information about the study if I need it?

If you have any questions about the study or require further details, please ask me when I return next week. My contact details are also below.

What if I wish to make a complaint or I have any concerns about the project?

If you wish to make a complaint or raise concerns about any aspect of this study and do not want to discuss them with me directly, please speak to ward staff or my field supervisor (Dr [redacted] who can communicate these concerns to me or to my academic supervisor (Dr [redacted]

Alternatively, you can contact my academic supervisor at the university directly:

Dr [redacted]
Clinical Psychology
Division of Health Research
Lancaster University
Lancaster
LA1 4YG
Tel: [redacted]
Email: [redacted]@lancs.ac.uk

Thank you for taking the time to read this information sheet.

I will be returning next week.
If you would like to take part in the study, please let me know when I return.

[redacted]
Clinical Psychology
Division of Health Research
Lancaster University
Lancaster
LA1 4YG
Tel: [redacted]

LANCASTER UNIVERSITY
DIVISION OF HEALTH RESEARCH
Doctorate in Clinical Psychology

Appendix D: Consent Form

Consent Form – [redacted] (V 4 26.09.2013)

Study Title: **The impact of schema therapy on narratives of individuals in secure settings**

We are asking if you would like to take part in a research project to explore people's experiences of schema therapy in secure settings, and how this fits with the way they make sense of their life stories and their understanding of themselves.

Before you consent to participating in the study, we ask that you read the participant information sheet and mark each box below with your initials if you agree. If you have any questions or queries before signing the consent form, please ask the principal investigator, [redacted]

	Please initial box after each statement
I confirm that I have read the information sheet and fully understand what is expected of me within this study	
I confirm that I have had the opportunity to ask any questions and to have them answered.	
I understand that my interview will be audio recorded and then made into an anonymised written transcript.	
I understand that audio recordings will be listened to by the researcher and her *academic supervisor only*, and will be kept until the research project has been examined. *The field supervisor will not have access to the recordings or transcripts.*	
I understand that I am not obliged to take part in this study and can withdraw my participation before, during, or up to a week after my interview.	
I understand that the information from my interview will be pooled with other participants' responses, anonymised, and may be published.	
I consent to information and quotations from my interview being used in reports, conferences, and training events.	
I understand that any information I give will remain strictly confidential and anonymous unless it is thought that there is a risk of harm to others or myself, in which case the principal investigator will need to share this information with her supervisors.	
I consent to Lancaster University keeping the project data for 5 years after the study has finished, or 5 years after any associated publications (whichever is later).	
I consent to take part in the above study.	
Data access by regulatory authorities: I understand that relevant sections of my medical notes and data collected during the study may be looked at by individuals from Lancaster University or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.	

Name of Participant _____ **Signature** _____ **Date** _____

Name of Researcher _____ **Signature** _____ **Date** _____

Appendix E: Summary Participant Information Sheet

Summary Information for Participants – [redacted] (V 1 07.10.2013)

Have you engaged in schema therapy for at least 12 months?

LANCASTER UNIVERSITY

DIVISION OF HEALTH RESEARCH
Doctorate in Clinical Psychology

Please consider taking part in this research project...

My name is [redacted] and I am a Trainee Clinical Psychologist. I would like to invite you to take part in my project: 'The impact of schema therapy on narratives of individuals in secure settings'.

- *What is the study about?*

This research is looking at people's experiences of schema therapy in secure settings, and how this fits with the way they make sense of their life stories and their understanding of themselves.

- *Why have I been approached?*

We are approaching individuals who have engaged in schema therapy for at least twelve months in 1:1 sessions and/or in a group, while in a secure setting.

What will I have to do if I take part?

If you decide you would like to take part, please let me know when I return next week. We can then arrange an interview at a date and time convenient to you; this will take place on site. You might be asked to take part in more than one interview. Interview will be on a 1:1 basis and will be audio-recorded.

- *What will happen to the results?*

All data will be anonymised so you cannot be identified individually. The results will be written up in the form of a thesis research project. Findings may also be published in a journal.

Thank you for taking the time to read this.

I will be coming back next week.
If you would like to take part in the study or want to know more, please let me know then.

Appendix F: Full Participant Information

LANCASTER UNIVERSITY

DIVISION OF HEALTH RESEARCH
Doctorate in Clinical Psychology

The impact of schema therapy on narratives of individuals in secure settings

Participant Information Sheet – [redacted] ***(V 1 07.10.2013)***

My name is [redacted] and I am conducting this research as a Trainee Clinical Psychologist. I am studying at the Doctorate of Clinical Psychology programme at Lancaster University.

What is the study about?

The purpose of this study is to explore people's experiences of schema therapy in secure settings, and how this fits with the way they make sense of their life stories and their understanding of themselves. By doing this research with individuals in secure settings, we hope to highlight stories that are seldom heard but which are important for the further development of best practice of schema therapy with forensic populations.

Secure settings are hospitals / clinics / wards where individuals are required to stay for a certain period of time so they can receive help for difficulties with behaviours that may harm themselves or others, and / or mental health issues.

Why have I been approached?

You have been approached because the study requires information from individuals who have engaged in schema therapy for at least twelve months, whether in 1:1 sessions or in a group, while in a secure setting.

Do I have to take part?

No. It is up to you to decide to join the study. We will describe the study and go through the information sheet. If you agree to take part, we will then ask you to sign a consent form. You are free to withdraw at any time without giving a reason. This would not affect the standard of care you receive.

What will I be asked to do if I take part?

If you decide you would like to take part, please let me know when I return next week. You can also express your interest to nursing or ward staff. We can then make arrangements for an interview at a date and time convenient to you; this will take place on site.

At the point of interview, we will review the information sheet to provide an opportunity for you to ask any questions you might have. I will then ask you to sign a consent form before starting the interview. The interview will be on a 1:1 basis and will be audio-recorded using a digital recorder.

It is possible that I may ask you to take part in more than one interview. If this is the case, I will discuss this with you. Taking part in one interview does not mean you have to take part in any further interviews. Interviews will last 1-2 hours in total (approximately 1 hour at a time), with breaks in between as needed.

If you decide you no longer wish to take part in the study after your interview, you can inform the nursing or ward staff who will communicate this to Dr [redacted] She will let me know and I will ensure any information obtained/recorded from you will be deleted / destroyed. You may withdraw from the study up to a week after your interview; at this point; data analysis may be underway and it will be difficult to identify your individual data to remove it.

Will my data be confidential?

The information you provide is confidential. My academic supervisor for this project is Dr [redacted] from Lancaster University and will not be known to you. However, my field supervisor (Dr [redacted] will be known to you as she is, or has been, involved in your care, and this means she will know if you choose to take part in this study. Whether you choose to participate or not, it will not have any impact on the care and therapy you receive. If you do choose to participate, what you say will not have any impact on your care.

Part of the purpose of the project is to explore your experiences of therapy and whether you think it has been helpful. Nevertheless, we understand you may feel uncomfortable about speaking freely and might not wish the field supervisor to know what you have said. For this reason, the field supervisor will not have access to the interview recordings or transcripts; they will only see the data once it has been anonymised and analysed. At that point, your contribution will not be identifiable as yours, so while the field supervisor will be aware that you have participated, she will not be able to identify any of the comments as yours.

Furthermore, the data collected for this study will be stored securely to ensure it is only accessed by the researchers involved in the study as appropriate:

- Audio recordings will not leave the hospital at any time. They will be typed up by psychology administration staff and then securely deleted. Recordings will remain confidential and will not be discussed with anyone involved in your care.
- The typed version of your interview will be made anonymous by removing any identifying information including your name, so you will not be identifiable from the transcript. Pseudonyms will be used where appropriate. Only the researcher and the academic supervisor involved in the project will read them.
- All computer files will be encrypted (that is, no-one other than the researchers will be able to access them) and the computer itself password protected.
- Anonymised direct quotations from your interview may be used in the reports or publications from the study, but your name will not be attached to them.
- The university and the hospital will keep all electronic data and hard copies for a period of five years following completion of the study and any associated publications, after which they will be destroyed.

The only exceptions to confidentiality are if what is said in the interview makes me think that you, or someone else, is at significant risk of harm, or if what is said in the interview amounts to new offence-related information. In these cases, I will have to break confidentiality and speak to my supervisors. If possible, I will tell you if I have to do this.

I will also be checking with the care team before the interview to make sure it has been arranged at a time that will be best for you. If there have been recent stressful events or incidents for you, the care team might let me know and suggest that we rearrange the interview.

What will happen to the results?

The results will be summarised and reported in the form of a thesis research paper and presentation to fulfil part of the requirements for the Doctorate in Clinical Psychology. This will be completed by May 2014. Findings may also be submitted for publication in an academic or professional journal.

A summary report of the findings will be available upon request. If you are interested in finding out more, please let me know after your interview.

Are there any risks?

The interviews may involve discussion of experiences you could find distressing. In the event that this occurs, you would be advised to speak to appropriate staff as required. This may be your schema therapist, your primary nurse, or other nursing staff. If you become distressed, you have the option of pausing or terminating the interview. All participants will also be offered an opportunity to discuss any negative feelings after the interview.

Are there any benefits to taking part?

Although you may find participation interesting, there are no direct benefits in taking part. However, the interview will provide you with an opportunity to share your story. Your experiences can be valuable in further developing schema therapy programmes in secure settings.

Who has reviewed the project?

This study has been reviewed and approved by the Liverpool East Research Ethics Committee.

Where can I obtain further information about the study if I need it?

If you have any questions about the study or require further details, please ask me when I return next week.

What if I wish to make a complaint or I have any concerns about the project?

If you wish to make a complaint or raise concerns about any aspect of this study and do not want to discuss them with me directly, please speak to ward staff or my field supervisor (Dr [redacted] who can communicate these concerns to me or to my academic supervisor (Dr [redacted] Alternatively, you can contact [redacted] from the Research and Development Department for [redacted] – please ask ward staff for further details on how to get in touch with him.

Thank you for taking the time to read this information sheet.

I will be returning next week.
If you would like to take part in the study, please let me know when I return.

LANCASTER UNIVERSITY

DIVISION OF HEALTH RESEARCH
Doctorate in Clinical Psychology

Appendix G: Consent Form

Consent Form – [redacted] (V 1 07.10.2013)

Study Title: The impact of schema therapy on narratives of individuals in secure settings

We are asking if you would like to take part in a research project to explore people's experiences of schema therapy in secure settings, and how this fits with the way they make sense of their life stories and their understanding of themselves.

Before you consent to participating in the study, we ask that you read the participant information sheet and mark each box below with your initials if you agree. If you have any questions or queries before signing the consent form, please ask the principal investigator, [redacted]

	Please initial box after each statement
I confirm that I have read the information sheet and fully understand what is expected of me within this study	
I confirm that I have had the opportunity to ask any questions and to have them answered.	
I understand that my interview will be audio recorded and then made into an anonymised written transcript.	
I understand that audio recordings will be listened to by the researcher and transcribed by psychology administration staff at [redacted] I understand transcripts will be read by the researcher and her *academic supervisor only*, and will be kept until the research project has been examined. *The field supervisor will not have access to the recordings or transcripts.*	
I understand that I am not obliged to take part in this study and can withdraw my participation before, during, or up to a week after my interview.	
I understand that the information from my interview will be pooled with other participants' responses, anonymised, and may be published.	
I consent to information and quotations from my interview being used in reports, conferences, and training events.	
I understand that any information I give will remain strictly confidential and anonymous unless it is thought that there is a risk of harm to others or myself, in which case the principal investigator will need to share this information with her supervisors.	
I consent to Lancaster University and [redacted] keeping the project data for 5 years after the study has finished, or 5 years after any associated publications (whichever is later).	
I consent to take part in the above study.	
Data access by regulatory authorities: I understand that relevant sections of my medical notes and data collected during the study may be looked at by individuals from Lancaster University or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.	

Name of Participant _____ **Signature** _____ **Date** _____

Name of Researcher _____ **Signature** _____ **Date** _____

Appendix H: RC Approval Letter

LANCASTER UNIVERSITY
DIVISION OF HEALTH RESEARCH
Doctorate in Clinical Psychology

RC Approval Letter – [redacted] (V 1 10.10.2013)

Date: _____

Dear Dr _____

Re:

Patient name: _____ NHS number: _____

Patient name: _____ NHS number: _____

Patient name: _____ NHS number: _____

Study Title: The impact of schema therapy on narratives of individuals in secure settings

My name is [redacted] and I am a Trainee Clinical Psychologist studying at the Doctorate of Clinical Psychology programme at Lancaster University. I am writing to ask your assistance with my thesis research project that I am conducting at [redacted] with approval from Dr [redacted] (Lead Psychologist, PDS) and the [redacted] R&D department. My field supervisor at this site is Dr [redacted] (Consultant Clinical & Forensic Psychologist).

The aims of this research are to explore individuals' experiences of schema therapy and how this fits with their understanding of their offending behavior and risk, and to consider if therapy has impacted on the way they perceive themselves and their relationships with others, and their previous experiences. By doing this research with individuals in secure settings, we hope to highlight stories that are seldom heard but which are important for the further development of best practice of schema therapy with forensic populations.

This will be a qualitative study with a sample size of five to ten participants. Individuals who meet the inclusion criteria comprise a small and hard to reach population, and the scarcity of qualitative research with such individuals means there is a high value to hearing their stories. Furthermore, qualitative research does not require large numbers of participants, as the aim is to elicit rich and detailed individual accounts for the purpose of developing a deeper understanding of a particular phenomenon in a specific cohort of individuals, rather than producing generalisable findings as in quantitative methodologies. However, it is hoped that findings will have utility and clinical implications for best practice.

All participants will be interviewed on a 1:1 basis; these interviews will be audio-recorded and transcribed verbatim by psychology administration staff at [redacted] Narrative analysis will be conducted on transcriptions of interview recordings. For further details please see the enclosed research protocol.

My inclusion / exclusion criteria are as follows:

Inclusion criteria:

- Previously convicted of violent offence(s)
- Has engaged in schema therapy on 1:1 and/or group basis for a minimum of 12 months

Exclusion criteria:

- Recent serious incident (depending on type of incident and length of time prior to interview – risk assessment conducted by clinical staff on site)
- Participants will not be excluded based on when they completed therapy

The results will be summarised and reported in the form of a thesis research paper and presentation to fulfil part of the requirements for the Doctorate in Clinical Psychology. This will be completed by May 2014. Findings may also be submitted for publication in an academic or professional journal, and / or presented at conferences. A summary report of the findings for participants will be available upon request. No individuals' information will be identifiable.

I would like to include the above named individuals, for whom you are the Responsible Clinician, and who have been receiving schema therapy for a minimum of one year. Please could you let me know of any individuals on this list whom, for clinical reasons, you would prefer not to be included.

If you have any questions about this study, please do not hesitate to contact me.

Yours sincerely,

[redacted]
Trainee Clinical Psychologist
Email: [redacted]@lancaster.ac.uk
Tel: [redacted]

Field Supervisor:
Dr [redacted]
Consultant Clinical & Forensic Psychologist

Enc. Research protocol (including participant information sheet, consent form, interview guide)

Research Ethics Committee (REC) Form

NHS REC Form | Reference: 13/NW/0558 | IRAS Version 3.5

Welcome to the Integrated Research Application System

IRAS Project Filter

The integrated dataset required for your project will be created from the answers you give to the following questions. The system will generate only those questions and sections which (a) apply to your study type and (b) are required by the bodies reviewing your study. Please ensure you answer all the questions before proceeding with your applications.

Please enter a short title for this project (maximum 70 characters)
Impact of schema therapy on narratives in secure settings

1. Is your project research?

◉ Yes ○ No

2. Select one category from the list below:

○ Clinical trial of an investigational medicinal product
○ Clinical investigation or other study of a medical device
○ Combined trial of an investigational medicinal product and an investigational medical device
○ Other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice
○ Basic science study involving procedures with human participants
○ Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology
◉ Study involving qualitative methods only
○ Study limited to working with human tissue samples (or other human biological samples) and data (specific project only)
○ Study limited to working with data (specific project only)
○ Research tissue bank
○ Research database

If your work does not fit any of these categories, select the option below:

○ Other study

2a. Please answer the following question(s):

a) Does the study involve the use of any ionising radiation?	○ Yes	◉ No
b) Will you be taking new human tissue samples (or other human biological samples)?	○ Yes	◉ No
c) Will you be using existing human tissue samples (or other human biological samples)?	○ Yes	◉ No

3. In which countries of the UK will the research sites be located? *(Tick all that apply)*

☑ England
☐ Scotland
☐ Wales
☐ Northern Ireland

3a. In which country of the UK will the lead NHS R&D office be located:

- (●) England
- ( ) Scotland
- ( ) Wales
- ( ) Northern Ireland
- ( ) This study does not involve the NHS

4. Which review bodies are you applying to?

- [x] NHS/HSC Research and Development offices
- [ ] Social Care Research Ethics Committee
- [x] Research Ethics Committee
- [ ] National Information Governance Board for Health and Social Care (NIGB)
- [ ] National Offender Management Service (NOMS) (Prisons & Probation)

For NHS/HSC R&D offices, the CI must create Site-Specific Information Forms for each site, in addition to the study-wide forms, and transfer them to the PIs or local collaborators.

5. Will any research sites in this study be NHS organisations?

(●) Yes ( ) No

5a. Are all the research costs and infrastructure costs for this study provided by an NIHR Biomedical Research Centre, NIHR Biomedical Research Unit, NIHR Collaboration for Leadership in Health Research and Care (CLAHRC) or NIHR Research Centre for Patient Safety & Service Quality in all study sites?

( ) Yes (●) No

If yes, NHS permission for your study will be processed through the NIHR Coordinated System for gaining NHS Permission (NIHR CSP).

5b. Do you wish to make an application for the study to be considered for NIHR Clinical Research Network (CRN) support and inclusion in the NIHR Clinical Research Network (CRN) Portfolio? Please see information button for further details.

( ) Yes (●) No

If yes, NHS permission for your study will be processed through the NIHR Coordinated System for gaining NHS Permission (NIHR CSP) and you must complete a NIHR Clinical Research Network (CRN) Portfolio Application Form immediately after completing this project filter and before completing and submitting other applications.

6. Do you plan to include any participants who are children?

( ) Yes (●) No

7. Do you plan at any stage of the project to undertake intrusive research involving adults lacking capacity to consent for themselves?

( ) Yes (●) No

Answer Yes if you plan to recruit living participants aged 16 or over who lack capacity, or to retain them in the study following loss of capacity. Intrusive research means any research with the living requiring consent in law. This includes use of identifiable tissue samples or personal information, except where application is being made to the NIGB Ethics and Confidentiality Committee to set aside the common law duty of confidentiality in England and Wales. Please consult the guidance notes for further information on the legal frameworks for research involving adults lacking capacity in the UK.

8. Do you plan to include any participants who are prisoners or young offenders in the custody of HM Prison Service or who are offenders supervised by the probation service in England or Wales?

○ Yes ◉ No

9. Is the study or any part of it being undertaken as an educational project?

◉ Yes ○ No

Please describe briefly the involvement of the student(s):
The student is completing the study as part of a Doctorate in Clinical Psychology, and will be the chief investigator.

9a. Is the project being undertaken in part fulfilment of a PhD or other doctorate?

◉ Yes ○ No

10. Will this research be financially supported by the United States Department of Health and Human Services or any of its divisions, agencies or programs?

○ Yes ◉ No

11. Will identifiable patient data be accessed outside the care team without prior consent at any stage of the project (including identification of potential participants)?

○ Yes ◉ No

Integrated Research Application System
Application Form for Research involving qualitative methods only

NHS
Health Research Authority

Application to NHS/HSC Research Ethics Committee

The Chief Investigator should complete this form. Guidance on the questions is available wherever you see this symbol displayed. We recommend reading the guidance first. The complete guidance and a glossary are available by selecting Help.

Please define any terms or acronyms that might not be familar to lay reviewers of the application.

Short title and version number: (maximum 70 characters - this will be inserted as header on all forms)
Impact of schema therapy on narratives in secure settings

Please complete these details after you have booked the REC application for review.

REC Name:
North West Liverpool East

REC Reference Number:
13/NW/0558

Submission date:
18/07/2013

PART A: Core study information

1. ADMINISTRATIVE DETAILS

A1. Full title of the research:

The impact of schema therapy on narratives of individuals in secure settings

A2-1. Educational projects

Name and contact details of student(s):

Student 1

Title	Forename/Initials	Surname
Mrs	[redacted]	[redacted]

Address [redacted]

Post Code [redacted]

E-mail [redacted]@lancaster.ac.uk

Telephone [redacted]

Fax

Give details of the educational course or degree for which this research is being undertaken:

Name and level of course/ degree:
Doctorate in Clinical Psychology

Name of educational establishment:
Lancaster University

Name and contact details of academic supervisor(s):

Academic supervisor 1

	Title Forename/Initials Surname
	Dr [redacted] [redacted]
Address	C15 Furness College
	Lancaster University
	Lancaster
Post Code	LA1 4YG
E-mail	[redacted]@lancaster.ac.uk
Telephone	[redacted]
Fax	[redacted]

Please state which academic supervisor(s) has responsibility for which student(s):
Please click "Save now" before completing this table. This will ensure that all of the student and academic supervisor details are shown correctly.

Student(s)	Academic supervisor(s)
Student 1 Mrs[redacted]	☑ Dr[redacted]

A copy of a current CV for the student and the academic supervisor (maximum 2 pages of A4) must be submitted with the application.

A2-2. Who will act as Chief Investigator for this study?

- (•) Student
- ( ) Academic supervisor
- ( ) Other

A3-1. Chief Investigator:

	Title Forename/Initials Surname
	Mrs [redacted] [redacted]
Post	Trainee Clinical Psychologist
Qualifications	BSc(Joint Hons) MSc
Employer	Lancashire Care NHS Foundation Trust
Work Address	C27 Furness College
	Lancaster University
	Lancaster
Post Code	LA1 4YG
Work E-mail	[redacted]@lancaster.ac.uk

* Personal E-mail	[redacted]@gmail.com
Work Telephone	[redacted]
* Personal Telephone/Mobile	[redacted]
Fax	

** This information is optional. It will not be placed in the public domain or disclosed to any other third party without prior consent.*
A copy of a current CV (maximum 2 pages of A4) for the Chief Investigator must be submitted with the application.

A4. Who is the contact on behalf of the sponsor for all correspondence relating to applications for this project?
This contact will receive copies of all correspondence from REC and R&D reviewers that is sent to the CI.

	Title	Forename/Initials	Surname
	Mrs	[redacted]	[redacted]
Address	B Floor, Bowland Main Lancaster University Lancaster		
Post Code	LA1 4YT		
E-mail	ethics@lancaster.ac.uk		
Telephone	[redacted]		
Fax	[redacted]		

A5-1. Research reference numbers. *Please give any relevant references for your study:*

Applicant's/organisation's own reference number, e.g. R & D (if available):	n/a
Sponsor's/protocol number:	n/a
Protocol Version:	3
Protocol Date:	15/05/2013
Funder's reference number:	n/a

Project website: n/a

Additional reference number(s):

Ref.Number Description	Reference Number

Registration of research studies is encouraged wherever possible. You may be able to register your study through your NHS organisation or a register run by a medical research charity, or publish your protocol through an open access publisher. If you have registered your study please give details in the "Additional reference number(s)" section.

A5-2. Is this application linked to a previous study or another current application?

○ Yes ◉ No

Please give brief details and reference numbers.

2. OVERVIEW OF THE RESEARCH

To provide all the information required by review bodies and research information systems, we ask a number of specific questions. This section invites you to give an overview using language comprehensible to lay reviewers and members of the public. Please read the guidance notes for advice on this section.

A6-1. Summary of the study. *Please provide a brief summary of the research (maximum 300 words) using language easily understood by lay reviewers and members of the public. Where the research is reviewed by a REC within the UK Health Departments Research Ethics Service, this summary will be published on the website of the National Research Ethics Service following the ethical review.*

Schema therapy has been shown to be an effective psychotherapeutic intervention for individuals who present with chronic psychological distress, and who are often given a diagnosis of 'personality disorder'. Forensic populations have a high prevalence of individuals with such interpersonal difficulties, and research indicates these individuals are more likely to reoffend after leaving secure hospitals. Increasingly, schema therapy is also being implemented in forensic settings and preliminary outcome data is encouraging.

This research aims to explore whether engaging in schema therapy has an impact on the personal narratives of individuals with a history of violent offending, by considering how individuals make sense of their life stories, their understanding of their previous offending behaviour, and where schema therapy fits with that understanding. Focussing this research on individuals in secure settings would highlight stories that are seldom heard but which are important for the further development of best practice of schema therapy with forensic populations.

The researcher hopes to recruit 5-10 participants from a medium secure unit, who have engaged in schema therapy for at least twelve months. As this is a qualitative study, a flexible semi-structured interview style will be used. Participants may be asked to take part in up to three interviews, lasting 1-2 hours in total with breaks as appropriate. Narrative analysis will then be conducted on transcriptions of interview audio-recordings.

A6-2. Summary of main issues. *Please summarise the main ethical, legal, or management issues arising from your study and say how you have addressed them.*

Not all studies raise significant issues. Some studies may have straightforward ethical or other issues that can be identified and managed routinely. Others may present significant issues requiring further consideration by a REC, R&D office or other review body (as appropriate to the issue). Studies that present a minimal risk to participants may raise complex organisational or legal issues. You should try to consider all the types of issues that the different reviewers may need to consider.

The purpose and design of the project was initially discussed and reviewed by the academic supervisor and field supervisor. The proposal was then presented for peer review at Lancaster University to a panel including trainee clinical psychologists, service users, and two research tutors who are not part of the study. The proposal was modified on the basis of feedback and has since been reviewed again by the academic supervisor and field supervisor.

RISK/DISTRESS

All interviews will remain confidential unless any concern of risk to the participants themselves or to others is highlighted. If this should occur, it will be discussed with supervisors who would take appropriate action to manage the risk. This may include notifying other professionals at the site.

If participants have any concerns about the study or wish to raise any issues, they will be advised to contact the Patient Advice and Liaison Service (PALS) through ward staff, who would then be able to assist them with any concerns or direct them to advocacy or complaints services as appropriate. The chief investigator has contacted [redacted] PALS to inform them of the study and make them aware of this possibility, and copies of the participant information sheets and consent form have been sent to them.

It is possible that the interviews will involve discussion of experiences participants could potentially find distressing. If this occurs, participants would be advised to speak to the field supervisor and other appropriate staff such as their primary nurse (or other nursing staff) following the interview. The interview may be paused or terminated if a participant becomes distressed, and all participants will be offered the opportunity of debriefing. Potential participants will be made aware of this in advance through the information sheets. The chief investigator is a trainee clinical psychologist and therefore has skills and training enabling her to conduct the interviews in a sensitive and appropriate manner.

There can also be an emotional impact on the researcher, depending on the content and interactional processes of the interviews. If this occurs, supervision and support will be accessed as required.

All interviews will be conducted in line with Trust/service policies relating to risk management at each site. The researcher will ensure she is aware of site-specific aspects of risk management prior to starting recruitment. All interviews will take place on site and according to Trust/service guidelines.

CAPACITY

Capacity will not be assessed prior to recruitment, as the Mental Capacity Act (2005) states individuals should be presumed to have capacity unless indicated otherwise, and detention under the Mental Health Act (1983) is not sufficient to indicate incapacity. Furthermore, if individuals did not have capacity to consent and participate in research, it would be unlikely they would be engaging with schema therapy.

It will therefore be assumed that participants have capacity to consent and participate, unless it becomes apparent during the interview that this is not the case. In such a situation, appropriate action in line with the guidelines of the Mental Capacity Act (2005) would be taken.

CONFIDENTIALITY & ANONYMITY

The field supervisor will be aware of who is participating due to processes around risk assessment and logistics of recruitment in secure settings. Moreover, the field supervisor is, or has been, involved in the care/treatment of potential participants. However, the field supervisor will not have access to interview recordings or transcripts and will only see the data after analysis, so she will be unable to identify individual contributions from specific participants. Use of pseudonyms throughout transcription and analysis will also maintain anonymity.

The academic supervisor will have access to all recordings and transcripts for the purposes of supervision, for example, listening to and providing feedback on interview technique. The academic supervisor is not involved with the care/treatment of potential participants in any way.

Potential participants will be made aware of the above in advance through the information sheets. It will be made explicit that participation will have no impact on care/treatment, and their individual contributions will not be identifiable after analysis has been completed, so the field supervisor will be unable to determine what individual participants have said in their interviews. Any concerns participants may have about this aspect of the study will be discussed during the recruitment approaches and prior to obtaining consent.

A6-3. Proportionate review of REC application *The initial project filter has identified that your study may be suitable for proportionate review by a REC sub-committee. Please consult the current guidance notes from NRES and indicate whether you wish to apply through the proportionate review service or, taking into account your answer to A6-2, you consider there are ethical issues that require consideration at a full REC meeting.*

○ Yes - proportionate review ◉ No - review by full REC meeting

Further comments (optional):

Note: This question only applies to the REC application.

3. PURPOSE AND DESIGN OF THE RESEARCH

A7. Select the appropriate methodology description for this research. *Please tick all that apply:*

- ☐ Case series/ case note review
- ☐ Case control
- ☐ Cohort observation
- ☐ Controlled trial without randomisation
- ☐ Cross-sectional study
- ☐ Database analysis
- ☐ Epidemiology
- ☐ Feasibility/ pilot study
- ☐ Laboratory study
- ☐ Metanalysis
- ☑ Qualitative research
- ☑ Questionnaire, interview or observation study
- ☐ Randomised controlled trial
- ☐ Other (please specify)

A10. What is the principal research question/objective? *Please put this in language comprehensible to a lay person.*

What are the personal narratives of individuals with a history of violent offending, following engagement in schema therapy?

A11. What are the secondary research questions/objectives if applicable? *Please put this in language comprehensible to a lay person.*

Secondary aims include exploring individuals' narratives of engaging in schema therapy and how they feel the schema model may or may not apply to them, whether they have found the model helpful in understanding their previous offending behaviours, and if their therapeutic experiences have impacted on their self-constructs and ways of relating to others.

A12. What is the scientific justification for the research? *Please put this in language comprehensible to a lay person.*

PURPOSE & DESIGN
Positive outcomes are important with forensic populations, and using qualitative methods to exploring their experiences would be valuable in informing future clinical practice and effective risk management. Furthermore, eliciting the personal stories of individuals engaging in therapy provides an opportunity to hear the voices of a population that is often disempowered, and returns the focus of research to those who are most directly involved in and affected by the services provided. This is especially true for individuals in secure settings, as they often experience the greatest power imbalances and the fewest opportunities to express their perspectives. Using qualitative methodologies to explore these perspectives would enable these voices and stories to be heard to a greater degree, and facilitate a richer understanding of their therapeutic experiences.

There is an increased focus on using narrative approaches with forensic client groups in assessment, therapy, and recommendations for future research. Understanding how individuals perceive themselves in relation to others and in the context of their settings is an important part of the engagement, assessment, and formulation process, and can be a factor in improving the effectiveness of assessments and interventions by making them more responsive to individual needs and risks. Using a narrative approach to explore the experiences and stories of offenders who have engaged in schema therapy would provide a timely and much-needed insight into the experiences, effectiveness, and outcome of this therapy from the service user's perspective. Moreover, narrative analysis is a useful approach for research where only a small number of individuals are likely to fit the criteria, as each participant's narrative can be explored in depth.

Individuals who meet the inclusion criteria are a small and hard to reach population, and the scarcity of qualitative research with such individuals means there is a high value to hearing their stories. Furthermore, qualitative research does not require large numbers of participants, as the aim is to elicit rich and detailed individual accounts for the purpose of developing a deeper understanding of a particular phenomenon in a specific group of individuals, rather than producing generalisable findings as in quantitative studies. However, it is hoped that findings will have utility and clinical implications for best practice.

A13. Please summarise your design and methodology. *It should be clear exactly what will happen to the research participant, how many times and in what order. Please complete this section in language comprehensible to the lay person. Do not simply reproduce or refer to the protocol. Further guidance is available in the guidance notes.*

METHOD
A phased recruitment strategy will be used. The first stage of recruitment is aimed to recruit enough participants for the study:

1. Preliminary discussions with the field supervisors will take place to identify potential participants
2. The chief investigator will make an initial visit to the site for the purposes of introductions, outlining study, and distributing information sheets.
3. The chief investigator will make a follow-up visit to the site after one week to answer any questions, ascertain interest and arrange dates/times for interviews.
4. Interviews will be conducted at the site by the chief investigator – dates/times will be arranged in collaboration with participants and ward staff.
5. Interviews will be conducted individually, audio-recorded, and transcribed.

If insufficient numbers of participants come forward, the second stage of the recruitment strategy will be implemented and the options below carried out as required:

1. The recruitment process identified above will be repeated one month later.
2. The inclusion criteria will be modified to include individuals who have engaged in schema therapy on 1:1 and/or group basis for a minimum of six to nine months (instead of twelve months); this will increase the pool of potential participants.
3. Another site may be added to further increase the pool of potential participants and thereby facilitate recruitment; in this case, additional research governance approval will be sought from the Research and Development (R&D) Department at the relevant NHS Trust.

Recruitment approaches can only take place when the chief investigator is on site therefore potential participants will also be offered study information, the opportunity to enquire about the study, and discuss participation when the researcher visits the site to conduct interviews. It is hoped that this approach will potentially maximise recruitment and participation.

In addition to the detailed participant information sheets, potential participants will also be given a summary information sheet providing an overview of the important information. Before starting the interview, the information sheet will be reviewed and a further opportunity will be provided to ask any questions, following which the consent form will be signed.

Participants will have the option of withdrawing consent up to a week after the date of the interview; after this point, transcription will have been completed and analysis may have started making it difficult to identify and remove a specific participant's contributions from the complete dataset.

Up to three interviews may be conducted with each participant, depending on the amount of data obtained and the number of individuals willing to participate, to ensure sufficient depth of analysis. This possibility will be made clear to potential participants in the information sheets and consent forms. If further interviews are required, the researcher will revisit the site, contact participants, and arrange interviews as appropriate. Interviews will take approximately 1-2 hours in total, with each interview lasting approximately 45 minutes-1 hour, and breaks will be offered in line with participants' needs to ensure their comfort.

The recruitment and data collection process will be reviewed in supervision on a monthly basis. Reflections on reflexivity and audit trails to evidence the data collection and analysis will be provided in the final report. Supervision will also be accessed as appropriate to minimise potential researcher bias by discussing and reviewing the analytic process with the academic supervisor.

DESIGN
Narrative analysis will be conducted on transcriptions of interview recordings. For this methodology, interviews would usually be minimally structured in order to elicit participants' self-generated narratives, giving priority to their perspectives and their processes of making sense of their experiences. This would allow a focus on exploring whether individuals' stories reflect an understanding that fits with the schema therapy they have engaged in. The process of telling one's personal story is a reflection of, and provides insight into, the way an individual makes sense of their experiences and behaviours, including offending behaviour. Since schema therapy aims to promote changes in individuals' understanding of themselves, a narrative approach would therefore provide a more appropriate indication of whether participants have internalised new learning from therapy in comparison to approaches such interpretive phenomenological analysis (IPA), which would ask more direct questions relating to therapeutic experiences. Furthermore, unlike other approaches, narrative analysis also allows an individual's story to be considered as a whole, rather than being fragmented into codes across the whole dataset. This allows the researcher to gain a more holistic understanding of an individual and their experiences.

Potential drawbacks of this method include the difficulties in eliciting participants' narratives when the population is difficult to engage or the interview topic is sensitive or distressing; both these issues may be pertinent in this study. A narrative approach does offer a way of approaching the interview from a more person-centred and less 'expert' position; however, it is acknowledged that a balance will need to be achieved between allowing narratives to emerge naturally and eliciting the information required to answer the research question. The interview guide will therefore be semi-structured rather than open-ended, with reflexive conversational prompts to be used as needed to facilitate responses, as well as specific prompt questions to cover areas not addressed spontaneously by participants. The resulting interview will therefore still be flexible and responsive to individual participants' responses and way of telling their story. It is possible participants may be more willing to discuss their therapeutic experiences than aspects of their personal experiences, but it is hoped this interview approach will create space for participants to feel comfortable with sharing both types of narratives.

A14-1. In which aspects of the research process have you actively involved, or will you involve, patients, service users, and/or their carers, or members of the public?

- [x] Design of the research
- [ ] Management of the research
- [ ] Undertaking the research
- [ ] Analysis of results
- [ ] Dissemination of findings
- [ ] None of the above

Give details of involvement, or if none please justify the absence of involvement.
The project proposal was presented at a peer review panel at Lancaster University where service users were present and had the opportunity to comment.

4. RISKS AND ETHICAL ISSUES

RESEARCH PARTICIPANTS

A17-1. Please list the principal inclusion criteria (list the most important, max 5000 characters).

•Previously convicted of violent offence(s)
•Has engaged in schema therapy on 1:1 and/or group basis for a minimum of 12 months

A17-2. Please list the principal exclusion criteria (list the most important, max 5000 characters).

•Recent serious incident (depending on type of incident and length of time prior to interview – risk assessment conducted by clinical staff on site)
•Participants will not be excluded based on when they completed therapy (e.g. some participants may have completed therapy and been discharged into the community by the time of recruitment)
•Participants will not be excluded based on whether they are accessing / have accessed schema therapy on an inpatient / outpatient basis

RESEARCH PROCEDURES, RISKS AND BENEFITS

A18. Give details of all non-clinical intervention(s) or procedure(s) that will be received by participants as part of the research protocol. *These include seeking consent, interviews, non-clinical observations and use of questionnaires.*

Please complete the columns for each intervention/procedure as follows:

1. Total number of interventions/procedures to be received by each participant as part of the research protocol.
2. If this intervention/procedure would be routinely given to participants as part of their care outside the research, how many of the total would be routine?
3. Average time taken per intervention/procedure (minutes, hours or days)
4. Details of who will conduct the intervention/procedure, and where it will take place.

Intervention or procedure	1	2	3	4
Initial recruitment approach to introduce the study, distribute information sheets, and answer questions	1	n/a	15-30	Chief investigator will visit the site for this purpose
Ascertaining interest, answering any further questions, arranging interviews	1	n/a	15-30	Chief investigator will revisit the site for this purpose
Interview	1-3	n/a	45-120	Chief investigator will return to the site to conduct the interviews at a time/date convenient to the participants - if more than one interview is arranged with an individual, these will not take place on the same day

A21. How long do you expect each participant to be in the study in total?

Recruitment is planned from October-December 2013, but each participant will only be required to engage for a maximum of approximately two hours during their interview(s).

A22. What are the potential risks and burdens for research participants and how will you minimise them?

For all studies, describe any potential adverse effects, pain, discomfort, distress, intrusion, inconvenience or changes to lifestyle. Only describe risks or burdens that could occur as a result of participation in the research. Say what steps would be taken to minimise risks and burdens as far as possible.

It is possible that interviews will involve discussion of experiences participants could potentially find distressing. If this occurs, participants would be advised to speak to the field supervisor and other appropriate staff such as their primary nurse (or other nursing staff) as required following the interview. The researcher may also offer to pause or terminate the interview if a participant becomes distressed, and all participants will be offered the opportunity of debriefing. Potential participants will be made aware of this in advance through the information sheets. The chief investigator is a trainee clinical psychologist and therefore has skills and training enabling her to conduct the interviews in a sensitive and appropriate manner. Breaks will also be offered during interviews in line with participants' needs to ensure their comfort.

If participants have any concerns about the study or wish to raise any issues, they will be advised to contact the Patient Advice and Liaison Service (PALS) through ward staff, who would then be able to assist them with any concerns or direct them to advocacy or complaints services as appropriate. The researcher has contacted [redacted] PALS to inform them of the study and make them aware of this possibility, and copies of the participant information sheets and consent form have been sent to them.

A23. Will interviews/ questionnaires or group discussions include topics that might be sensitive, embarrassing or upsetting, or is it possible that criminal or other disclosures requiring action could occur during the study?

(●) Yes ( ) No

If Yes, please give details of procedures in place to deal with these issues:

All interviews will remain confidential unless any concern of risk to the participants themselves or to others is highlighted. If this should occur, it will be discussed with supervisors who would take appropriate action to manage the risk. This may include notifying other professionals at the sites.

If participants have any concerns about the study or wish to raise any issues, they will be advised to contact the Patient Advice and Liaison Service (PALS) through ward staff, who would then be able to assist them with any concerns or direct them to advocacy or complaints services as appropriate. The chief investigator has contacted [redacted] PALS to inform them of the study and make them aware of this possibility, and copies of the participant information sheets and consent form have been sent to them.

It is possible that participation in this study could elicit negative emotions, as the interviews will involve discussion of experiences participants could potentially find distressing. If this occurs, participants would be advised to speak to the field supervisor and other appropriate staff such as their primary nurse (or other nursing staff) as required following the interview. The researcher may also offer to pause or terminate the interview if a participant becomes distressed, and all participants will be offered the opportunity of debriefing to minimise any lasting impact. Potential participants will be made aware of this in advance through the information sheets. The chief investigator is a trainee clinical psychologist and therefore has skills and training enabling her to conduct the interviews in a sensitive and appropriate manner.

A24. What is the potential for benefit to research participants?

Individuals may find participation interesting but there are no direct benefits in taking part.

A26. What are the potential risks for the researchers themselves? *(if any)*

There can be an emotional impact on the researcher depending on the content and interactional processes of the interviews. If this should occur, supervision and support will be accessed as required.

The chief investigator will conduct all interviews in line with Trust/service policies relating to risk management at each

site. The chief investigator will have already completed breakaway training through the DClinPsy course. All interviews will take place on site and according to any Trust/service guidelines governing such processes.

RECRUITMENT AND INFORMED CONSENT

In this section we ask you to describe the recruitment procedures for the study. Please give separate details for different study groups where appropriate.

A27-1. How will potential participants, records or samples be identified? Who will carry this out and what resources will be used? *For example, identification may involve a disease register, computerised search of GP records, or review of medical records. Indicate whether this will be done by the direct healthcare team or by researchers acting under arrangements with the responsible care organisation(s).*

Preliminary discussions with the field supervisor will identify potential participants. The field supervisor has been or is currently involved in the care and treatment of potential participants and is therefore part of their clinical teams.

However, the field supervisor will not be directly involved in recruitment approaches to potential participants, thereby allowing individuals to make decisions on whether or not to participate without undue influence. The chief investigator will visit each site to introduce herself and provide information about the study to potential participants identified by the field supervisor.

A27-2. Will the identification of potential participants involve reviewing or screening the identifiable personal information of patients, service users or any other person?

○ Yes ◉ No

Please give details below:

A28. Will any participants be recruited by publicity through posters, leaflets, adverts or websites?

○ Yes ◉ No

A29. How and by whom will potential participants first be approached?

The field supervisor will initially identify potential participants who meet the inclusion criteria. The chief investigator will then conduct initial visit to each site for the purposes of introductions, outlining study, and distributing information sheets. This will be followed by a follow-up visit to each site after one week to answer any questions, ascertain interest and arrange dates/times for interviews.

Field supervisors are involved in individuals' care/treatment and will not be directly involved in recruitment approaches to potential participants, thereby allowing individuals to make decisions on whether or not to participate without undue influence.

A30-1. Will you obtain informed consent from or on behalf of research participants?

◉ Yes ○ No

If you will be obtaining consent from adult participants, please give details of who will take consent and how it will be done, with details of any steps to provide information (a written information sheet, videos, or interactive material). Arrangements for adults unable to consent for themselves should be described separately in Part B Section 6, and for children in Part B Section 7.

If you plan to seek informed consent from vulnerable groups, say how you will ensure that consent is voluntary and fully informed.

In addition to the detailed participant information sheets, potential participants will also be given a summary information sheet providing an overview of pertinent information. At the point of interview, the information sheet will be reviewed and a further opportunity will be provided to ask any questions, following which the consent form will be signed.

Participants will have the option of withdrawing consent up to a week after the date of the interview; after this point,

transcription will have been completed and analysis may have started making it difficult to identify and remove a specific participant's contributions from the complete dataset.

If you are not obtaining consent, please explain why not.

Please enclose a copy of the information sheet(s) and consent form(s).

A30-2. Will you record informed consent (or advice from consultees) in writing?

◉ Yes ○ No

A31. How long will you allow potential participants to decide whether or not to take part?

There will be an initial visit to the site for the purposes of introductions, outlining study, and distributing information sheets. The chief investigator will then conduct a follow-up visit to the site after one week to answer any questions, ascertain interest and arrange dates/times for interviews.

Recruitment approaches can only take place when the chief investigator is on site therefore potential participants will also be offered study information, the opportunity to enquire about the study, and discuss participation on the occasions when the chief investigator visits the site to conduct interviews. This approach will potentially maximise recruitment and participation, and is more flexible in allowing potential participants time to make/communicate decisions on participation.

A33-1. What arrangements have been made for persons who might not adequately understand verbal explanations or written information given in English, or who have special communication needs? *(e.g. translation, use of interpreters)*

In addition to the detailed participant information sheets, potential participants will also be given a summary information sheet providing an overview of pertinent information. At the point of interview, the information sheet will be reviewed and a further opportunity will be provided to ask any questions.

Due to lack of funding, it is not possible to provide a translation or interpretation service for individuals who might not understand English or require additional aids to communication. Consequently, they would not be included in the study. However, it is likely that all individuals who meet the inclusion criteria of having engaged in schema therapy for twelve months will be able to understand the information provided, therefore it is not expected that any potential participants would be excluded on this basis.

A35. What steps would you take if a participant, who has given informed consent, loses capacity to consent during the study? *Tick one option only.*

◉ The participant and all identifiable data or tissue collected would be withdrawn from the study. Data or tissue which is not identifiable to the research team may be retained.

○ The participant would be withdrawn from the study. Identifiable data or tissue already collected with consent would be retained and used in the study. No further data or tissue would be collected or any other research procedures carried out on or in relation to the participant.

○ The participant would continue to be included in the study.

○ Not applicable – informed consent will not be sought from any participants in this research.

○ Not applicable – it is not practicable for the research team to monitor capacity and continued capacity will be assumed.

Further details:

It will be assumed that participants have capacity to consent and participate, unless it becomes apparent during the interview that this is not the case. In such a situation, the chief investigator will take appropriate action in line with the guidelines of the Mental Capacity Act (2005).

CONFIDENTIALITY

In this section, personal data means any data relating to a participant who could potentially be identified. It includes pseudonymised data capable of being linked to a participant through a unique code number.

Storage and use of personal data during the study

A36. Will you be undertaking any of the following activities at any stage (including in the identification of potential participants)? *(Tick as appropriate)*

- ☐ Access to medical records by those outside the direct healthcare team
- ☑ Electronic transfer by magnetic or optical media, email or computer networks
- ☐ Sharing of personal data with other organisations
- ☐ Export of personal data outside the EEA
- ☐ Use of personal addresses, postcodes, faxes, emails or telephone numbers
- ☑ Publication of direct quotations from respondents
- ☐ Publication of data that might allow identification of individuals
- ☑ Use of audio/visual recording devices
- ☑ Storage of personal data on any of the following:
  - ☑ Manual files including X-rays
  - ☐ NHS computers
  - ☑ Home or other personal computers
  - ☑ University computers
  - ☐ Private company computers
  - ☑ Laptop computers

Further details:
Interview recordings will be encrypted and stored securely on a password-protected and encrypted computer / laptop, and will then be transcribed verbatim by the chief investigator, and anonymised by assigning pseudonyms to names and places. Only the chief investigator and academic supervisor will have access to audio recordings and transcriptions.

A38. How will you ensure the confidentiality of personal data? *Please provide a general statement of the policy and procedures for ensuring confidentiality, e.g. anonymisation or pseudonymisation of data.*

Transcripts of the interviews will be fully anonymised and pseudonyms will be assigned to each of the participants. Only the chief investigator will be aware of which participant each pseudonym corresponds to.

The audio recorder cannot be encrypted but interview recordings will be transferred to a secure medium such as a password-protected and encrypted computer / laptop within two hours of completing each interview; until this point, the recorder will be stored securely. Interview recordings will be deleted from the audio recorder once transfer to a secure medium takes place. Audio files will be securely deleted from the computer / laptop once analysis is completed.

All electronic data and hard copies will be encrypted and kept securely on a university server and a locked filing cabinet at Lancaster University for a period of five years following completion of the study and any associated publications, after which they will be destroyed. If publication is achieved, data will be retained for a further five years post-publication.

A40. Who will have access to participants' personal data during the study? *Where access is by individuals outside the direct care team, please justify and say whether consent will be sought.*

The field supervisor will be aware of who is participating due to processes around risk assessment and logistics of recruitment in secure settings. Moreover, the field supervisor is, or has been, involved in the care/treatment of potential participants. However, the field supervisor will not have access to interview recordings or transcripts and will only see the data after analysis, so she will be unable to identify individual contributions from specific participants. Use of pseudonyms throughout transcription and analysis will serve to further maintain anonymity.

The academic supervisor will have access to all recordings and transcripts for the purposes of supervision, for example, listening to and providing feedback on interview technique. The academic supervisor is not involved with the care/treatment of potential participants in any way.

Potential participants will be made aware of the above in advance through the information sheets. It will be made explicit that participation will have no impact on care/treatment, and their individual contributions will not be identifiable after analysis has been completed, so the field supervisor will be unable to ascertain what individual participants have said in their interviews. Any concerns participants may have about this aspect of the study will be discussed during the recruitment approaches and prior to obtaining consent.

Storage and use of data after the end of the study

A43. How long will personal data be stored or accessed after the study has ended?

- (●) Less than 3 months
- ( ) 3 – 6 months
- ( ) 6 – 12 months
- ( ) 12 months – 3 years
- ( ) Over 3 years

INCENTIVES AND PAYMENTS

A46. Will research participants receive any payments, reimbursement of expenses or any other benefits or incentives for taking part in this research?

( ) Yes (●) No

A47. Will individual researchers receive any personal payment over and above normal salary, or any other benefits or incentives, for taking part in this research?

( ) Yes (●) No

A48. Does the Chief Investigator or any other investigator/collaborator have any direct personal involvement (e.g. financial, share holding, personal relationship etc.) in the organisations sponsoring or funding the research that may give rise to a possible conflict of interest?

( ) Yes (●) No

NOTIFICATION OF OTHER PROFESSIONALS

A49-1. Will you inform the participants' General Practitioners (and/or any other health or care professional responsible for their care) that they are taking part in the study?

( ) Yes (●) No

If Yes, please enclose a copy of the information sheet/letter for the GP/health professional with a version number and date.

PUBLICATION AND DISSEMINATION

A50. Will the research be registered on a public database?

◉ Yes ○ No

Please give details, or justify if not registering the research.
Upon completion, the research will be submitted for publication to an appropriate peer-reiewed journal. If accepted, the abstract will be publicly available from the journal's website.

Registration of research studies is encouraged wherever possible.
You may be able to register your study through your NHS organisation or a register run by a medical research charity, or publish your protocol through an open access publisher. If you are aware of a suitable register or other method of publication, please give details. If not, you may indicate that no suitable register exists. Please ensure that you have entered registry reference number(s) in question A5-1.

A51. How do you intend to report and disseminate the results of the study? *Tick as appropriate:*

- ☑ Peer reviewed scientific journals
- ☑ Internal report
- ☐ Conference presentation
- ☐ Publication on website
- ☐ Other publication
- ☐ Submission to regulatory authorities
- ☐ Access to raw data and right to publish freely by all investigators in study or by Independent Steering Committee on behalf of all investigators
- ☐ No plans to report or disseminate the results
- ☑ Other (please specify)

The research will be submitted as a thesis as partial requirement for the Doctorate in Clinical Psychology at Lancaster University.

A53. Will you inform participants of the results?

◉ Yes ○ No

Please give details of how you will inform participants or justify if not doing so.
Participants will be offered the opportunity to obtain feedback on the findings once the study has been completed if they indicate an interest in the outcomes when asked at interview.

5. Scientific and Statistical Review

A54. How has the scientific quality of the research been assessed? *Tick as appropriate:*

- ☐ Independent external review
- ☐ Review within a company
- ☐ Review within a multi−centre research group
- ☑ Review within the Chief Investigator's institution or host organisation
- ☑ Review within the research team
- ☑ Review by educational supervisor
- ☐ Other

Justify and describe the review process and outcome. If the review has been undertaken but not seen by the researcher, give details of the body which has undertaken the review:
The proposal was initially discussed and reviewed by the academic supervisor and the field supervisor. It was then presented for peer review at Lancaster University to a panel including trainee clinical psychologists, service users, and two research tutors who are not part of the study. The proposal was modified on the basis of feedback and has since been reviewed again by the academic supervisor and the field supervisor.

For all studies except non-doctoral student research, please enclose a copy of any available scientific critique reports, together with any related correspondence.

For non-doctoral student research, please enclose a copy of the assessment from your educational supervisor/ institution.

A59. What is the sample size for the research? *How many participants/samples/data records do you plan to study in total? If there is more than one group, please give further details below.*

Total UK sample size: 10
Total international sample size (including UK): 10
Total in European Economic Area: 0

Further details:
The total number of participants for the study will be 5-10.

A60. How was the sample size decided upon? *If a formal sample size calculation was used, indicate how this was done, giving sufficient information to justify and reproduce the calculation.*

Qualitative research typically involves small sample sizes. The sample for this study was decided on after discussions with supervisors. Individuals who meet the inclusion criteria comprise a small and hard to reach population, and the scarcity of qualitative research with such individuals means there is a high value to hearing their stories. Furthermore, qualitative research does not require large numbers of participants, as the aim is to elicit rich and detailed individual accounts for the purpose of developing a deeper understanding of a particular phenomenon in a specific cohort of individuals, rather than producing generalisable findings as in quantitative methodologies.

A62. Please describe the methods of analysis (statistical or other appropriate methods, e.g. for qualitative research) by which the data will be evaluated to meet the study objectives.

The methodology used will be narrative analysis whereby transcripts of audio recordings will be analysed with a view to identifying the boundaries of narrative segments; content and underlying themes of these segments will be noted, followed by the identification of thematic and linguistic connections. Analysis will be completed by manual coding.

Reflections on reflexivity and audit trails to evidence the data collection and analysis will be provided in the final report. Supervision will also be accessed as appropriate to minimise potential researcher bias by discussing and reviewing the analytic process with the academic supervisor.

6. MANAGEMENT OF THE RESEARCH

A63. Other key investigators/collaborators. *Please include all grant co-applicants, protocol co-authors and other key members of the Chief Investigator's team, including non-doctoral student researchers.*

	Title Forename/Initials Surname
	Dr [redacted] [redacted]
Post	Highly Specialist Clinical Psychologist
Qualifications	
Employer	[redacted] NHS Trust
Work Address	[redacted]
	[redacted]
	[redacted]
Post Code	[redacted]
Telephone	[redacted]
Fax	
Mobile	
Work Email	[redacted]@[redacted]nhs.uk

A64. Details of research sponsor(s)

A64-1. Sponsor

Lead Sponsor

Status:
- ○ NHS or HSC care organisation
- ◉ Academic
- ○ Pharmaceutical industry
- ○ Medical device industry
- ○ Local Authority
- ○ Other social care provider (including voluntary sector or private organisation)
- ○ Other

Commercial status:

If Other, please specify:

Contact person

Name of organisation	Lancaster University
Given name	[redacted]
Family name	[redacted]
Address	B Floor, Bowland Main, Lancaster University
Town/city	Lancaster
Post code	LA1 4YW
Country	UNITED KINGDOM
Telephone	[redacted]
Fax	[redacted]
E-mail	ethics@lancaster.ac.uk

Is the sponsor based outside the UK?

○ Yes ◉ No

Under the Research Governance Framework for Health and Social Care, a sponsor outside the UK must appoint a legal representative established in the UK. Please consult the guidance notes.

A65. Has external funding for the research been secured?

- ☐ Funding secured from one or more funders
- ☐ External funding application to one or more funders in progress
- ☑ No application for external funding will be made

What type of research project is this?

- ○ Standalone project
- ○ Project that is part of a programme grant
- ○ Project that is part of a Centre grant
- ○ Project that is part of a fellowship/ personal award/ research training award
- ◉ Other

Other – please state:
Part of Doctorate in Clinical Psychology

A67. Has this or a similar application been previously rejected by a Research Ethics Committee in the UK or another country?

○ Yes ◉ No

Please provide a copy of the unfavourable opinion letter(s). You should explain in your answer to question A6-2 how the reasons for the unfavourable opinion have been addressed in this application.

A68-1. Give details of the lead NHS R&D contact for this research:

	Title Forename/Initials Surname
	Mrs [redacted] [redacted]
Organisation	[redacted] NHS Trust Research & Development Department
Address	Hostel 1
	Parkbourn
	Maghull
Post Code	L31 1HW
Work Email	[redacted]@[redacted]nhs.uk
Telephone	[redacted]
Fax	
Mobile	

Details can be obtained from the NHS R&D Forum website: http://www.rdforum.nhs.uk

A69-1. How long do you expect the study to last in the UK?

Planned start date: 01/09/2013
Planned end date: 31/05/2014
Total duration:
Years: 0 Months: 8 Days: 31

A71-2. Where will the research take place? *(Tick as appropriate)*

- ☑ England
- ☐ Scotland
- ☐ Wales
- ☐ Northern Ireland
- ☐ Other countries in European Economic Area

Total UK sites in study 1

Does this trial involve countries outside the EU?
○ Yes ◉ No

A72. What host organisations (NHS or other) in the UK will be responsible for the research sites? *Please indicate the type of organisation by ticking the box and give approximate numbers of planned research sites:*

☑ NHS organisations in England	1
☐ NHS organisations in Wales	
☐ NHS organisations in Scotland	
☐ HSC organisations in Northern Ireland	
☐ GP practices in England	
☐ GP practices in Wales	
☐ GP practices in Scotland	
☐ GP practices in Northern Ireland	
☐ Social care organisations	
☐ Phase 1 trial units	
☐ Prison establishments	
☐ Probation areas	
☐ Independent hospitals	
☐ Educational establishments	
☐ Independent research units	
☐ Other (give details)	
Total UK sites in study:	1

A76. Insurance/ indemnity to meet potential legal liabilities

Note: in this question to NHS indemnity schemes include equivalent schemes provided by Health and Social Care (HSC) in Northern Ireland

A76-1. What arrangements will be made for insurance and/or indemnity to meet the potential legal liability of the sponsor(s) for harm to participants arising from the management of the research? *Please tick box(es) as applicable.*

Note: Where a NHS organisation has agreed to act as sponsor or co-sponsor, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For all other sponsors, please describe the arrangements and provide evidence.

☐ NHS indemnity scheme will apply (NHS sponsors only)

☑ Other insurance or indemnity arrangements will apply (give details below)

Lancaster University legal liability cover will apply.

Please enclose a copy of relevant documents.

A76-2. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of the sponsor(s) or employer(s) for harm to participants arising from the design of the research? *Please tick box(es) as applicable.*

Note: Where researchers with substantive NHS employment contracts have designed the research, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For other protocol authors (e.g. company employees, university members), please describe the arrangements and provide evidence.

☐ NHS indemnity scheme will apply (protocol authors with NHS contracts only)

☑ Other insurance or indemnity arrangements will apply (give details below)

Lancaster University legal liability cover will apply.

Please enclose a copy of relevant documents.

A76-3. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of investigators/collaborators arising from harm to participants in the conduct of the research?

Note: Where the participants are NHS patients, indemnity is provided through the NHS schemes or through professional indemnity. Indicate if this applies to the whole study (there is no need to provide documentary evidence). Where non-NHS sites are to be included in the research, including private practices, please describe the arrangements which will be made at these sites and provide evidence.

☑ NHS indemnity scheme or professional indemnity will apply (participants recruited at NHS sites only)

☐ Research includes non-NHS sites (give details of insurance/ indemnity arrangements for these sites below)

Please enclose a copy of relevant documents.

A76-1. What arrangements will be made for insurance and/or indemnity to meet the potential legal liability of the sponsor(s) for harm to participants arising from the management of the research? *Please tick box(es) as applicable.*

Note: Where a NHS organisation has agreed to act as sponsor or co-sponsor, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For all other sponsors, please describe the arrangements and provide evidence.

☐ NHS indemnity scheme will apply (NHS sponsors only)

☑ Other insurance or indemnity arrangements will apply (give details below)

Lancaster University legal liability cover will apply.

Please enclose a copy of relevant documents.

A76-2. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of the sponsor(s) or employer(s) for harm to participants arising from the design of the research? *Please tick box(es) as applicable.*

Note: Where researchers with substantive NHS employment contracts have designed the research, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For other protocol authors (e.g. company employees, university members), please describe the arrangements and provide evidence.

☐ NHS indemnity scheme will apply (protocol authors with NHS contracts only)

☑ Other insurance or indemnity arrangements will apply (give details below)

Lancaster University legal liability cover will apply.

Please enclose a copy of relevant documents.

A76-3. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of investigators/collaborators arising from harm to participants in the conduct of the research?

Note: Where the participants are NHS patients, indemnity is provided through the NHS schemes or through professional indemnity. Indicate if this applies to the whole study (there is no need to provide documentary evidence). Where non-NHS sites are to be included in the research, including private practices, please describe the arrangements which will be made at these sites and provide evidence.

☑ NHS indemnity scheme or professional indemnity will apply (participants recruited at NHS sites only)

☐ Research includes non-NHS sites (give details of insurance/ indemnity arrangements for these sites below)

Please enclose a copy of relevant documents.

PART C: Overview of research sites

Please enter details of the host organisations (Local Authority, NHS or other) in the UK that will be responsible for the research sites. *For NHS sites, the host organisation is the Trust or Health Board. Where the research site is a primary care site, e.g. GP practice, please insert the host organisation (PCT or Health Board) in the Institution row and insert the research site (e.g. GP practice) in the Department row.*

Research site		Investigator/ Collaborator/ Contact	
Institution name	[redacted] NHS Trust	Title	Dr
Department name	[redacted]	First name/ Initials	[redacted]
Street address	[redacted]	Surname	[redacted]
Town/city	[redacted]		
Post Code	[redacted]		

PART D: Declarations

D1. Declaration by Chief Investigator

1. The information in this form is accurate to the best of my knowledge and belief and I take full responsibility for it.

2. I undertake to abide by the ethical principles underlying the Declaration of Helsinki and good practice guidelines on the proper conduct of research.

3. If the research is approved I undertake to adhere to the study protocol, the terms of the full application as approved and any conditions set out by review bodies in giving approval.

4. I undertake to notify review bodies of substantial amendments to the protocol or the terms of the approved application, and to seek a favourable opinion from the main REC before implementing the amendment.

5. I undertake to submit annual progress reports setting out the progress of the research, as required by review bodies.

6. I am aware of my responsibility to be up to date and comply with the requirements of the law and relevant guidelines relating to security and confidentiality of patient or other personal data, including the need to register when necessary with the appropriate Data Protection Officer. I understand that I am not permitted to disclose identifiable data to third parties unless the disclosure has the consent of the data subject or, in the case of patient data in England and Wales, the disclosure is covered by the terms of an approval under Section 251 of the NHS Act 2006.

7. I understand that research records/data may be subject to inspection by review bodies for audit purposes if required.

8. I understand that any personal data in this application will be held by review bodies and their operational managers and that this will be managed according to the principles established in the Data Protection Act 1998.

9. I understand that the information contained in this application, any supporting documentation and all correspondence with review bodies or their operational managers relating to the application:

   - Will be held by the REC (where applicable) until at least 3 years after the end of the study; and by NHS R&D offices (where the research requires NHS management permission) in accordance with the NHS Code of Practice on Records Management.
   - May be disclosed to the operational managers of review bodies, or the appointing authority for the REC (where applicable), in order to check that the application has been processed correctly or to investigate any complaint.
   - May be seen by auditors appointed to undertake accreditation of RECs (where applicable).
   - Will be subject to the provisions of the Freedom of Information Acts and may be disclosed in response to requests made under the Acts except where statutory exemptions apply.
   - May be sent by email to REC members.

10. I understand that information relating to this research, including the contact details on this application, may be held on national research information systems, and that this will be managed according to the principles established in the Data Protection Act 1998.

11. Where the research is reviewed by a REC within the UK Health Departments Research Ethics Service, I understand that the summary of this study will be published on the website of the National Research Ethics Service (NRES), together with the contact point for enquiries named below. Publication will take place no earlier than 3 months after issue of the ethics committee's final opinion or the withdrawal of the application.

Contact point for publication *(Not applicable for R&D Forms)*

NRES would like to include a contact point with the published summary of the study for those wishing to seek further information. We would be grateful if you would indicate one of the contact points below.

(●) Chief Investigator
( ) Sponsor

- ◯ Study co-ordinator
- ◯ Student
- ◯ Other – please give details
- ◯ None

Access to application for training purposes *(Not applicable for R&D Forms)*

Optional – please tick as appropriate:

☐ I would be content for members of other RECs to have access to the information in the application in confidence for training purposes. All personal identifiers and references to sponsors, funders and research units would be removed.

Signature: [redacted]

Print Name: [redacted]

Date: 11/07/2013 *(dd/mm/yyyy)*

D2. Declaration by the sponsor's representative

If there is more than one sponsor, this declaration should be signed on behalf of the co-sponsors by a representative of the lead sponsor named at A64-1.

I confirm that:

1. This research proposal has been discussed with the Chief Investigator and agreement in principle to sponsor the research is in place.
2. An appropriate process of scientific critique has demonstrated that this research proposal is worthwhile and of high scientific quality.
3. Any necessary indemnity or insurance arrangements, as described in question A76, will be in place before this research starts. Insurance or indemnity policies will be renewed for the duration of the study where necessary.
4. Arrangements will be in place before the study starts for the research team to access resources and support to deliver the research as proposed.
5. Arrangements to allocate responsibilities for the management, monitoring and reporting of the research will be in place before the research starts.
6. The duties of sponsors set out in the Research Governance Framework for Health and Social Care will be undertaken in relation to this research.
7. Where the research is reviewed by a REC within the UK Health Departments Research Ethics Service, I understand that the summary of this study will be published on the website of the National Research Ethics Service (NRES), together with the contact point for enquiries named in this application. Publication will take place no earlier than 3 months after issue of the ethics committee's final opinion or the withdrawal of the application.

Signature: ...[redacted].....

Print Name:

Post:

Organisation: Lancaster University

Date: 11/07/2013 *(dd/mm/yyyy)*

D3. Declaration for student projects by academic supervisor(s)

1. I have read and approved both the research proposal and this application. I am satisfied that the scientific content of the research is satisfactory for an educational qualification at this level.

2. I undertake to fulfil the responsibilities of the supervisor for this study as set out in the Research Governance Framework for Health and Social Care.

3. I take responsibility for ensuring that this study is conducted in accordance with the ethical principles underlying the Declaration of Helsinki and good practice guidelines on the proper conduct of research, in conjunction with clinical supervisors as appropriate.

4. I take responsibility for ensuring that the applicant is up to date and complies with the requirements of the law and relevant guidelines relating to security and confidentiality of patient and other personal data, in conjunction with clinical supervisors as appropriate.

Academic supervisor 1

Signature:	[redacted]
Print Name:	[redacted]
Post:	Lecturer in Health Research & Clinical Tutor
Organisation:	Lancaster University
Date:	11/07/2013 *(dd/mm/yyyy)*

Site Specific Information (SSI) Form (Medium Secure Site)

NHS SSI IRAS Version 3.5

Welcome to the Integrated Research Application System

IRAS Project Filter

The integrated dataset required for your project will be created from the answers you give to the following questions. The system will generate only those questions and sections which (a) apply to your study type and (b) are required by the bodies reviewing your study. Please ensure you answer all the questions before proceeding with your applications.

Please enter a short title for this project (maximum 70 characters)
Impact of schema therapy on narratives in secure settings

1. Is your project research?

◉ Yes ○ No

2. Select one category from the list below:

○ Clinical trial of an investigational medicinal product
○ Clinical investigation or other study of a medical device
○ Combined trial of an investigational medicinal product and an investigational medical device
○ Other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice
○ Basic science study involving procedures with human participants
○ Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology
◉ Study involving qualitative methods only
○ Study limited to working with human tissue samples (or other human biological samples) and data (specific project only)
○ Study limited to working with data (specific project only)
○ Research tissue bank
○ Research database

If your work does not fit any of these categories, select the option below:

○ Other study

2a. Please answer the following question(s):

a) Does the study involve the use of any ionising radiation?	○ Yes	◉ No
b) Will you be taking new human tissue samples (or other human biological samples)?	○ Yes	◉ No
c) Will you be using existing human tissue samples (or other human biological samples)?	○ Yes	◉ No

3. In which countries of the UK will the research sites be located? *(Tick all that apply)*

☑ England
☐ Scotland
☐ Wales
☐ Northern Ireland

3a. In which country of the UK will the lead NHS R&D office be located:

- (●) England
- ( ) Scotland
- ( ) Wales
- ( ) Northern Ireland
- ( ) This study does not involve the NHS

4. Which review bodies are you applying to?

- [x] NHS/HSC Research and Development offices
- [ ] Social Care Research Ethics Committee
- [x] Research Ethics Committee
- [ ] National Information Governance Board for Health and Social Care (NIGB)
- [ ] National Offender Management Service (NOMS) (Prisons & Probation)

For NHS/HSC R&D offices, the CI must create Site-Specific Information Forms for each site, in addition to the study-wide forms, and transfer them to the PIs or local collaborators.

5. Will any research sites in this study be NHS organisations?

(●) Yes ( ) No

5a. Are all the research costs and infrastructure costs for this study provided by an NIHR Biomedical Research Centre, NIHR Biomedical Research Unit, NIHR Collaboration for Leadership in Health Research and Care (CLAHRC) or NIHR Research Centre for Patient Safety & Service Quality in all study sites?

( ) Yes (●) No

If yes, NHS permission for your study will be processed through the NIHR Coordinated System for gaining NHS Permission (NIHR CSP).

5b. Do you wish to make an application for the study to be considered for NIHR Clinical Research Network (CRN) support and inclusion in the NIHR Clinical Research Network (CRN) Portfolio? Please see information button for further details.

( ) Yes (●) No

If yes, NHS permission for your study will be processed through the NIHR Coordinated System for gaining NHS Permission (NIHR CSP) and you must complete a NIHR Clinical Research Network (CRN) Portfolio Application Form immediately after completing this project filter and before completing and submitting other applications.

6. Do you plan to include any participants who are children?

( ) Yes (●) No

7. Do you plan at any stage of the project to undertake intrusive research involving adults lacking capacity to consent for themselves?

( ) Yes (●) No

Answer Yes if you plan to recruit living participants aged 16 or over who lack capacity, or to retain them in the study following loss of capacity. Intrusive research means any research with the living requiring consent in law. This includes use of identifiable tissue samples or personal information, except where application is being made to the NIGB Ethics and Confidentiality Committee to set aside the common law duty of confidentiality in England and Wales. Please consult the guidance notes for further information on the legal frameworks for research involving adults lacking capacity in the UK.

8. Do you plan to include any participants who are prisoners or young offenders in the custody of HM Prison Service or who are offenders supervised by the probation service in England or Wales?

○ Yes ◉ No

9. Is the study or any part of it being undertaken as an educational project?

◉ Yes ○ No

Please describe briefly the involvement of the student(s):
The student is completing the study as part of a Doctorate in Clinical Psychology, and will be the chief investigator.

9a. Is the project being undertaken in part fulfilment of a PhD or other doctorate?

◉ Yes ○ No

10. Will this research be financially supported by the United States Department of Health and Human Services or any of its divisions, agencies or programs?

○ Yes ◉ No

11. Will identifiable patient data be accessed outside the care team without prior consent at any stage of the project (including identification of potential participants)?

○ Yes ◉ No

[redacted]

Site-Specific Information Form (NHS sites)

Is the site hosting this research a NHS site or a non-NHS site? *NHS sites include Health and Social Care organisations in Northern Ireland. The sites hosting the research are the sites in which or through which research procedures are conducted. For NHS sites, this includes sites where NHS staff are participants.*

- (•) NHS site
- ( ) Non-NHS site

This question must be completed before proceeding. The filter will customise the form, disabling questions which are not relevant to this application.

One Site-Specific Information Form should be completed for each research site and submitted to the relevant R&D office with the documents in the checklist. See guidance notes.

The data in this box is populated from Part A:

Title of research:
The impact of schema therapy on narratives of individuals in secure settings

Short title: Impact of schema therapy on narratives in secure settings

Chief Investigator:

Title	Forename/Initials	Surname
Mrs	[redacted]	[redacted]

Name of NHS Research Ethics Committee to which application for ethical review is being made:

Project reference number from above REC:

1-1. Give the name of the NHS organisation responsible for this research site

[redacted] NHS Trust

1-3. In which country is the research site located?

- (•) England
- ( ) Wales
- ( ) Scotland
- ( ) Northern Ireland

1-4. Is the research site a GP practice or other Primary Care Organisation?

( ) Yes (•) No

2. Who is the Principal Investigator or Local Collaborator for this research at this site?

Select the appropriate title: ○ Principal Investigator ◉ Local Collaborator

	Title	Forename/Initials	Surname
	Dr	[redacted]	[redacted]

Post	Highly Specialist Clinical Psychologist
Qualifications	DClinPsy
Organisation	[redacted] NHS Trust
Work Address	[redacted]
PostCode	[redacted]
Work E-mail	[redacted]@[redacted]nhs.uk
Work Telephone	[redacted]
Mobile	
Fax	

a) Approximately how much time will this person allocate to conducting this research? *Please provide your response in terms of Whole Time Equivalents (WTE).*
0.1

b) Does this person hold a current substantive employment contract, Honorary Clinical Contract or Honorary Research Contract with the NHS organisation or accepted by the NHS organisation? ◉ Yes ○ No

A copy of a current CV for the Principal Investigator (maximum 2 pages of A4) must be submitted with this form.

3. Please give details of all locations, departments, groups or units at which or through which research procedures will be conducted at this site and describe the activity that will take place.

Please list all locations/departments etc where research procedures will be conducted within the NHS organisation, describing the involvement in a few words. Where access to specific facilities will be required these should also be listed for each location.

Name the main location/department first. Give details of any research procedures to be carried out off site, for example in participants' homes.

	Location	Activity/facilities
1	[redacted]	Activities: recruitment, interviews Facilities: room for conducting interviews

5. Please give details of all other members of the research team at this site.

6. Does the Principal Investigator or any other member of the site research team have any direct personal involvement (e.g. financial, share-holding, personal relationship etc) in the organisation sponsoring or funding the research that may give rise to a possible conflict of interest?

○ Yes ◉ No

7. What is the proposed local start and end date for the research at this site?

Start date: 01/09/2013

End date: 31/05/2014
Duration (Months): 17

8-1. Give details of all non-clinical intervention(s) or procedure(s) that will be received by participants as part of the research protocol. *(These include seeking consent, interviews, non-clinical observations and use of questionnaires.)*

Columns 1-4 have been completed with information from A18 as below:

1. *Total number of interventions/procedures to be received by each participant as part of the research protocol.*
2. *If this intervention would have been routinely given to participants as part of their care, how many of the total would have been routine?*
3. *Average time taken per intervention (minutes, hours or days)*
4. *Details of who will conduct the procedure, and where it will take place*

Please complete Column 5 with details of the names of individuals or names of staff groups who will conduct the procedure at this site.

Intervention or procedure	1	2	3	4	5
Initial recruitment approach to introduce the study, distribute information sheets, and answer questions	1	n/a	15-30	Chief investigator will visit the site for this purpose	
Ascertaining interest, answering any further questions, arranging interviews	1	n/a	15-30	Chief investigator will revisit the site for this purpose	
Interview	1-3	n/a	45-120	Chief investigator will return to the site to conduct the interviews at a time/date convenient to the participants - if more than one interview is arranged with an individual, these will not take place on the same day	

8-2. Will any aspects of the research at this site be conducted in a different way to that described in Part A or the protocol?

○ Yes ◉ No

If Yes, please note any relevant changes to the information in the above table.

Are there any changes other than those noted in the table?

10. How many research participants/samples is it expected will be recruited/obtained from this site?

The study requires 5-10 participants.

11. Give details of how potential participants will be identified locally and who will be making the first approach to them to take part in the study.

Preliminary discussions with the field supervisor (local collaborator) will identify potential participants. The field supervisor has been or is currently involved in the care and treatment of potential participants and is therefore part of their clinical
teams.

However, the field supervisor will not be directly involved in recruitment approaches to potential participants, thereby allowing individuals to make decisions on whether or not to participate without undue influence. The chief investigator

will visit each site to introduce herself and provide information about the study to potential participants identified by the field supervisor.

12. Who will be responsible for obtaining informed consent at this site? What expertise and training do these persons have in obtaining consent for research purposes?

Name	Expertise/training
Chief investigator	The chief investigator has experience of obtaining informed consent from previous research. Academic and field supervisors will also provide advice.

15-1. Is there an independent contact point where potential participants can seek general advice about taking part in research?

If participants have any concerns about the study or wish to raise any issues, they will be advised to contact the Patient Advice and Liaison Service (PALS) through ward staff, who would then be able to assist them with any concerns or direct them to advocacy or complaints services as appropriate. The researcher has contacted [redacted] PALS to inform them of the study and make them aware of this possibility, and copies of the participant information sheets and consent form have been sent to them.

15-2. Is there a contact point where potential participants can seek further details about this specific research project?

There will be an initial visit to the site by the chief investigator for the purposes of introductions, outlining study, and distributing information sheets. The chief investigator will then conduct a follow-up visit to the site after one week to answer any questions, ascertain interest and arrange dates/times for interviews.

Potential participants will also be offered study information, the opportunity to enquire about the study, and discuss participation on the occasions when the researcher visits the site to conduct interviews. This approach will potentially maximise recruitment and participation.

In addition to the detailed participant information sheets, potential participants will also be given a summary information sheet providing an overview of pertinent information. At the point of interview, the information sheet will be reviewed and a further opportunity will be provided to ask any questions, following which the consent form will be signed.

16. Are there any changes that should be made to the generic content of the information sheet to reflect site-specific issues in the conduct of the study? *A substantial amendment may need to be discussed with the Chief Investigator and submitted to the main REC.*

n/a

Please provide a copy on headed paper of the participant information sheet and consent form that will be used locally. Unless indicated above, this must be the same generic version submitted to/approved by the main REC for the study while including relevant local information about the site, investigator and contact points for participants (see guidance notes).

17. What local arrangements have been made for participants who might not adequately understand verbal explanations or written information given in English, or who have special communication needs? *(e.g. translation, use of interpreters etc.)*

n/a

18. What local arrangements will be made to inform the GP or other health care professionals responsible for the care of the participants?

The field supervisor is, or has been, involved in the care/treatment of potential participants and will be aware of who is participating due to processes around risk assessment and logistics of recruitment in secure settings.

19. What arrangements (e.g. facilities, staffing, psychosocial support, emergency procedures) will be in place at the site, where appropriate, to minimise the risks to participants and staff and deal with the consequences of any harm?

All interviews will remain confidential unless any concern of risk to the participants themselves or to others is highlighted. If this should occur, it will be discussed with supervisors who would take appropriate action to manage the risk. This may include notifying other professionals at the sites.

It is possible that participation in this study could elicit negative emotions, as the interviews will involve discussion of experiences participants could potentially find distressing. In the event that this occurs, participants would be advised to speak to the field supervisors and other appropriate staff such as their primary nurse (or other nursing staff) as required following the interview. The chief investigator may also offer to pause or terminate the interview if a participant becomes distressed, and all participants will be offered the opportunity of debriefing to minimise any lasting impact. Potential participants will be made aware of this in advance through the information sheets. The chief investigator is a trainee clinical psychologist and therefore has skills and training enabling her to conduct the interviews in a sensitive and appropriate manner.

There can also be an emotional impact on the researcher in these contexts, depending on the content and interactional processes of the interviews. If this should occur, the chief investigator will access supervision and support as required.

The chief investigator will conduct all interviews in line with Trust/service policies relating to risk management at each site. The chief investigator will have already completed breakaway training through the DClinPsy course. All interviews will take place on site and according to any Trust/service guidelines governing such processes.

20. What are the arrangements for the supervision of the conduct of the research at this site? *Please give the name and contact details of any supervisor not already listed in the application.*

Academic supervisor:
Dr[redacted](Lecturer in Health Research & Clinical Tutor, Lancaster University)[redacted]
[redacted]@lancaster.ac.uk

Field Supervisor:
Dr[redacted](Highly Specialist Clinical Psychologist,[redacted]@[redacted]nhs.uk

21. What external funding will be provided for the research at this site?

- ○ Funded by commercial sponsor
- ○ Other funding
- ◉ No external funding

How will the costs of the research be covered?
Costs associated with recruitment and interviews will be covered by Lancaster University.

23. Authorisations required prior to R&D approval

The local research team are responsible for contacting the local NHS R&D office about the research project. Where the research project is proposed to be coordinated centrally and therefore there is no local research team, it is the responsibility of the central research team to instigate this contact with local R&D.

NHS R&D offices can offer advice and support on the set-up of a research project at their organisation, including information on local arrangements for support services relevant to the project. These support services may include clinical supervisors, line managers, service managers, support department managers, pharmacy, data protection officers or finance managers depending on the nature of the research.

Obtaining the necessary support service authorisations is not a pre-requisite to submission of an application for NHS research permission, but all appropriate authorisations must be in place before NHS research permission will be granted. Processes for obtaining authorisations will be subject to local arrangements, but the minimum expectation is that the local R&D office has been contacted to notify it of the proposed research project and to discuss the project's needs **prior** to submission of the application for NHS research permission via IRAS.

Failure to engage with local NHS R&D offices **prior** to submission may lead to unnecessary delays in the process of this application for NHS research permissions.

Declaration:
☑ **I confirm that the relevant NHS organisation R&D office has been contacted to discuss the needs of the project and local arrangements for support services. I understand that failure to engage with the local NHS R&D office before submission of this application may result in unnecessary delays in obtaining NHS research permission for this project.**

Please give the name and contact details for the NHS R&D office staff member you have discussed this application with:
Please note that for some sites the NHS R&D office contact may not be physically based at the site. For contact details refer to the guidance for this question.

	Title	Forename/Initials	Surname
	Mr	[redacted]	[redacted]
Work E-mail	[redacted]@[redacted]nhs.uk		
Work Telephone	[redacted]		

Declaration by Principal Investigator or Local Collaborator

1. The information in this form is accurate to the best of my knowledge and I take full responsibility for it.
2. I undertake to abide by the ethical principles underpinning the World Medical Association's Declaration of Helsinki and relevant good practice guidelines in the conduct of research.
3. If the research is approved by the main REC and NHS organisation, I undertake to adhere to the study protocol, the terms of the application of which the main REC has given a favourable opinion and the conditions requested by the NHS organisation, and to inform the NHS organisation within local timelines of any subsequent amendments to the protocol.
4. If the research is approved, I undertake to abide by the principles of the Research Governance Framework for Health and Social Care.
5. I am aware of my responsibility to be up to date and comply with the requirements of the law and relevant guidelines relating to the conduct of research.
6. I undertake to disclose any conflicts of interest that may arise during the course of this research, and take responsibility for ensuring that all staff involved in the research are aware of their responsibilities to disclose conflicts of interest.
7. I understand and agree that study files, documents, research records and data may be subject to inspection by the NHS organisation, the sponsor or an independent body for monitoring, audit and inspection purposes.
8. I take responsibility for ensuring that staff involved in the research at this site hold appropriate contracts for the duration of the research, are familiar with the Research Governance Framework, the NHS organisation's Data Protection Policy and all other relevant policies and guidelines, and are appropriately trained and experienced.
9. I undertake to complete any progress and/or final reports as requested by the NHS organisation and understand that continuation of permission to conduct research within the NHS organisation is dependent on satisfactory completion of such reports.
10. I undertake to maintain a project file for this research in accordance with the NHS organisation's policy.
11. I take responsibility for ensuring that all serious adverse events are handled within the NHS organisation's policy for reporting and handling of adverse events.
12. I understand that information relating to this research, including the contact details on this application, will be held by the R&D office and may be held on national research information systems, and that this will be managed according to the principles established in the Data Protection Act 1998.

13. I understand that the information contained in this application, any supporting documentation and all correspondence with the R&D office and/or the REC system relating to the application will be subject to the provisions of the Freedom of Information Acts and may be disclosed in response to requests made under the Acts except where statutory exemptions apply.

Signature of Principal Investigator or Local Collaborator: [redacted]

Print Name: [redacted]

Date:

Site Specific Information (SSI) Form (High Secure Site)

NHS SSI IRAS Version 3.5

Welcome to the Integrated Research Application System

IRAS Project Filter

The integrated dataset required for your project will be created from the answers you give to the following questions. The system will generate only those questions and sections which (a) apply to your study type and (b) are required by the bodies reviewing your study. Please ensure you answer all the questions before proceeding with your applications.

Please enter a short title for this project (maximum 70 characters)
Impact of schema therapy on narratives in secure settings

1. Is your project research?

◉ Yes ○ No

2. Select one category from the list below:

○ Clinical trial of an investigational medicinal product
○ Clinical investigation or other study of a medical device
○ Combined trial of an investigational medicinal product and an investigational medical device
○ Other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice
○ Basic science study involving procedures with human participants
○ Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology
◉ Study involving qualitative methods only
○ Study limited to working with human tissue samples (or other human biological samples) and data (specific project only)
○ Study limited to working with data (specific project only)
○ Research tissue bank
○ Research database

If your work does not fit any of these categories, select the option below:

○ Other study

2a. Please answer the following question(s):

a) Does the study involve the use of any ionising radiation?	○ Yes	◉ No
b) Will you be taking new human tissue samples (or other human biological samples)?	○ Yes	◉ No
c) Will you be using existing human tissue samples (or other human biological samples)?	○ Yes	◉ No

3. In which countries of the UK will the research sites be located? *(Tick all that apply)*

☑ England
☐ Scotland
☐ Wales
☐ Northern Ireland

3a. In which country of the UK will the lead NHS R&D office be located:

- (●) England
- ( ) Scotland
- ( ) Wales
- ( ) Northern Ireland
- ( ) This study does not involve the NHS

4. Which review bodies are you applying to?

- [x] NHS/HSC Research and Development offices
- [ ] Social Care Research Ethics Committee
- [x] Research Ethics Committee
- [ ] National Information Governance Board for Health and Social Care (NIGB)
- [ ] National Offender Management Service (NOMS) (Prisons & Probation)

For NHS/HSC R&D offices, the CI must create Site-Specific Information Forms for each site, in addition to the study-wide forms, and transfer them to the PIs or local collaborators.

5. Will any research sites in this study be NHS organisations?

(●) Yes ( ) No

5a. Are all the research costs and infrastructure costs for this study provided by an NIHR Biomedical Research Centre, NIHR Biomedical Research Unit, NIHR Collaboration for Leadership in Health Research and Care (CLAHRC) or NIHR Research Centre for Patient Safety & Service Quality in all study sites?

( ) Yes (●) No

If yes, NHS permission for your study will be processed through the NIHR Coordinated System for gaining NHS Permission (NIHR CSP).

5b. Do you wish to make an application for the study to be considered for NIHR Clinical Research Network (CRN) support and inclusion in the NIHR Clinical Research Network (CRN) Portfolio? Please see information button for further details.

( ) Yes (●) No

If yes, NHS permission for your study will be processed through the NIHR Coordinated System for gaining NHS Permission (NIHR CSP) and you must complete a NIHR Clinical Research Network (CRN) Portfolio Application Form immediately after completing this project filter and before completing and submitting other applications.

6. Do you plan to include any participants who are children?

( ) Yes (●) No

7. Do you plan at any stage of the project to undertake intrusive research involving adults lacking capacity to consent for themselves?

( ) Yes (●) No

Answer Yes if you plan to recruit living participants aged 16 or over who lack capacity, or to retain them in the study following loss of capacity. Intrusive research means any research with the living requiring consent in law. This includes use of identifiable tissue samples or personal information, except where application is being made to the NIGB Ethics and Confidentiality Committee to set aside the common law duty of confidentiality in England and Wales. Please consult the guidance notes for further information on the legal frameworks for research involving adults lacking capacity in the UK.

8. Do you plan to include any participants who are prisoners or young offenders in the custody of HM Prison Service or who are offenders supervised by the probation service in England or Wales?

○ Yes ◉ No

9. Is the study or any part of it being undertaken as an educational project?

◉ Yes ○ No

Please describe briefly the involvement of the student(s):
The student is completing the study as part of a Doctorate in Clinical Psychology, and will be the chief investigator.

9a. Is the project being undertaken in part fulfilment of a PhD or other doctorate?

◉ Yes ○ No

10. Will this research be financially supported by the United States Department of Health and Human Services or any of its divisions, agencies or programs?

○ Yes ◉ No

11. Will identifiable patient data be accessed outside the care team without prior consent at any stage of the project (including identification of potential participants)?

○ Yes ◉ No

Site-Specific Information Form (NHS sites)

Is the site hosting this research a NHS site or a non-NHS site? *NHS sites include Health and Social Care organisations in Northern Ireland. The sites hosting the research are the sites in which or through which research procedures are conducted. For NHS sites, this includes sites where NHS staff are participants.*

- (•) NHS site
- ( ) Non-NHS site

This question must be completed before proceeding. The filter will customise the form, disabling questions which are not relevant to this application.

One Site-Specific Information Form should be completed for each research site and submitted to the relevant R&D office with the documents in the checklist. See guidance notes.

The data in this box is populated from Part A:

Title of research:
The impact of schema therapy on narratives of individuals in secure settings

Short title: Impact of schema therapy on narratives in secure settings

Chief Investigator:

Title	Forename/Initials	Surname
Mrs	[redacted]	[redacted]

Name of NHS Research Ethics Committee to which application for ethical review is being made:
North West Liverpool East

Project reference number from above REC: 13/NW/0558

1-1. Give the name of the NHS organisation responsible for this research site

[redacted] NHS Trust

1-3. In which country is the research site located?

- (•) England
- ( ) Wales
- ( ) Scotland
- ( ) Northern Ireland

1-4. Is the research site a GP practice or other Primary Care Organisation?

( ) Yes (•) No

2. Who is the Principal Investigator or Local Collaborator for this research at this site?

Select the appropriate title: ○ Principal Investigator ◉ Local Collaborator

	Title	Forename/Initials	Surname
	Dr	[redacted]	[redacted]

Post	Consultant Clinical & Forensic Psychologist
Qualifications	DClinPsy
Organisation	[redacted] NHS Trust
Work Address	[redacted]
PostCode	[redacted]
Work E-mail	[redacted]@[redacted]nhs.uk
Work Telephone	[redacted]
Mobile	
Fax	

a) Approximately how much time will this person allocate to conducting this research? *Please provide your response in terms of Whole Time Equivalents (WTE).*
0.1

b) Does this person hold a current substantive employment contract, Honorary Clinical Contract or Honorary Research Contract with the NHS organisation or accepted by the NHS organisation? ◉ Yes ○ No

A copy of a current CV for the Principal Investigator (maximum 2 pages of A4) must be submitted with this form.

3. Please give details of all locations, departments, groups or units at which or through which research procedures will be conducted at this site and describe the activity that will take place.

Please list all locations/departments etc where research procedures will be conducted within the NHS organisation, describing the involvement in a few words. Where access to specific facilities will be required these should also be listed for each location.

Name the main location/department first. Give details of any research procedures to be carried out off site, for example in participants' homes.

	Location	Activity/facilities
1	[redacted]	Activities: recruitment, interviews, transcription Facilities: room for conducting interviews, audio-recording equipment,equipment / software for transcription

5. Please give details of all other members of the research team at this site.

6. Does the Principal Investigator or any other member of the site research team have any direct personal involvement (e.g. financial, share-holding, personal relationship etc) in the organisation sponsoring or funding the research that may give rise to a possible conflict of interest?

○ Yes ◉ No

7. What is the proposed local start and end date for the research at this site?

Start date:	02/12/2013
End date:	31/05/2014
Duration (Months):	5

8-1. Give details of all non-clinical intervention(s) or procedure(s) that will be received by participants as part of the research protocol. *(These include seeking consent, interviews, non-clinical observations and use of questionnaires.)*

Columns 1-4 have been completed with information from A18 as below:

1. *Total number of interventions/procedures to be received by each participant as part of the research protocol.*
2. *If this intervention would have been routinely given to participants as part of their care, how many of the total would have been routine?*
3. *Average time taken per intervention (minutes, hours or days)*
4. *Details of who will conduct the procedure, and where it will take place*

Please complete Column 5 with details of the names of individuals or names of staff groups who will conduct the procedure at this site.

Intervention or procedure	1	2	3	4	5
Initial recruitment approach to introduce the study, distribute information sheets, and answer questions	1	n/a	15-30	Chief investigator will visit the site for this purpose	
Ascertaining interest, answering any further questions, arranging interviews	1	n/a	15-30	Chief investigator will revisit the site for this purpose	
Interview	1-3	n/a	45-120	Chief investigator will return to the site to conduct the interviews at a time/date convenient to the participants - if more than one interview is arranged with an individual, these will not take place on the same day	

8-2. Will any aspects of the research at this site be conducted in a different way to that described in Part A or the protocol?

○ Yes ◉ No

If Yes, please note any relevant changes to the information in the above table.

Are there any changes other than those noted in the table?
Research protocol has been amended to incorporate site-specific issues, and has been submitted / approved by the REC as part of an amendment.

10. How many research participants/samples is it expected will be recruited/obtained from this site?

The study requires 5-10 participants in total, from two sites including this one.

11. Give details of how potential participants will be identified locally and who will be making the first approach to them to take part in the study.

Preliminary discussions with the field supervisor (local collaborator) will identify potential participants. The field supervisor has been or is currently involved in the care and treatment of potential participants and is therefore part of their clinical
teams.

However, the field supervisor will not be directly involved in recruitment approaches to potential participants, thereby allowing individuals to make decisions on whether or not to participate without undue influence. The chief investigator will visit each site to introduce herself and provide information about the study to potential participants identified by the field supervisor.

12. Who will be responsible for obtaining informed consent at this site? What expertise and training do these persons have in obtaining consent for research purposes?

Name	Expertise/training
Chief investigator	The chief investigator has experience of obtaining informed consent from previous research. Academic and field supervisors will also provide advice / guidance as appropriate.

15-1. Is there an independent contact point where potential participants can seek general advice about taking part in research?

If participants have any concerns about the study or wish to raise any issues, they will be advised to contact ward staff or the field supervisor, who will communicate these concerns to the chief investigator or to the academic supervisor.

Alternatively, if they wish to seek advice or raise concerns with somebody not directly involved in the study, they can contact [redacted] from the Research and Development Department for [redacted] and will be advised to ask ward staff for further details on how to get in touch with him.

This information will be provided in the participant information sheet.

15-2. Is there a contact point where potential participants can seek further details about this specific research project?

There will be an initial visit to the site by the chief investigator for the purposes of introductions, outlining study, and distributing information sheets. The chief investigator will then conduct a follow-up visit to the site after one week to answer any questions, ascertain interest and arrange dates / times for interviews.

Potential participants will also be offered study information, the opportunity to enquire about the study, and discuss participation on the occasions when the researcher visits the site to conduct interviews. This approach will potentially maximise recruitment and participation.

In addition to the detailed participant information sheets, potential participants will also be given a summary information sheet providing an overview of pertinent information. At the point of interview, the information sheet will be reviewed and a further opportunity will be provided to ask any questions, following which the consent form will be signed.

16. Are there any changes that should be made to the generic content of the information sheet to reflect site-specific issues in the conduct of the study? *A substantial amendment may need to be discussed with the Chief Investigator and submitted to the main REC.*

Research protocol (including information sheets) has been amended to incorporate site-specific issues, and has been submitted / approved by the REC as part of an amendment.

Please provide a copy on headed paper of the participant information sheet and consent form that will be used locally. Unless indicated above, this must be the same generic version submitted to/approved by the main REC for the study while including relevant local information about the site, investigator and contact points for participants (see guidance notes).

17. What local arrangements have been made for participants who might not adequately understand verbal explanations or written information given in English, or who have special communication needs? *(e.g. translation, use of interpreters etc.)*

n/a

18. What local arrangements will be made to inform the GP or other health care professionals responsible for the care of the participants?

The field supervisor is, or has been, involved in the care / treatment of potential participants and will be aware of who is participating due to processes around risk assessment and logistics of recruitment in secure settings.

19. What arrangements (e.g. facilities, staffing, psychosocial support, emergency procedures) will be in place at the site, where appropriate, to minimise the risks to participants and staff and deal with the consequences of any harm?

All interviews will remain confidential unless any concern of risk to the participants themselves or to others is highlighted. If this should occur, it will be discussed with supervisors who would take appropriate action to manage the risk. This may include notifying other professionals at the sites.

It is possible that participation in this study could elicit negative emotions, as the interviews will involve discussion of experiences participants could potentially find distressing. In the event that this occurs, participants would be advised to speak to the field supervisors and other appropriate staff such as their primary nurse (or other nursing staff) as required following the interview. The chief investigator may also offer to pause or terminate the interview if a participant becomes distressed, and all participants will be offered the opportunity of debriefing to minimise any lasting impact. Potential participants will be made aware of this in advance through the information sheets. The chief investigator is a trainee clinical psychologist and therefore has skills and training enabling her to conduct the interviews in a sensitive and appropriate manner.

There can also be an emotional impact on the researcher in these contexts, depending on the content and interactional processes of the interviews. If this should occur, the chief investigator will access supervision and support as required.

The chief investigator will conduct all interviews in line with Trust / service policies relating to risk management at each site. The chief investigator will have already completed breakaway training through the DClinPsy course. All interviews will take place on site and according to any Trust/service guidelines governing such processes.

20. What are the arrangements for the supervision of the conduct of the research at this site? *Please give the name and contact details of any supervisor not already listed in the application.*

Academic supervisor:
Dr [redacted] (Lecturer in Health Research & Clinical Tutor, Lancaster University) [redacted]@lancaster.ac.uk

Field Supervisor:
Dr [redacted] (Consultant Clinical & Forensic Psychologist, [redacted] [redacted]@[redacted]nhs.uk

21. What external funding will be provided for the research at this site?

- ○ Funded by commercial sponsor
- ○ Other funding
- ◉ No external funding

How will the costs of the research be covered?
Costs associated with recruitment, interviews, and transcription will be covered by Lancaster University. Some transcription costs may be covered by the chief investigator, depending on total cost of transcription which will be determined by number / length of interviews.

23. Authorisations required prior to R&D approval

The local research team are responsible for contacting the local NHS R&D office about the research project. Where the research project is proposed to be coordinated centrally and therefore there is no local research team, it is the responsibility of the central research team to instigate this contact with local R&D.

NHS R&D offices can offer advice and support on the set-up of a research project at their organisation, including information on local arrangements for support services relevant to the project. These support services may include clinical supervisors, line managers, service managers, support department managers, pharmacy, data protection officers or finance managers depending on the nature of the research.

Obtaining the necessary support service authorisations is not a pre-requisite to submission of an application for NHS research permission, but all appropriate authorisations must be in place before NHS research permission will be granted. Processes for obtaining authorisations will be subject to local arrangements, but the minimum expectation is that the local R&D office has been contacted to notify it of the proposed research project and to discuss the project's needs **prior** to submission of the application for NHS research permission via IRAS.

Failure to engage with local NHS R&D offices **prior** to submission may lead to unnecessary delays in the process of this application for NHS research permissions.

Declaration:

☑ **I confirm that the relevant NHS organisation R&D office has been contacted to discuss the needs of the project and local arrangements for support services. I understand that failure to engage with the local NHS R&D office before submission of this application may result in unnecessary delays in obtaining NHS research permission for this project.**

Please give the name and contact details for the NHS R&D office staff member you have discussed this application with:

Please note that for some sites the NHS R&D office contact may not be physically based at the site. For contact details refer to the guidance for this question.

	Title	Forename/Initials	Surname
	Dr	[redacted]	[redacted]
Work E-mail	[redacted]@[redacted]nhs.uk		
Work Telephone	[redacted]		

Declaration by Principal Investigator or Local Collaborator

1. The information in this form is accurate to the best of my knowledge and I take full responsibility for it.
2. I undertake to abide by the ethical principles underpinning the World Medical Association's Declaration of Helsinki and relevant good practice guidelines in the conduct of research.
3. If the research is approved by the main REC and NHS organisation, I undertake to adhere to the study protocol, the terms of the application of which the main REC has given a favourable opinion and the conditions requested by the NHS organisation, and to inform the NHS organisation within local timelines of any subsequent amendments to the protocol.
4. If the research is approved, I undertake to abide by the principles of the Research Governance Framework for Health and Social Care.
5. I am aware of my responsibility to be up to date and comply with the requirements of the law and relevant guidelines relating to the conduct of research.
6. I undertake to disclose any conflicts of interest that may arise during the course of this research, and take responsibility for ensuring that all staff involved in the research are aware of their responsibilities to disclose conflicts of interest.
7. I understand and agree that study files, documents, research records and data may be subject to inspection by the NHS organisation, the sponsor or an independent body for monitoring, audit and inspection purposes.
8. I take responsibility for ensuring that staff involved in the research at this site hold appropriate contracts for the duration of the research, are familiar with the Research Governance Framework, the NHS organisation's Data Protection Policy and all other relevant policies and guidelines, and are appropriately trained and experienced.
9. I undertake to complete any progress and/or final reports as requested by the NHS organisation and understand that continuation of permission to conduct research within the NHS organisation is dependent on satisfactory completion of such reports.

10. I undertake to maintain a project file for this research in accordance with the NHS organisation's policy.

11. I take responsibility for ensuring that all serious adverse events are handled within the NHS organisation's policy for reporting and handling of adverse events.

12. I understand that information relating to this research, including the contact details on this application, will be held by the R&D office and may be held on national research information systems, and that this will be managed according to the principles established in the Data Protection Act 1998.

13. I understand that the information contained in this application, any supporting documentation and all correspondence with the R&D office and/or the REC system relating to the application will be subject to the provisions of the Freedom of Information Acts and may be disclosed in response to requests made under the Acts except where statutory exemptions apply.

Signature of Principal Investigator or Local Collaborator: [redacted]

Print Name: [redacted]

Date:

Notice of Substantial Amendment (NOSA) Form (High Secure Site)

Notice of Amendment IRAS Version 3.5

Welcome to the Integrated Research Application System

IRAS Project Filter

The integrated dataset required for your project will be created from the answers you give to the following questions. The system will generate only those questions and sections which (a) apply to your study type and (b) are required by the bodies reviewing your study. Please ensure you answer all the questions before proceeding with your applications.

Please enter a short title for this project (maximum 70 characters)
Impact of schema therapy on narratives in secure settings

1. Is your project research?

◉ Yes ○ No

2. Select one category from the list below:

○ Clinical trial of an investigational medicinal product
○ Clinical investigation or other study of a medical device
○ Combined trial of an investigational medicinal product and an investigational medical device
○ Other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice
○ Basic science study involving procedures with human participants
○ Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology
◉ Study involving qualitative methods only
○ Study limited to working with human tissue samples (or other human biological samples) and data (specific project only)
○ Study limited to working with data (specific project only)
○ Research tissue bank
○ Research database

If your work does not fit any of these categories, select the option below:

○ Other study

2a. Please answer the following question(s):

a) Does the study involve the use of any ionising radiation? ○ Yes ◉ No
b) Will you be taking new human tissue samples (or other human biological samples)? ○ Yes ◉ No
c) Will you be using existing human tissue samples (or other human biological samples)? ○ Yes ◉ No

3. In which countries of the UK will the research sites be located? *(Tick all that apply)*

☑ England
☐ Scotland
☐ Wales
☐ Northern Ireland

3a. In which country of the UK will the lead NHS R&D office be located:

- (●) England
- ( ) Scotland
- ( ) Wales
- ( ) Northern Ireland
- ( ) This study does not involve the NHS

4. Which review bodies are you applying to?

- [x] NHS/HSC Research and Development offices
- [ ] Social Care Research Ethics Committee
- [x] Research Ethics Committee
- [ ] National Information Governance Board for Health and Social Care (NIGB)
- [ ] National Offender Management Service (NOMS) (Prisons & Probation)

For NHS/HSC R&D offices, the CI must create Site-Specific Information Forms for each site, in addition to the study-wide forms, and transfer them to the PIs or local collaborators.

5. Will any research sites in this study be NHS organisations?

(●) Yes ( ) No

5a. Are all the research costs and infrastructure costs for this study provided by an NIHR Biomedical Research Centre, NIHR Biomedical Research Unit, NIHR Collaboration for Leadership in Health Research and Care (CLAHRC) or NIHR Research Centre for Patient Safety & Service Quality in all study sites?

( ) Yes (●) No

If yes, NHS permission for your study will be processed through the NIHR Coordinated System for gaining NHS Permission (NIHR CSP).

5b. Do you wish to make an application for the study to be considered for NIHR Clinical Research Network (CRN) support and inclusion in the NIHR Clinical Research Network (CRN) Portfolio? Please see information button for further details.

( ) Yes (●) No

If yes, NHS permission for your study will be processed through the NIHR Coordinated System for gaining NHS Permission (NIHR CSP) and you must complete a NIHR Clinical Research Network (CRN) Portfolio Application Form immediately after completing this project filter and before completing and submitting other applications.

6. Do you plan to include any participants who are children?

( ) Yes (●) No

7. Do you plan at any stage of the project to undertake intrusive research involving adults lacking capacity to consent for themselves?

( ) Yes (●) No

Answer Yes if you plan to recruit living participants aged 16 or over who lack capacity, or to retain them in the study following loss of capacity. Intrusive research means any research with the living requiring consent in law. This includes use of identifiable tissue samples or personal information, except where application is being made to the NIGB Ethics and Confidentiality Committee to set aside the common law duty of confidentiality in England and Wales. Please consult the guidance notes for further information on the legal frameworks for research involving adults lacking capacity in the UK.

8. Do you plan to include any participants who are prisoners or young offenders in the custody of HM Prison Service or who are offenders supervised by the probation service in England or Wales?

○ Yes ◉ No

9. Is the study or any part of it being undertaken as an educational project?

◉ Yes ○ No

Please describe briefly the involvement of the student(s):
The student is completing the study as part of a Doctorate in Clinical Psychology, and will be the chief investigator.

9a. Is the project being undertaken in part fulfilment of a PhD or other doctorate?

◉ Yes ○ No

10. Will this research be financially supported by the United States Department of Health and Human Services or any of its divisions, agencies or programs?

○ Yes ◉ No

11. Will identifiable patient data be accessed outside the care team without prior consent at any stage of the project (including identification of potential participants)?

○ Yes ◉ No

Notice of Amendment IRAS Version 3.5

NOTICE OF SUBSTANTIAL AMENDMENT

Please use this form to notify the main REC of substantial amendments to all research other than clinical trials of investigational medicinal products (CTIMPs).
The form should be completed by the Chief Investigator using language comprehensible to a lay person.

Details of Chief Investigator:

	Title Forename/Initials Surname
	Mr [redacted] [redacted]
Work Address	C27 Furness College
	Lancaster University
	Lancaster
PostCode	LA1 4YG
Email	[redacted]@lancaster.ac.uk
Telephone	07762195363
Fax	

Full title of study:	The impact of schema therapy on narratives of individuals in secure settings
Lead sponsor:	Lancaster University
Name of REC:	North West Liverpool East
REC reference number:	13/NW/0558
Name of lead R&D office:	[redacted] Trust Research & Development Department
Date study commenced:	01.09.2013
Protocol reference (if applicable), current version and date:	V6 - 07.10.2013
Amendment number and date:	Amendment Number 1 - 08.11.2013

Type of amendment

(a) Amendment to information previously given in IRAS

○ Yes ◉ No

If yes, please refer to relevant sections of IRAS in the "summary of changes" below.

(b) Amendment to the protocol

◉ Yes ○ No

If yes, please submit either the revised protocol with a new version number and date, highlighting changes in bold, or a document listing the changes and giving both the previous and revised text.

Please see revised protocol.

Notice of Amendment IRAS Version 3.5

(c) Amendment to the information sheet(s) and consent form(s) for participants, or to any other supporting documentation for the study

(●) Yes ( ) No

If yes, please submit all revised documents with new version numbers and dates, highlighting new text in bold.

Please see revised protocol.

Is this a modified version of an amendment previously notified and not approved?

( ) Yes (●) No

Summary of changes

Briefly summarise the main changes proposed in this amendment. Explain the purpose of the changes and their significance for the study.
If this is a modified amendment, please explain how the modifications address the concerns raised previously by the ethics committee.
If the amendment significantly alters the research design or methodology, or could otherwise affect the scientific value of the study, supporting scientific information should be given (or enclosed separately). Indicate whether or not additional scientific critique has been obtained.

The pool of potential participants meeting the inclusion criteria is a small and hard to reach population. Another site from a different NHS Trust is being added to increase the participant pool - minor changes have been made to participant information sheets and consent forms to reflect site-specific issues.

The majority of individuals who meet the criteria are male, and this was therefore listed as one of the inclusion criteria within the research protocol, although there was no reason to exclude female participants. To facilitate recruitment, 'male' is now being removed from the inclusion criteria, allowing recruitment of both male and female participants.

These changes have been discussed and agreed with academic and field supervisors.

Any other relevant information

Applicants may indicate any specific issues relating to the amendment, on which the opinion of a reviewing body is sought.

n/a

List of enclosed documents

Document	*Version*	*Date*
Research Protocol	6	07/10/2013

Declaration by Chief Investigator

1. *I confirm that the information in this form is accurate to the best of my knowledge and I take full responsibility for it.*
2. *I consider that it would be reasonable for the proposed amendment to be implemented.*

Date: 19.11.2013

Declaration by the sponsor's representative

I confirm the sponsor's support for this substantial amendment.

Notice of Amendment

IRAS Version 3.5

Signature: .....

Print Name: [redacted]

Post: PRO VC RESEARCH

Organisation: LANCASTER UNIVERSITY

Date: 16.11.15 dd/mm/yyyy

1281481525280013/238/24211

Appendix A: REC Conditional Approval Letter

NHS
Health Research Authority

National Research Ethics Service

NRES Committee North West - Liverpool East
HRA NRES Centre Manchester
Barlow House
3rd Floor
4 Minshull Street
Manchester
M1 3DZ

Telephone: 0161 625 7832
Facsimile: 0161 625 7299

26 September 2013

Mrs [redacted]
Trainee Clinical Psychologist
Lancashire Care NHS Foundation Trust
C27 Furness College
Lancaster University
Lancaster
LA1 4YG

Dear Mrs [redacted]

Study title:	**The impact of schema therapy on narratives of individuals in secure settings**
REC reference:	**13/NW/0558**
Protocol number:	**n/a**
IRAS project ID:	**128148**

Thank you for your letter of 11 September 2013, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair and Dr [redacted]

We plan to publish your research summary wording for the above study on the NRES website, together with your contact details, unless you expressly withhold permission to do so. Publication will be no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to withhold permission to publish, please contact the Co-ordinator Miss [redacted] nrescommittee.northwest-liverpooleast@nhs.net.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management

permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study:

- The Committee appreciated that clarification of what is meant by 'secure setting' has been given. However, the wording suggests that a participant has accessed therapy while an in-patient. It would be useful to explain that they could be out-patients given that participants could have been discharged.

- On the Consent form the statement in relation to regulatory authorities should be included within a box in the table rather than below the table. As with the other statements, there should be space for the participant to initial the box.

You should notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. The REC will acknowledge receipt and provide a final list of the approved documentation for the study, which can be made available to host organisations to facilitate their permission for the study. Failure to provide the final versions to the REC may cause delay in obtaining permissions.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Covering Letter from [redacted]		11 July 2013
REC application	128148/474 908/1/252	18 July 2013
Investigator CV: [redacted]		
Investigator CV: Dr [redacted]		
Participant Information Sheet: Summary	2	11 July 2013
Interview Schedules/Topic Guides	3	11 July 2013

Letter from Sponsor from [redacted] Lancaster University		10 July 2013
Evidence of insurance or indemnity		09 July 2013
Response to Request for Further Information from [redacted]		11 September 2013
Protocol	4	28 August 2013
Participant Information Sheet	3	28 August 2013
Participant Consent Form	3	28 August 2013
Evidence of insurance or indemnity: Employers' and Public and Products Liability	Letter from [redacted] for UMAL	11 July 2013
Evidence of insurance or indemnity: Professional Indemnity	Letter from [redacted] for UMAL	15 July 2013

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.

After ethical review

Reporting requirements

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

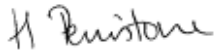
Further information is available at National Research Ethics Service website > After Review

13/NW/0558 Please quote this number on all correspondence

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at http://www.hra.nhs.uk/hra-training/

With the Committee's best wishes for the success of this project.

Yours sincerely



On behalf of
Mrs [redacted]
Chair

Email: nrescommittee.northwest-liverpooleast@nhs.net

Enclosures: "After ethical review – guidance for researchers"

Copy to: Mrs [redacted]
Lancaster University

Mrs [redacted]
[redacted] NHS Trust Research & Development Department

Appendix B: REC Final Approval Letter

NHS
Health Research Authority

National Research Ethics Service

NRES Committee North West - Liverpool East
HRA NRES Centre Manchester
Barlow House
3rd Floor
4 Minshull Street
Manchester
M1 3DZ

Telephone: 0161 625 7832
Facsimile: 0161 625 7299

30 September 2013

Mrs [redacted]
Trainee Clinical Psychologist
Lancashire Care NHS Foundation Trust
C27 Furness College
Lancaster University
Lancaster
LA1 4YG

Dear Mrs [redacted]

Study title:	**The impact of schema therapy on narratives of individuals in secure settings**
REC reference:	**13/NW/0558**
Protocol number:	**n/a**
IRAS project ID:	**128148**

Thank you for your email of 27 September 2013. I can confirm the REC has received the documents listed below and that these comply with the approval conditions detailed in our letter dated 26 September 2013

Documents received

The documents received were as follows:

Document	*Version*	*Date*
Covering Letter from [redacted]		27 September 2013
Protocol	5	26 September 2013
Participant Information Sheet: Summary	2	11 July 2013
Participant Information Sheet	4	26 September 2013
Participant Consent Form	4	26 September 2013
Interview Schedules/Topic Guides	3	11 July 2013

Approved documents

The final list of approved documentation for the study is therefore as follows:

Document	*Version*	*Date*
Covering Letter from [redacted]		11 July 2013
REC application	128148/474 908/1/252	18 July 2013
Investigator CV: [redacted]		
Investigator CV: Dr [redacted]		
Participant Information Sheet: Summary	2	11 July 2013
Interview Schedules/Topic Guides	3	11 July 2013
Letter from Sponsor from [redacted] Lancaster University		10 July 2013
Evidence of insurance or indemnity		09 July 2013
Response to Request for Further Information from [redacted]		11 September 2013
Protocol	5	26 September 2013
Participant Information Sheet	4	26 September 2013
Participant Consent Form	4	26 September 2013
Evidence of insurance or indemnity: Employers' and Public and Products Liability	Letter from [redacted] for UMAL	11 July 2013
Evidence of insurance or indemnity: Professional Indemnity	Letter from [redacted] for UMAL	15 July 2013
Covering Letter from [redacted]		27 September 2013

You should ensure that the sponsor has a copy of the final documentation for the study. It is the sponsor's responsibility to ensure that the documentation is made available to R&D offices at all participating sites.

13/NW/0558 **Please quote this number on all correspondence**

Yours sincerely

Miss [redacted]
REC Manager

E-mail: nrescommittee.northwest-liverpooleast@nhs.net

Copy to: Mrs [redacted]
Lancaster University

Mrs [redacted]
[redacted] NHS Trust Research & Development Department

Appendix C: R&D Approval Letter (Medium Secure Site

[redacted] NHS
NHS Trust

R&D Department
Building V7
[redacted] NHS Trust Offices
Kings Business Park
Prescot
[redacted] 1PJ
Tel: 0151 471 2638

Mrs [redacted]
Trainee Clinical Psychologist
Lancashire Care NHS Foundation Trust
C27 Furness College
Lancaster University
Lancaster LA1 4YG

10th October, 2013

Dear Mrs [redacted]

FORMAL LETTER OF APPROVAL

Project 2013/28; The impact of schema therapy on narratives of individuals in secure settings

As you are aware, your application was reviewed by the Trust's Research Governance Committee on the 19th September 2013 and the Committee were willing to approve subject to ethical approval.

Mr [redacted] R&D lead reported at the meeting that you had contacted the service well in advance before submission and had linked in with a member of the psychology staff during preparation of your application. Contacting the Trust early on in the process provided the opportunity for the service to answer any queries and to discuss how best to facilitate your research project. You attended service governance meetings which aided the review of the study for all parties. The service is fully supportive of your research.

The Committee wanted to commend you for getting in touch early in the process, and for submitting such a well written, clear and precise application, and the commendation be highlighted to your supervisor.

NRES Committee North West – Liverpool East gave conditional approval on the 26th September 2013. The Committee requested a small amendment to the consent form and gave final approval (conditions met) on the 30th September 2013 (reference 13/NW/0558). You have provided the R&D department with a copy of the amended document.

Chairman: [redacted] Chief Executive: [redacted]

Accordingly, please take this letter as confirmation of Trust R&D approval. Please read the attached 'Information for Researchers – Conditions of Research Governance Approval' leaflet. When contacting the R&D office please quote the above trust reference.

May I wish you every success with your research.

Yours sincerely

Mrs [redacted]
R&D Manager

cc. sponsor: [redacted]
ethics@lancaster.ac.uk

Chairman: [redacted] Chief Executive: [redacted]

[redacted] NHS

NHS Trust

R&D Department
Building V7
[redacted] HS Trust Offices
Kings Business Park
Prescot
[redacted] 1PJ
Tel: 0151 471 2638

Mrs [redacted]
Trainee Clinical Psychologist
Lancashire Care NHS Foundation Trust
C27 Furness College
Lancaster University
Lancaster LA1 4YG

15th October, 2013

Dear Mrs [redacted]

NHS to NHS Letter of Access for Research

Project 2013/2*: The impact of schema therapy on narriatives of individuals in secure settings

As an existing NHS employee you do not require an additional honorary research contract with this NHS organisation. We are satisfied that the research activities that you will undertake in this NHS organisation are commensurate with the activities you undertake for your employer. Your employer is fully responsible for ensuring such checks as are necessary have been carried out. Your employer has confirmed in writing to this NHS organisation that the necessary pre-engagement check are in place in accordance with the role you plan to carry out in this organisation. This letter confirms your right of access to conduct research th[redacted] HS Trust for the purpose and on the terms and conditions set out below. This right of access commences on the 15th October 2013 and ends on the 31st May 2014 * unless terminated earlier in accordance with the clauses below.

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

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

Chairman: [redacted] Chief Executive: [redacted]

While undertaking research th[redacted]HS Trust, you will remain accountable to your employer Lancashire Care NHS Foundation Trust but you are required to follow the reasonable instructions of [redacted]

Where any third party claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by this NHS organisation in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings.

You must act in accordance with [redacted]HS Trust policies and procedures, which are on the Trust website or available to you upon request, and the Research Governance Framework.

You are required to co-operate w[redacted]HS Trust in discharging its duties under the Health and Safety at Work etc Act 1974 and other health and safety legislation and to take reasonable care for the health and safety of yourself and others w[redacted] NHS Trust premises. Although you are not a contract holder, you must observe the same standards of care and propriety in dealing with patients, staff, visitors, equipment and premises as is expected of a contract holder and you must act appropriately, responsibly and professionally at all times.

If you have a physical or mental health condition or disability which may affect your research role and which might require special adjustments to your role, if you have not already done so, you must notify your employer and the Trust's R&D department prior to commencing your research role at the Trust.

You are required to ensure that all information regarding patients or staff remains secure and *strictly confidential* at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice (http://www.dh.gov.uk/assetRoot/04/06/92/54/04069254.pdf) and the Data Protection Act 1998. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

[redacted]HS Trust will not indemnify you against any liability incurred as a result of any breach of confidentiality or breach of the Data Protection Act 1998. Any breach of the Data Protection Act 1998 may result in legal action against you and/or your substantive employer.

You should ensure that, where you are issued with an identity or security card, a bleep number, email or library account, keys or protective clothing, these are returned upon termination of this arrangement. Please also ensure that while on the premises you wear your ID badge at all times, or are able to prove your identity if challenged. Please note that this NHS organisation accepts no responsibility for damage to or loss of personal property.

Chairman: [redacted] Chief Executive: [redacted]

We may terminate your right to attend at any time either by giving seven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you commit any act that we reasonably consider to amount to serious misconduct or to be disruptive and/or prejudicial to the interests and/or business of this NHS organisation or if you are convicted of any criminal offence. You must not undertake regulated activity if you are barred from such work. If you are barred from working with adults or children this letter of access is immediately terminated. Your employer will immediately withdraw you from undertaking this or any other regulated activity and you MUST stop undertaking any regulated activity immediately.

Your substantive employer is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you.

If your circumstances change in relation to your health, criminal record, professional registration or suitability to work with adults or children, or any other aspect that may impact on your suitability to conduct research, or your role in research changes, you must inform the NHS organisation that employs you through its normal procedures. You must also inform your nominated manager in this NHS organisation.

Yours sincerely

Mrs [redacted]
R&D Manager

* End date of project REC form

cc: HR dept: Lancashire Care NHS Foundation Trust

Chairman: [redacted] Chief Executive: [redacted]

Appendix D: R&D Approval Letter (High Secure Site)

positive

[redacted] NHS
NHS Trust
Positive about integrated healthcare

Research Support Services
Institute of Mental Health
University of Nottingham Innovation Park
Triumph Road
Nottingham
NG7 2TU

E-mail: [redacted]@notts.nhs.uk
Direct Line: 0115 748 4321

Date of NHS Permission: 14 January 2014

Mrs [redacted]
Trainee Clinical Psychologist
Lancashire Care NHS Foundation Trust
C27 Fulwood College
Lancaster University
Lancaster
LA1 4YG

Dear [redacted]

Study title: The impact of schema therapy on narratives of individuals in secure settings
IRAS/REC ID: 13/NW/0558
Sponsor: University of Lancaster
Chief Investigator: Mrs [redacted]

Thank you for submitting your project to the [redacted] NHS Trust's R&D Department. The project has now been given NHS permission for research on behalf of:

Dr [redacted] R & D Director, on behalf of [redacted] NHS Trust

NHS permission for the above research has been granted on the basis described in the application form, study protocol and supporting documentation. The following documents were reviewed:

Document	Version	Date
Protocol	3	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]

[redacted] granted on the understanding that the study is conducted in accordance with the Research Governance Framework, ICH GCP (ONLY if applicable), and NHS Trust policies and procedures available http://www[redacted]rmg.uk/contact-us/freedom-of-information/policies-and-procedures/

The research sponsor or the Chief Investigator, or the local Principal Investigator at a research site, may take appropriate urgent safety measures in order to protect research participants against any immediate hazard to their health or safety. The R&D office should be notified that such measures have been taken. The notification should also include the reasons why the measures were taken and the plan for further action. The R&D Office should be notified within the same time frame of notifying the REC and any other regulatory bodies. All amendments (including changes to the local research team) need to be submitted in accordance with guidance in IRAS.

Please note that the NHS organisation is required to monitor research to ensure compliance with the Research Governance Framework and other legal and regulatory requirements. This is achieved by random audit of research.

Yours Sincerely

[redacted]
Head of Research Management and Governance

Appendix E: NOSA Approval Letter (High Secure Site

NHS
Health Research Authority

National Research Ethics Service

NRES Committee North West - Liverpool East

HRA NRES Centre Manchester
Barlow House
3rd Floor
4 Minshull Street
Manchester
M1 3DZ

Tel: 0161 625 7832
Fax: 0161 625 7299

11 December 2013

Mrs [redacted]
Trainee Clinical Psychologist
Lancashire Care NHS Foundation Trust
C27 Furness College
Lancaster University
Lancaster
LA1 4YG

Dear Mrs [redacted]

Study title:	**The impact of schema therapy on narratives of individuals in secure settings**
REC reference:	**13/NW/0558**
Protocol number:	**n/a**
Amendment number:	**Amendment Number 1**
Amendment date:	**08 November 2013**
IRAS project ID:	**128148**

The above amendment was reviewed by the Sub-Committee in correspondence.

Ethical opinion

Approval was sought to now include both male and female participants in the study.

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-CTIMPs) Amendment Number 1		08 November 2013
Protocol	6	07 October 2013
Responsible Clinician Approval Letter [redacted]	1	07 October 2013
Participant Information Sheet: [redacted]	1	07 October 2013

The members of the Committee who took part in the review are listed on the attached sheet.

R&D approval

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

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 NRES committee members' training days – see details at http://www.hra.nhs.uk/hra-training/

13/NW/0558:	Please quote this number on all correspondence

Yours sincerely

On behalf of
Mrs [redacted]
Chair

E-mail: nrescommittee.northwest-liverpooleast@nhs.net

Enclosures: List of names and professions of members who took part in the review

Copy to: Mrs [redacted]
[redacted] NHS Trust Research & Development Department

[redacted]
Lancaster University

NRES Committee North West - Liverpool East

Attendance at Sub-Committee of the REC meeting

Name	*Profession*	*Capacity*
Mrs [redacted]	Lay member	Lay
Professor [redacted]	Professor of Orthodontics	Expert

Also in attendance:

Name	*Position (or reason for attending)*
Miss [redacted]	REC Manager