EXPECTATIONS AND EXPERIENCES OF PRISONERS WHO ARE ENGAGED IN THE DANGEROUS AND SEVERE PERSONALITY DISORDER TREATMENT PROGRAMME AT HMP WHITEMOOR

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The candidate confirms that the work submitted is her own and that appropriate credit has been given where reference has been made to the work of others.

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ABSTRACT

The aims of this research were to gain a better understanding of dangerous and severe personality disorder (DSPD) from the prisoners' perspective, to explore the expectations and experiences of those engaged in a treatment programme, and to gain an insight into how such individuals perceive their difficulties and the term DSPD. A group of prisoners who met the criteria for DSPD treatment, and who were enrolled at different stages on the Dangerous and Severe Personality Disorder (DSPD) Programme at Her Majesty's Prison (HMP) Whitemoor, were invited to discuss their expectations and experiences of their treatment. This research aimed to generate new theory, grounded in the interview data, and to provide feedback to the DSPD treatment service at HMP Whitemoor.

24 out of a possible 52 prisoners agreed to participate. Interviews were conducted using a semi-structured format. Eight interviews were selected for transcription and detailed analysis using a grounded theory approach.

The following five inter-related conceptual themes were generated to explain the data: Difficulties, Expectations, Experience of the DSPD wing (including treatment), Implications of the term DSPD, and Consent. A conceptual model was generated, which suggests a disparity between participants' expectations and the aims of treatment as described by the DSPD programme. It is hypothesised that as service users gain more experience of the treatment programme, their expectations tend to gradually converge with service objectives. Expectations about treatment outcome were generally high, a fact that is discussed in the context of the voluntary status of these participants. Findings also indicated that participants had a theoretical understanding of personality disorder in terms of their own difficulties, and that the term DSPD was associated with confusion and fear of negative connotations.

Implications, further directions for research and personal reflections on the research process are also discussed.

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LIST OF ABBREVIATIONS

Details are also given in the text the first time abbreviations appear.

APA: American Psychiatric Association

BPD: Borderline Personality Disorder

COREC: Central Office for Research Ethics Committees

D-wing: The Dangerous and Severe Personality Treatment Unit at HMP Whitemoor

DBT: Dialectical Behaviour Treatment

DSM: The Diagnostic and Statistical Manual of Mental Disorders, which is in its fourth and revised edition. It is published by the American Psychiatric Association

DSPD: Dangerous and Severe Personality Disorder (a criteria for treatment on DSPD units –see introduction for further explanation)

GMC: General Medical Council

HMP: Her Majesty's Prison Service

ICD-10: International Classification of Diseases (tenth edition), published by the World Health Organisation

IPDE: International Personality Disorder Examination

MHA: Mental Health Act

NHS: National Health Service

PCLR: Hare's Psychopathy Checklist in its revised form (PCL-R). This is a robust and well-researched instrument, which combines record analysis with a structured interview (Hare, 1991)

R&D: Research and Development

CHAPTER ONE: INTRODUCTION

This study aims to explore prisoners' expectations and experiences of a Dangerous and Severe Personality Disorder (DSPD) treatment wing at the high-security prison HMP Whitemoor, and generate a theoretical model grounded in the data. The findings of this research are intended to help this DSPD treatment service gain an insight into how prisoners who have begun treatment perceive and experience the difficulties associated with personality disorders. An understanding of what prisoners expect from treatment and their experiences of it will clarify whether there is a shared understanding between service provider and service user. There has been much confusion over the term 'DSPD' and this study will address prisoners' understanding of the implications of the term.

In this chapter, the literature relevant to this study is presented with the aim of setting the context of DSPD, personality disorder, and the intervention at the DSPD treatment unit at HMP Whitemoor (D-wing). Recent research regarding treatment issues is then examined, and it is proposed that a systematic explorative study on prisoners' perspectives is conducted.

Background

The Term DSPD

> *"The term Dangerous and Severe Personality Disorder (DSPD) is not a diagnosis, it is a working title used to describe a programme of work to develop better ways of managing the very small number of people with personality disorder who, because of their disorder, also pose a significant risk of serious harm to others."* (Home Office, HMP Service & Department of Health, 2004).

The Home Office, in conjunction with mental health professionals, created the term DSPD. Currently, in order for individuals to be considered for a DSPD programme, they must meet certain criteria. These will be outlined in the section 'The Clinical Population on D-wing'. It is meeting these criteria and the individuals' participation in the DSPD treatment programme that associates participants with the term DSPD. I will refer to DSPD as a 'term' throughout so as not to confuse it with a diagnosis.

The DSPD Programme

Specialist DSPD treatment programmes are being piloted in four high-security sites in the UK: Broadmoor Hospital, HMP Frankland, HMP Whitemoor and Rampton Hospital. These programmes are aimed at dangerous offenders whose violent and/or sexual crimes can be functionally linked to their disorder. Depending on the site at which the individual is being detained, they will either be held in the criminal justice system or under mental health legislation (Home Office, 2003; Home Office et al., 2004). There are currently no DSPD services aimed at women; all references to people being treated in DSPD treatment units in this study are therefore referring to men. The DSPD programme objectives as outlined by the Home Office (2003) are public protection and high-quality services which are both effective and improved in terms of 'outcome'. Currently, in the prison environment, all individuals who are engaged in treatment on DSPD programmes are volunteers. These individuals are prisoners with sentences being served in high-category, secure prisons.

History of the Programme

Part of the impetus for the DSPD programme stems from the limited availability of existing specialist treatment services. At present, there are few established services providing specifically for individuals who have diagnoses of personality disorders and who, because of their disorder, also pose a significant risk of serious harm to others (Bell et al., 2003). Under existing legislation, only those who are considered "treatable" can be detained by the Mental Health Act (MHA) (Department of Health, 1983).

Professionals are in disagreement over the treatability of this group of people, and as a consequence, they have often been excluded from mental health services (Bell et al., 2003; Benjamin, 1997). It is true that evidence as to whether personality disorder can be treated is lacking, and there is a corresponding shortage of current research programmes seeking to find effective treatment for this population (Maden & Tyrer, 2003; Sanislow & McGlashan, 1998). It could be argued that this is often because of the contentious status of the diagnosis of personality disorder, in addition to a poor understanding of the difficulties experienced by this group. As well as the clinical need, the public awareness of this group has grown recently through media coverage (e.g. "*Killer who wanted fame murdered four in random attacks*" (The Guardian newspaper, 2006) and "*Psycho crackdown collapses in chaos*" (The Sun newspaper, 2004). In the last 10 years, the public have been becoming increasingly concerned by the number of *"apparently*

motiveless" violent attacks committed by personality disordered individuals (Maden & Tyrer, 2003).

In response to public concern and the service need, the government published a white paper entitled 'Managing people with dangerous and severe personality disorders' (Department of Health & Home Office, 1999). In this paper, a proposal was put forward to allow for this group of people to be detained and receive treatment under mental health legalisation. The government proposed to provide a specialist DSPD programme, intended to provide effective treatment for this population, while at the same time reducing risk and fulfilling the obligation of the State to protect the public.

The proposals would also allow the detention of those people with personality disorders who are believed to be a risk to others but have not committed an offence. This preventative approach has raised objections and concerns from human rights campaigners, service users, mental health professionals and the expert panel in the House of Lords (e.g. House of Lords & House of Commons, 2005; Mental Health Alliance, 2002; Mind, 2000, 2004).

There have been numerous papers debating the ethical aspects of the proposals, including the lack of clarity about the term DSPD and the removal of the 'treatability clause' (e.g. Applebaum, 2005; Buchanan & Leese, 2001; Farnham & James, 2001; White, 2002). In a systematic review on the detention of people with severe personality disorders, they found that the lack of clarity over the meaning of DSPD may result in six people being detained to prevent one violent act (Buchanan & Leese, 2001). It should be noted that many papers have misused the term DSPD and refer to DSPD as a diagnosis (e.g. White, 2002). Clearly, further research is needed to explore the meaning of this term.

The lack of clarity of the term is further iterated by a survey of forensic psychiatrists' opinions on the subject of DSPD (Haddock, Snowden, Dolan, Parker, & Rees, 2001). This found that psychiatrists worried that their role as doctors may change to allow the detention of individuals purely in the interest of public protection, with no consideration given to possible therapeutic benefit. They argued that this may be in breach of the General Medical Council (GMC) guidelines, which state that care of the patient should be the doctor's primary concern (Haddock et al., 2001).

This contention only holds true if one accepts that no treatment is available to care for this population, and ignores the specialist services this population would be gaining.

The treatability clause present in the 1983 MHA means that individuals cannot be detained under section if they are not deemed medically treatable. There are many arguments about whether personality disorder is treatable or not (e.g. Sanislow & McGlashan, 1998) and there is no consensus as to how to measure or assess treatability (Sainsbury, Krishnan, & Evans, 2004). With regard to people being treated on DSPD programmes, there is no established treatment model that is superior in addressing both the dangerous behaviour and the interpersonal difficulties associated with personality disorder. Treatment models aimed at offenders often neglect the personality disorder and vice versa. No treatment model is able to claim superiority in reducing the risk of dangerous prisoners who have personality disorders (Burke & Hart, 2000). Warren et al. (2003) reviewed studies evaluating the treatment of severe personality disorder. They found the studies hard to compare as they all used different criteria to describe their participants and used different criteria and measurements for outcome. Using descriptive comparisons, they were unable to draw confident conclusions, but noted that the therapeutic community model was showing the most promising results of any treatment modality. This review highlighted the need for all future research to define the population clearly and consistently.

It is important to note that in March 2006, the government announced that it was going to abandon the new proposed MHA, and instead introduce an amendment to the existing act, which would come into force later in 2006. The new bill retains many of the proposed changes to the 1983 MHA. However, with regards to personality disorder, it intends to clarify the 'treatability clause' by replacing it with a wider concept of "appropriate treatment". Appropriate treatment can include basic care (Dillon-Hooper, 2006). This is still a contentious issue and most recent proposed amendments will be subjected to multiple further reviews before the changes come into fruition.

It was felt necessary to outline the history and highlight the political context for DSPD treatment units and reiterate that there is still much debate, confusion and controversy over the existence of such units.

While acknowledging that people in this study are in a DSPD treatment unit and are therefore currently regarded as being 'dangerous', it is beyond the scope of this thesis to debate the issues of risk assessment and public safety. However, this study does address the confusion over the term DSPD and the implications of this, as seen from the perspective of those associated with it.

The remainder of this chapter will continue with a general introduction to the nature of personality disorder and how the literature describes the difficulties experienced by the participants in this study. The aetiology of personality is briefly presented, before describing D-wing's treatment model. The literature review then focuses on recent literature addressing issues affecting treatment, and the questions arising relevant to this current study.

The Nature of Personality Disorder

It is difficult to pinpoint a general definition of personality disorder as it describes a *"wide range of disparate behaviours"* (O'Rourke, Hammond, & Bird, 2003:1). Blackburn (1998) provides a broad definition, including the difficulties and behaviours associated with personality disorder.

> *"... personality disorders are currently defined as enduring patterns of cognition, affectivity, interpersonal behaviour and impulse control that are culturally deviant, pervasive and inflexible, and lead to distress or social impairment."*
> (Blackburn, 1998, cited in O'Rourke et al., 2003:1).

Magnavita (2004) suggests that the categorical classification system used predominantly by psychotherapists in research is the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association (APA). This text is currently in its fourth edition (DSM IV) and has recently been subjected to a revision (DSM-IV-TR). Both these editions define personality disorder as:

> *"An enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment."* (APA, 1994, 2000)

The current DSM-IV-TR describes many sub-types of personality disorder with different extreme and pervasive personality characteristics. Ten official personality disorders are listed (see Appendix One for this listing). The changes in the new edition are that passive-aggressive and depressive personality disorders are now listed as criteria sets for further study in the appendix of the manual. The new edition also includes diagnostic criteria called 'personality disorder not otherwise specified'. This diagnosis is reserved for people who present with symptoms of different personality disorders but do not meet the threshold for a specific one (Siegal, Coolidge, Rosowsky, 2006).

Livesley (2001) uses a comprehensive integrated approach to personality disorder. He argues that alongside 'idiosyncratic features' observable in individual cases, personality disorder involves a number of readily identifiable 'core features' common to all cases and all personality disorders. He described these as:

1. Unstable and poorly integrated representations of self.
2. Problems in self regulation/emotional management.
3. Interpersonal deficits.
4. Fragmented representations of others (page 572).

Bell et al. (2003) inferred that these features or difficulties would interfere with the individual's quality of life.

In the last five years, there has been a preoccupation with 'high-risk patients', and the relationship between personality disorder and dangerous antisocial behaviour. The subject of this thesis is people who have a functional link between their personality disorder and dangerous behaviour. Most people who have personality disorders do not go on to become dangerous offenders. Some estimates suggest that approximately 10% of the general population experience some form of personality disorder, and that personality disorder is present in a third to a half of the adult psychiatric population in the United Kingdom (O'Rourke et al., 2003). The link with dangerous behaviours is that some of the difficulties that people with personality disorders have are likely to contribute to inappropriate or antisocial activity.

Individuals classified as having a dangerous and severe personality disorder are likely to have:

> *"... dysfunctional traits of personality disorder such as impulsivity, hostility, irritability, anger, egocentricity, dependency, lack of empathy, lack of perspective taking, cognitive distortions and relationship problems... they may present with a variety of other clinical problems such as mood disorder, anxiety and post-traumatic stress. Finally, they are likely to present with specific criminal and antisocial behaviour or lifestyles."* (O'Rourke et al., 2003:9)

Prisoners on D-wing have been described in their treatment rationale as having the same range of presentations depicted in this section. This is how D-wing's clinical team describe their problems:

1. They have difficulties with regulating interpersonal relationships and impulse control. They are prone to "*infantile rage*" and emotional outbursts. They want to have the proximity of relationships but find them frightening and confusing. They are likely to have endured some form of persistent neglect or abuse in their past. They present with an increase in addictive and self-destructive behaviour, a tendency to re-enact abuse as victim or perpetrator, an impairment of trust, a lack of sense of responsibility and a lack of identity.
2. They lack understanding of their own feelings and those of others. In most cases they have little access or understanding of most affective states other than anger. They will tend to avoid experiencing negative affect such as sadness or they become fixated on one single emotion that they have developed strategies to manage.
3. They suffer with anxiety and are especially sensitive to any form of change. Change is associated with high anxiety, whether it is a change to their routine or a change in their expected reactions from others (Butler et al., 2006).

In this section, I have attempted to help the reader become familiar with the characteristics of the participants in this study. The next section will go on to explain some of the relevant theory behind how these difficulties can occur, and how this theory underpins the psychological model at HMP Whitemoor.

Aetiology of Personality Disorder

This current research study will explore the difficulties experienced by individuals engaged in a pilot DSPD programme. It is beyond the scope of this thesis to review all the literature regarding the multiple theories of functional and dysfunctional development (for a summary, see Livesley, 2001; Magnavita, 2004). I have therefore selected theories relevant to the participants' experience of D-wing's treatment approach. The aim of this section is to provide an explanation and a context to maladaptive personality development. The theoretical underpinning of the treatment model adopted on D-wing has been used to inform this section.

The following section addresses how early experiences of attachments and trauma can have an impact on our ability to develop adaptive interpersonal skills and regulate emotion. Contributions from neurobiology are referred to in relation to the impact early life experience can have on the developing brain.

Trauma and Personality Disorder

> *"There is little question that traumatic events are strongly implicated in the development of personality dysfunction."* (Magnavita, 2004:17)

Research by Meichenbaum (1994) suggests that exposure to chronic trauma in childhood would predispose an individual to developing abnormal personality pathology. It should not be assumed, however, that all cases of childhood abuse or traumatic events will lead to mental disorders. Paris (2001) has helped clarify this often-misinterpreted relationship, saying that adversities increase the risk of mental disorders, but are not the primary cause of the disorders. He goes on to say: *"Whereas most individuals are resilient to adversity, people who develop clinical symptoms have an underlying vulnerability to the same risk factors."* (Paris, 2001:231).

Paris (2001) reviewed the literature on the association between adversities and mental disorders and found that the main risk factors associated with personality disorders are: (1) dysfunctional families (the effects of parental pathology, family breakdown or pathogenic parenting practices; (2) traumatic experiences (e.g. childhood sexual abuse or physical abuse); and (3) social stressors. Therefore, the experience of trauma plays a significant part in abnormal personality development.

Trauma and abuse however, do not only come in the form of physical or sexual abuse, but also in the form of absence of love or care. Herman (1992) writes:

> *"Repeated trauma in adult life erodes the structure of the personality already formed, but repeated trauma in childhood forms and deforms the personality."* (Page 97)

Early experience of emotional neglect or physical trauma has a particular influence on the development of early attachment relationships. These formative early experiences are what interpersonal relationships in later life are based on.

Psychological literature that deals with attachment relationships (e.g. Bowlby, 1988; Hughes, 1997; Winnicott, 1964) proposes that children need to experience secure attachment relationships in early life. They also need a safe, predictable and containing environment to manage their fear of the unknown and feel secure enough to explore the world. Safe attachments facilitate individuals in developing a positive sense of self, and in the future, having healthy, functional relationships. The absence of this secure environment can result in children growing up with interpersonal difficulties, a negative sense of self and a persistent fear that the world is unpredictable and unsafe.

A psychoanalytic perspective would argue that a certain amount of hurt and pain is inevitable, and in order to survive in the world, we have to be able to tolerate and manage emotional pain (e.g. loss). Being able to bear such pain is necessary for our healthy cognitive and emotional development (Sedlak, 2004). Psychoanalytic literature (e.g. Klein, 1946; Waddell, 1998) proposes that all children will use primitive defences such as projective identification[1] to manage feelings of anxiety and pain they don't understand. It is in the presence of high anxiety, and with the persistent absence of an emotionally containing adult to make sense of the frightening and painful feelings, that the defence strategy can become pathological and maladaptive (Waddell, 1998).

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[1] Projective Identification: Klein (1946) describes the process of projective identification as a defence that arises in the paranoid-schizoid phase of development. Projective Identification is a psychodynamic concept which begins in early infant development. It is an unconscious process developed in infancy to manage feelings that are frightening or painful. During this process, the projector rids himself of bad or unwanted feelings by splitting them off and projecting them into someone else. An emotionally containing adult will validate and make sense of these feelings, making them less frightening and tolerable, and thus they can then be re-integrated into the self of the projector.

The infant might unconsciously feel that he or she is literally fragmenting and falling apart. Where carers are able to help children make sense of their feelings, they are likely to develop a sense of security, of their own internal holding capacity, and of integration. In this way (from a psychoanalytic perspective), a child will grow up with an 'emotional repertoire' for coping with and containing emotional experiences such as transitions and losses in adult life (Sedlak, 2004). For those children whose environment was not meaningful and contained, their defences become maladaptive in adult life and can become part of a pathological personality structure (Steiner, 1993).

There have been well-documented links between the experience of persistent violent trauma and subsequent personality development (e.g. de Zulueta, 1994; van de Kolk, 1996; van de Kolk, McFarlane, & Weisaeth, 1996). van de Kolk (1996) and others (e.g. Flannery, 1999) have contributed to our understanding of the impact that trauma can have on neurological functioning and subsequent personality development. Current thinking suggests that the early experience of trauma (e.g. cases of severe and enduring abuse) is overwhelming to the neurobiological system and that the recurrent trauma results in the 'over excitation' of emotion centres in the brain, such as the limbic system, creating a *"kindling effect"* that results in disorganised and easily triggered intense emotional responses (van de Kolk, 1996). The consequence of this is a lack of emotional regulation (Siegel, 1999, 2001). The impact of early trauma has been associated with the disorganised and intense emotional responses prevalent in the personality-disordered population of this current study.

Siegel's (1999, 2001) integrative theory refers to how early trauma has an effect on a neurological level in terms of the developing mind, and on a social level, in the ability to form healthy attachment relationships, and the development of empathy. He suggests that the effects of unresolved trauma and grief are that they remain at a *"lower order of processing"* (resulting in impulsive, emotionally-driven behaviour), as opposed to higher order, which involves the rational and reflective thought associated with the orbitofrontal region[2]. He suggests that unresolved trauma makes processing at a lower order more likely, more easily triggered and more intense. He also explains that lower-order states are associated with sensitive and excessive emotional reactions, such as terror, shame and humiliation.

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[2] See Siegal (2001) for more details.

This theory goes some way to explaining the *"infantile rage"* and the seemingly uncontrolled extreme emotional reactions associated with this population. He believes that the *"process of resolution"* of the trauma would encourage the mind to integrate higher-order processing, therefore making impulsive lower-order processing less likely (Siegel, 2001:88).

Recent case studies have suggested that the development of adaptive interpersonal skills and emotional regulation requires development of neural networks in the prefrontal region of the brain (e.g. Anderson, Bechara, Damasio, Tranel, & Damasio, 1999)[3]. Cozolino (2002) proposes that these neurological pathways develop not just in early life as previously thought, but continue to change throughout the lifespan. It is thought that *"experiences of secure relationships promote socially adaptive and morally responsible behaviours through the impact of interpersonal relationships on neural structures"* (Butler et al., 2006:4). Schore (2001) and Siegel (1999, 2001) state that there is a dynamic relationship between neurological development and an individual's experience and behaviour, and that each person's neurological make-up will be different, depending on their life experience.

Herman (1992) suggests that it is in the way children adapt to cope with persistent trauma that affects the characteristics of a person in adulthood. The adaptations would have been functional survival strategies within their abusive environment but are maladaptive when attempting to engage with people outside of that environment. The three major forms of adaptations she describes are (1) the elaboration of dissociative defences; (2) fragmenting their identity; and (3) pathologically regulating their emotional states[4]. By implication, these adaptations maintain the individual's proximity to their abusive care givers.

The population of this study all have difficulties with emotional regulation, understanding empathy and forming interpersonal relationships, and they have all been victims and perpetrators of physical or violent abuse. de Zulueta (1994) suggests that at the origin of perpetrator violence lies distress associated with their trauma as a victim.

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[3]Anderson, Bechara, Damasia, Tranet, and Damasio (1999): a case study of two adults. As children, the two cases had lesions in the prefrontal cortex of the brain. In adulthood, they both showed behaviour associated with psychopathy.

[4] Please see Herman (1992) chapter 5 for further details.

She proposes that the dysfunctional behaviours that people with personality disorder adopt can be partly explained as attempts to maintain relationships with others, in the only way they know how. These behaviours are likely to have evolved from unusually adverse childhood relationships. She termed this *"complex attachment disorder"* (de Zulueta, 1994).

The emotional, behavioural and interpersonal difficulties associated with personality disorder and early experiences of trauma often only surface as problems when the person leaves their abusive environment and attempts to survive in society. Despite not having to cope with abusive relationships, personality-disordered individuals tend to prefer to maintain their current style of relating to others, regardless of how dysfunctional this is (Butler et al., 2006). They may also attempt to recreate the abusive relationships they have had in the past (Dunn & Parry, 1997). Abandoning the status quo is extremely anxiety provoking, even if in changing they become more likely to experience healthy relationships (Young, 1994).

In addition, Cognitive-Interpersonal Theory, adapted by Young (1994) for the treatment of personality disorder, provides an explanation for continued maladaptive behaviour associated with personality disorder. Young's schema-focused approach proposes that early life experiences form templates (which he termed schemas) for interpersonal behaviour. He suggests that individuals will cognitively distort information that threatens to contradict their view of the world, their beliefs about themselves, or how they expect to be treated by others, and will actively engage in strategies to protect the validity of their schemas.

So far, I have presented the relevant background theory to personality disorder, the difficulties that characterise the population in this current study and the risk factors that make certain individuals more vulnerable to dysfunctional behaviour associated with personality disorder. Since all participants in this study were engaged in the treatment model on D-wing at the time of interview, the next section describes that treatment model and intervention.

The Integrated Multi-Disciplinary Treatment Model for the DSPD Unit (D-wing) at HMP Whitemoor

The treatment model involves the different yet interacting roles of nursing and uniformed staff, occupational therapy, psychiatry and psychology (Butler et al., 2006). In this section I will briefly introduce D-wing's clinical criteria for inclusion in their programme, the aims of the treatment and a brief description of their model of intervention. This section provides the context for D-wing's treatment.

The Clinical Population on D-wing

For an individual to be considered for inclusion on D-wing's treatment programme, they must be assessed as:

1. Being more likely than not to commit an offence that might be expected to lead to serious physical or psychological harm, from which the victim would find it difficult or impossible to recover.
2. Having a severe personality disorder, as determined by one of the following:
    i) A high psychopathy score, as measured by the PCL-R[5]. Men meeting a high psychopathy criteria are indicated by a score of more than 30.
    ii) A PCL-R score of 25 or more, plus at least one personality disorder (excluding antisocial), according to ICD-10 or DSM-IV criteria.
    iii) Two or more personality disorders (one of which can be antisocial), according to ICD-10 or DSM-IV criteria.
3. Having a link between their personality disorder and previous offence(s) and/or offence-like behaviour in prison.

There must be a functional link established between their dangerous offending behaviour and their clinical diagnosis of personality disorder and/or psychopathy.

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[5] Hare's Psychopathy Checklist in its revised form (PCL-R) is a robust and well-researched instrument, which combines record analysis with a structured interview (Hare, 1991).

At the time of the current research study, 42% of the prisoners were held under security Category A[6], 56% were held under Category B and one prisoner was held under Category C. Their sentences ranged from life sentences (40 of the 52) to eight years. Many of those on life sentences were 'over tariff', which means they were considered too dangerous to release on licence after they had served the minimum time recommended by the judge at their trial. The PCL-R scores range from 23-39.

Aims of Treatment (D-wing)

D-wing is a pilot treatment programme and has not been previously applied to prisoners. The treatment model's aims are:

> *"The treatment targets aim to address the fundamental issues that result in the prisoner maintaining a lifestyle that is both dangerous and distressing to himself and others. Treatment needs to be aimed at both reducing dangerous offending behaviour and modifying the prisoner's personality disorder." (Butler et al., 2006:1)*

These are concurrent with the national DSPD programme aims, which were compiled by the joint Home Office, Department of Health and HM Prison Service initiative. Their published literature states that the aims of the DSPD programme are:

> *"... to protect the public from some of the most dangerous people in society; and to provide appropriate and effective services to improve mental health outcomes, enabling positive progress"* (Home Office, 2003).

Model of Intervention (D-wing)

The model of intervention on D-wing is an integrative approach and comprises multiple therapeutic contacts and a range of different interventions. An overarching cognitive-interpersonal theoretical approach (Livesley, 2001) forms the basic structure for D-wing's therapeutic model.

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[6] Formal definitions of prison security categories in the UK:
Category A: prisoners whose escape would be highly dangerous to the public, police or security of the State, and for whom the aim must be to make escape impossible.
Category B: prisoners who do not need the highest conditions of security but for whom escape must be made very difficult.
Category C: prisoners who cannot be trusted in open conditions but who do not have the ability or resources to make a determined escape attempt.
Category D: prisoners who can reasonably be trusted to serve their sentences in open conditions.

A number of different theoretical interventions (e.g. psychodynamic, behavioural) are also represented and accommodated within the model. In contrast to other DSPD treatment programmes (HMP Frankland, Rampton and Broadmoor hospitals), D-wing emphasises an affective component in its treatment model.

Their treatment model has five key assumptions, which are based largely on the theory outlined in the previous section, *The Aetiology of Personality Disorder*. These assumptions are:

1. To meet the multiple needs of a diverse client group with diffuse problems, who may have varying levels of insight and motivation.
2. It is acknowledged that personality has a survival function. In modifying personality, the treatment will need to support prisoners in finding less dysfunctional survival strategies.
3. Persistent maladaptive behaviour is based on perceptions, expectations or constructions of the characteristics of other people. These tend to be reinforced by the interpersonal consequences of their behaviour.
4. Personality only changes with emotional experience (McCray & Costa, 2003).
5. To treat offending behaviour in those who have themselves experienced trauma requires that the trauma also be treated (de Zulueta, 1994).

The different stages of D-wing's model will now be presented in order show where the participants had reached in terms of their treatment at the time of this study.

D-wing bases its treatment model on five stages. Stages Two to Five have been adapted from Livesley's (2003, 2001) four-stage treatment model for personality disorder, whereby individuals move between stages in treatment termed *"problem recognition"*, *"exploration"*, *"acquisition of alternative behaviours"*, *"consolidation"* and *"generalisation"*[7]. On D-wing, individuals first engage in a preliminary stage (Stage One) of therapy. This is termed 'emotional engagement' and begins when prisoners join the assessment part of the unit, and it continues throughout the initial treatment phase.

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[7] See Livesley, (2001) chapter 28, page 570-600 'Treatment modalities and special issues', where he discusses core features of personality disorder in relation to the principles of the four-stage model of intervention.

Emotional engagement aims to enable the prisoner to establish a therapeutic relationship with the wing. The emphasis of this phase is to provide emotional support and understanding, as well as contain difficult behaviour and provide a safe environment for therapeutic change. The prisoner's personal therapist and personal officer attempt to engage them in more *"emotionally meaningful relationships"* (Butler et al., 2006). Therapeutic work begins in Stage One to formulate the prisoners' difficulties and validate their life experiences.

The treatment model on D-wing envisages that prisoners will eventually be engaged in four psychological interventions a week, but the number will increase gradually Following the assessment and entry to the treatment phase on the unit, all individuals will have access to weekly individual therapy, as well as weekly group cognitive interpersonal therapy. The content of these is flexible and will reflect the stage of treatment the prisoner is at. Prisoners are also encouraged to engage in activities that do not have a therapeutic focus. Movement between stages is led by formulation and individual case discussion by the whole integrated team.

Most of the participants in this study were being treated at Stage One and Two of the model. At this point, they are receiving individual and cognitive interpersonal group therapy, as well as psycho education about their personality disorder diagnosis. Prison officers and nursing staff work on preparing prisoners for treatment, targeting motivational issues and anxiety. The main focus of these stages is to establish a therapeutic alliance with their therapist and personal officer. A number of participants at the time of interview seemed to be working at Stage Three of the model. At this point, they are also engaged in schema-focused therapy groups.

Stage Four involves individuals moving to a more active and challenging level of therapy. Prisoners participate both in the schema-focused group, as well as an affect regulation group. At this stage, the groups begin to challenge prisoners' beliefs and behaviour, while there is also a strong emphasis on using further skills to self-regulate their emotions. At Stage Five, behaviour modification programmes are offered *"to consolidate and strengthen some of the work they have completed within other psychological interventions"* (Butler et al., 2006). As this is the final stage of the model, supportive work is carried out to assist in their transition to another environment.

Issues Affecting Treatment: Recent Research

I have given a detailed account of D-wing's model of intervention to provide a context for what participants in this study should expect from their treatment. It also provides background to the stages of treatment the participants in this study are experiencing. The remaining literature review now focuses on recent research that has addressed issues affecting the treatment of the population in this current study, and how this study proposes to contribute to the existing literature.

DSPD is a relatively new concept and there is little shared understanding of the term. It is a growing field of research and most of the recent studies have been exploratory in nature. I have already explained that there is a paucity of evidence as to which is the most effective treatment model for treating personality disorder. There has been one study by Sainsbury et al. (2004) conducted on the motivating factors that service users consider important for engagement in therapy, while another study investigated the preferences of those being detained in high-security settings under the diagnosis 'psychopathic disorder' (Ryan et al, 2002).

There has been considerable research conducted by Bowers and his colleagues (2005), exploring the attitudes of staff working in high-security therapeutic settings. In addition, Castillo (2000, 2001, 2003) has examined the experience of having a diagnosis of personality disorder in the community. I have divided this part of the literature review into the following sections:

1. The views of service users and staff in personality disorder treatment settings.
2. Service users' experience of the personality disorder diagnosis.

The Views of Service Users and Staff in Personality Disorder Treatment Settings

A recent review by Coffey (2006) on service users' views of forensic mental health emphasised the need for services to hear the views of their patients and clients, as this would help determine the needs of individuals using the services. It would also improve the quality of the service provisions, and the satisfaction levels of those involved. He commented that:

"Mentally disordered offenders are often treated differently from other groups and consequently they experience discrimination and social exclusion, limiting opportunities for recovery and reintegration." (Page 74)

Reasons given for not engaging service users in feedback and service development have been that they lack objectivity and understanding of their own care needs (Coffey, 2006). Both past and more recent research has, however, found that forensic patients, prisoners and mentally disordered individuals are able to offer clear and valuable feedback regarding their perspectives of services (e.g. Sainsbury et al., 2004; Ryan et al., 2002; Hoge et al., 1998).

Coffey's (2006) main findings, were that for much of the research, the methodology used lacked consistency and quality. He concluded that little was known of the perspectives of forensic service users, and the lack of rigorous, transparent and systematic methods of analysis meant that services would not be able to judge the findings of studies reliable. This current research intends to uphold good-quality research practice (Elliott, Fisher, & Rennie, 1999, Henwood & Pidgeon, 2003), providing transparent analysis with examples and a detailed reflective component.

Ryan and colleagues (2002) conducted a study exploring the opinions of detainees in a high-security setting. All their participants were identified as possible residents for a new DSPD unit at Rampton hospital. 61 participants were interviewed, most of whom had experience of being detained in both hospital and prison environments, and they were asked about their preferences for detention. The findings were that when security conditions could not be changed, about half expressed a preference for being detained in a hospital environment, while a quarter favoured a prison environment. Those detainees who preferred the hospital environment felt they could *"soften up more"* in hospital – there were anxieties that prison was intimidating, due to the increased levels of violence and bullying. They anticipated that a prison would not validate their illness, would not be therapeutic, and would be more punitive.

Those who stated a preference for a prison environment said that as well as valuing the privacy of their own space in their own cell, in prison they would have an expected release date and so they would not feel stuck in the psychiatric system.

In terms of factors affecting the experience of treatment, the most valued qualities in staff were being *"caring and understanding"* and having *"experience"* (Ryan et al., 2002:254). This view was shared by a recent study by Sainsbury et al. (2004) on motivating factors for male forensic patients with personality disorder. They found that among other motivating factors, the attributes in staff that they valued were support and the therapeutic relationship. Regarding style of intervention, findings suggested that one-to-one therapy was preferred to group work, and that treatment should be more directive. There were comments about improvements to treatment, such as *"... more in-depth groups, which don't skirt around the issues; personality disordered people need to be confronted"* (page 262). Findings also revealed a wariness of having wards solely consisting of personality disordered patients – most would prefer mixed units (Ryan et al., 2002).

Ryan and his colleagues' (2002) research was the first study to focus on the views of DSPD service users. The method for analysis used was content analysis, which enabled them to study a large data sample. However, they may have compromised on the depth of analysis. Within their clinical implications, they recommended that further, more detailed research was warranted with this population because their interview format yielded only general recommendations. The aim of this current study was to conduct a detailed grounded theory analysis using fewer interviews, with an interview format flexible enough to focus and explore in depth the topics important to the participants.

A more recent qualitative study, conducted by Sainsbury and colleagues (2004) with a forensic and personality-disordered population, investigated motivating factors for engagement in treatment. Their study aimed to develop theory into the broader factors that affect treatability of this client group, with particular emphasis on external motivators, such as the therapeutic environment. Findings indicated that a positive therapeutic relationship, feeling supported by staff and feeling safe – both through practical means, such as security cameras, and through psychological methods, such as feeling contained by confident staff – were motivating factors associated with engagement in therapy.

Most of the categories identified were interpersonal in nature, and included the positive impact of the following: staff providing consistent and repeated understanding with day-to-day problems, and understanding of their anxieties regarding intervention

(particularly group work); feeling genuinely cared for by staff; staff having a persistent and containing therapeutic approach, which enables patients to develop acknowledgement of their difficulties; having an influence on treatment content; and gaining a sense of belonging. Negative motivators included: losing and having to change their one-to-one therapist; feeling that the change process exposed their weaknesses and vulnerabilities; indecision from management; having to wait for treatment; and not understanding the relevance of the assessment.

Sainsbury et al.'s (2004) findings indicate that the staff's interpersonal approach seems crucial to the motivation of this client group for positive experience of treatment and their motivation to engage in treatment. They queried whether the results were reflected in the intervention models adopted when working with personality disorder.
The specific therapeutic model, or content of intervention, was not discussed. Sainsbury et al. highlighted that the different accounts may be explained by the specific difficulties of their participants and concluded that more research of this kind was needed to gain a better understanding of this population.

This current study intends to further our understanding of those in this area, and of the process of treatment for this group. More specifically, it has been explicit regarding the model of treatment and the types of intervention being engaged in at the time of interview. The types of difficulties experienced by the participants are also addressed.

Complementing the research on the importance of the environment and treatability of this population, there has been considerable literature regarding the attitudes of staff working with individuals with personality disorders. Mental health professionals have written extensively on their efforts (e.g. Bowers, 2002; Bowers et al., 2005; Butler et al., 2006; Hinshelwood, 1999). Research has focused on the attitudes of nurses and prison officers working with individuals with personality disorders in hospital and prison settings. Bowers' (2002) hospital-based study found that positive attitudes from nurses correlated positively with the nature in which they managed their own emotional reactions to patients, their understanding of the patients' difficulties, and their own moral commitment to their work. Results from interviews suggested that those nurses who had positive attitudes were able to invest in relationships and expressed respect for their patients (Bowers, 2002). A follow-up longitudinal study was carried out on HMP Whitemoor DSPD unit (Bowers et al., 2005).

The prison-based study (Bowers et al., 2005) revealed many positive change events contributed to the prison officer having a positive attitude to the prisoners. Examples of positive change events were: having interactions with the multidisciplinary team; enjoying the wider therapeutic role of the prison officer; gaining awareness and sympathy for the individual's difficulties; developing relationships with the prisoners; seeing subsequent therapeutic improvements; and seeing changes in prisoner behaviour. Negative events included: struggling to understand the difficulties and behaviour associated with personality disorder; anxiety regarding the different aspects of their role; and receiving disorganised messages from management.

The implication from this research is that for the positive attitudes of prison officers to be maintained, they need to feel that they make a meaningful contribution to the unit, have awareness and sympathy for the difficulties prisoners experience, and have good management, with clear goals and a clear timetable of service delivery.
The studies on nurses' and prison officers' attitudes working with this population revealed that awareness of the individual and understanding of his difficulties, as well as developing a positive therapeutic relationship, contributed to positive attitudes towards this population.

Bowers's (2002) and Bowers et al.'s (2005) research has focused on factors that maintain a positive attitude from staff. This is extremely important since, from the perspective of the service user, it is an important motivating factor for engagement in treatment (Sainsbury et al., 2004), and the therapeutic relationship is of pivotal significance in the treatment model on D-wing. The current study examines the prisoner perspective of a DSPD unit and aims to further the understanding of this population's experience of treatment. The final part of the literature review will concentrate on studies that have focused on the experience of the diagnosis of personality disorder.

Service Users' Experience of the Personality Disorder Diagnosis

There is a limited literature base investigating the experience of having a personality disorder. Current literature has a focus on diagnosis, observable symptomatology and the management of symptoms and risk. How individuals personally describe their experience of being given the diagnosis 'personality disorder', or their understanding of what the disorder means, or the difficulties associated with it, are issues that are sparsely addressed in psychological literature.

In her Dialectical Behaviour Treatment (DBT) manual for borderline personality disordered (BPD) patients, Linehan (1993a, 1993b) stresses that labelling an individual's difficulties with a diagnosis is a validating experience. Her studies emphasise treatment success in terms of a reduction of symptoms over a period of two years. To date, she has not measured the experience of the 'validation' she claims patients feel on being given a tangible label.

Lewis and Appleby (1988), in their study 'The Patients Psychiatrists Dislike', found that psychiatrists viewed this population as difficult, annoying, manipulative, attention seeking, in control of their suicidal urges and less deserving of care. They concluded that personality disorder was less a diagnosis and more of a pejorative judgment. Castillo (2000, 2001, 2003) conducted the only research exploring users' views regarding the diagnosis of personality disorder from their own perspective. In her paper 'Temperament or trauma?' (2000), she addresses service users' views regarding the diagnosis of personality disorder. Out of 50 participants, 20 were men and 30 were women. 14 had a diagnosis of dissocial personality disorder, 27 had a diagnosis of borderline personality disorder, and the remaining nine had unspecified personality disorder. When participants were asked what personality disorder meant, Castillo reported that 26% said they did not know, 22 % said it was a label you get when they don't know what to do, 18% described mood swings or personality change (*"Jekyll and Hyde"*), and 10% described (*"life sentence-untreatable-no hope"*). Other responses included identity (*"I don't know who I am"*); developmental difficulties (*"I didn't develop emotionally as a child"*) self-destructive tendencies, relationship difficulties, and dissociation (*"My mind and body are separate"*, *"I'm angry and disappointed and not able to cope"*) (2000:55).

Castillo's research allowed users to describe their diagnosis, and findings indicated that it felt like being categorised as having enduring, inflexible and undesirable character traits. Her participants interpreted the diagnosis as 'untreatability', and as a result, they describe a sense of hopelessness. They reported feeling *"tarred with a brush of being bad as well as mad"* (2000:55), as well as feeling like outcasts. Many described a sense of alienation and reported a stigma associated with the diagnosis, from both professionals and society as a whole.

Castillo (2000, 2001, 2003) reported on the participants feelings about professionals working in the field of personality disorder, in particular the professionals who used derogatory terminology to describe service users' coping strategies, such as *"attention seeking"*. Many interpreted this as 'not deserving of attention', and participants felt that their behaviour was categorised by professionals, and little attention was paid to why it was so. Many of the service users offered explanations for their behaviour, relating to early trauma; however, few felt they were receiving any validation or treatment in how to deal with this. 50% of the men in their study had a diagnosis of antisocial personality disorder and felt that their condition resulted in a 'Jekyll and Hyde' phenomenon, which embodied both compassion and aggression. They stated that their aggression had a context.

Castillo (2000) listed many implications for practice, including how professionals may appear to this population and the need for patients to be understood and treated as individuals. In order for this population to be better understood, there is a need for more research asking how they understand their difficulties in context (2000: 55).

Assuming that a personality disorder label is largely a negative experience, to have the word 'dangerous' added to it may infer even more negative feeling and be experienced as potentially more stigmatising. As such, there may be both positive and negative attributions associated with the term DSPD.

The Current Study

This study uses a qualitative research approach to explore the expectations and experiences of individuals receiving treatment on the DSPD programme at HMP Whitemoor. It is concerned with individuals' own perspectives of their difficulties and the intervention they volunteered to engage in, as well as prisoners' own understanding of the term DSPD and what they see as the implications of treatment. The following section explains the rationale for the research, followed by details of the aims and hypothesis. As is common with qualitative research, there is no specific hypothesis: instead, a broad range of aims are set in order to explore flexibly and in detail an area of interest, with the intention to generate further questions and theory.

The Rationale

The clinical team on D-wing have a carefully thought-out theoretical model for the pilot treatment programme at HMP Whitemoor. However, there has been little published on the perspectives of prisoners engaged in treatment programmes for personality disorder in high-security settings. As Coffey (2006) concluded in his literature review on service user views: *"We still know relatively little of the experience and perspectives of people who use forensic mental health services"* (page 73). An objective of this study is to give the clinical and wider team an insight into how a population in the programme perceive their difficulties and their experience of treatment.

There is a lack of research in this area, mainly because it is such a new clinical field, the practical and ethical problems involved in interviewing people in prisons may also have an influence. In the clinical implications of their studies, Sainsbury et al. (2004) and Ryan et al. (2002) have both commented on the ability of personality-disordered offenders to be interviewed, and give clear views on their experiences of treatment and services. They recommended that more research should be conducted by interviewing the service users themselves.

Research Aims

The aims of this study were:

1. To hear the views of those receiving treatment at the DSPD unit in HMP Whitemoor in order to gain a better understanding of this population.
2. To explore the experiences and expectations of those receiving treatment at Whitemoor DSPD unit and generate theory that is grounded in the data.
3. To provide feedback to the service (D-wing) regarding what prisoners expect from treatment, how the prisoners on the unit perceive their difficulties, and their experience of treatment.

Initially, I expected participants to talk about their understanding of the term DSPD and how being on the unit would affect them in the future. Participants, however, spoke at length about their expectations of treatment, including their anxieties, personal difficulties and experiences of life on D-wing. Participants' perceived implications of spending time on D-wing were also discussed. I was not expecting them to disclose so eloquently details of their difficulties and treatment to a researcher they did not know well.

As this research aimed to report on the views and experiences of the participants, it was felt appropriate to allow the interviews to develop in order to explore the subjects that prisoners wanted to talk about.

Summary of chapter

The introduction has presented the DSPD programme and the relevant developmental theory of personality disorder. The intervention that the participants in this study are engaged in has been described. More specific research has been presented and the rationale for this research outlined. The next chapter will present the method and analysis of the research.

CHAPTER TWO: METHOD

The following chapter will present the qualitative approach to investigation. My position as the author is introduced. The design of the study will be detailed including a description of the participants and the structured interview, plus a brief introduction to grounded theory as the qualitative method of analysis. Issues of quality and good practice are outlined. The final sections document the procedure of the study, including a consideration of ethical and safety issues, details of the interview process, selection of interviews for analysis, the analytic process and validation.

The Approach

Qualitative Methodology

One of the main aims of this study was to explore the subjective experiences of men who are receiving psychological treatment in a DSPD unit in the context of their environment. The views of this population have tended to be under-represented in published research. My interest lay in capturing the understanding and emotional experiences of those who decided to engage in a pilot treatment suited to their difficulties. I wanted to adopt a qualitative approach to explore this population's experiences and perspectives.

The aim of qualitative research is to explore subjective meaning and experience from the participant's perspective. *"It can 'give voice' to those whose accounts tend to be marginalized or discounted"* (Willig, 2001:12). It is also very effective in reporting on how a group feels about a particular experience. Elliott et al. (1999) summarised the purpose of qualitative research:

> *"The aim of qualitative research is to understand and represent the experiences and actions of people as they encounter, engage and live through situations. In qualitative research, the researcher attempts to develop understandings of the phenomena under study, based as much as possible on the perspective of those being studied."* (Page 216)

There are numerous qualitative approaches adopted in psychological research. Stiles (1993) has reviewed common features that characterise qualitative research on human

experience. He describes these investigations as reporting collected data linguistically rather than empirically, that researchers use personal interpretation, including pre-theoretical knowledge (Rosenwald, 1986) and empathy in reporting and understanding results (Stiles, 1992). They are described and reported in context, with explicit acknowledgement of the personal histories of both participant and investigator, as well as the setting of the observation (Mishler, 1979, 1986; Waitzkin, 1990).

Qualitative methods are frequently compared with quantitative methods, creating the impression for some observers that the two methods are in some way competing with one another (Silverman, 2000). There are different epistemological positions (theories of knowledge) associated with the two broad categories, but they usually address different types of research problems. Some of the strengths of quantitative methods lie in hypothesis testing, standardising test scores, establishing the reliability and validity of psychometric testing, and generalising broad trends in behaviour. Researchers employing these methods will utilise statistical methodology to quantify and explain the significance of their results. Quantitative methods generally hold a realist position (Guba & Lincoln, 1994). In its purest form, it is assumed that true knowledge exists, and that it can be quantified and rationalised (Henwood & Pidgeon, 1992). In contrast, qualitative research methodology does not attempt to search for objective truth, and most approaches adopt philosophically a broadly 'interpretive' or contextual constructivist stance: *"... it concerns itself with how the social world is interpreted, understood, experienced, produced or constituted"* (Mason, 2004:3).

For the purpose of this study, I will be talking an interpretive stance. This position acknowledges that there is a relationship between participant and investigator, and that what participants say is contextual. For example, participants may be motivated by wanting to be seen in a certain light by the interviewer, or that the male prisoners interviewed may have selected the experiences they chose to talk about based on their level of comfort with a female interviewer. I understand that I am being subjective, and that my experience and beliefs will have a part to play in informing the analysis.

I therefore considered my personal reflections and the records of my reactions during the design, data collection, analysis and interpretation of results (also see the sections on issues of quality and analytic procedure). I will now introduce myself as the researcher of this study to inform the reader of my position within the research.

The Researcher

As I have already declared, I am adopting an interpretive stance in this study (Charmaz, 2006; Henwood & Pidgeon, 1992). My position in the research is acknowledged from the start to enable the reader to gather the context for my analysis.

My interest in forensic psychology began while working in a hostel for male ex-offenders who were considered high risk after leaving prison on licence. At the time, I was fascinated by the different lives these men had experienced, and being saddened when several of them seemed unable to survive in the world outside prison, knowing they would re-offend and return. More recently, I learnt about the term DSPD when I carried out a joint piece of research commissioned by the clinical team on D-wing at HMP Whitemoor. This was a qualitative piece of work specifically evaluating the cognitive interpersonal group that formed part of the therapy programme on the wing. As a result, I had met several prisoners on D-wing before. However, when undertaking this study, I did not interview anyone who I had interviewed previously.

My background is in psychology, and this thesis forms part of my doctorate in clinical psychology. I have worked with a variety of clinical models. More specifically, my final placement involved working with children who had attachment difficulties, and I completed an elective teaching module in psychodynamic psychotherapy. My existing theoretical knowledge and clinical experience will inform my interpretation of the data.

I believe that I have been open-minded and have approached this research without strong personal or political bias, although I should declare that I am sympathetic to the difficult lives that all of the participants in my study have had.

The Design

Design Overview

All prisoners on D-wing were invited to participate in this qualitative study. 24 volunteer participants were interviewed on site, using a prepared semi-structured interview. These interviews lasted no more than 55 minutes. Eight interviews were then strategically selected and transcribed for analysis using grounded theory methods. With reference to maintaining the quality of the research throughout the study, a reflexive and transparent approach, among other good practice guidelines proposed by Elliott et al. (1999), Henwood and Pidgeon (1992) and Yardley (2000) were adopted.

Participants

Participants were recruited from D-wing at HMP Whitemoor, and all met the criteria for treatment on the wing (see Introduction). D-wing at Whitemoor is separated into Blue, Green and Red Spurs (similar to self-contained hospital wards). Prisoners from each spur are at different stages of assessment or treatment, and they rarely mix. Prisoners are assessed for DSPD criteria and suitability for treatment on Red Spur. Blue Spur is the longest-running treatment spur – it first began treating prisoners in 2001 – while Green Spur is the second treatment spur and has been open since 2004.

The pilot participant who volunteered to be interviewed was initially on Red Spur, but resided on Green Spur when the main interviews began. All Green and Blue Spur prisoners were sent a letter of invitation and a participant information sheet (see Appendix Two). At the time of invitation, there were 52 prisoners engaged in the programme. 24 prisoners agreed to take part in the study and all 24 volunteers were interviewed (the pilot participant was interviewed on two occasions, giving twenty five interview transcripts). From the interviews, eight were selected for transcription and analysis (to be discussed later in this chapter).

Semi-structured Interviews

This study used a semi-structured interview format (Smith, 1995). This allowed the researcher to use prepared questions to guide the interview, but at the same time to allow flexibility in gaining a detailed picture of a respondent's beliefs about, or perceptions of, a particular topic. As has been discussed, the prisoners on D-wing at HMP Whitemoor are considered high risk. This is a factor that had to be considered when thinking about how to collect meaningful data. Bearing in mind that participating in the interview may have raised prisoners' anxiety levels, it was decided that using an interview schedule would provide some structure and allow the interviewer to move the interview forward, or skip over questions, should the need arise.

A copy of the semi-structured interview can be seen in Appendix Two. It was developed through consultation with the head of psychological therapy on D-wing (Consultant Clinical and Forensic Psychologist), my academic supervisor, and through role-play between myself and another trainee psychologist conducting her thesis using semi-structured interviews. I also tested the interview schedule with a pilot participant on the assessment spur (Red Spur). General topics did not change through the development of

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the interview script. However, subtle wording was altered when it was thought that there might be a risk that the emphasis of the question could be misunderstood. Questions covered topics such as the participant's feelings about coming onto D-wing, their experiences of life on the wing, as well as their experience of therapeutic intervention. I asked questions about the term DSPD and how they felt their treatment would affect them in the future.

During the course of the interviews, the questions did not alter. However, more time was spent exploring the participants' difficulties and experiences on the wing than expected, since participants had less to say on their understanding of the term DSPD. The style of interviewing allowed for this change in emphasis.

Grounded Theory Method of Analysis

Grounded theory uses a systematic method to collect, synthesise, analyse, and conceptualise qualitative data, with the aim to construct theory (Charmaz, 2001). It allows the investigator to observe, interact with and interpret material gathered about a topic of research (Charmaz, 2006). *"... grounded theory methods consist of systematic yet flexible guidelines for collecting and analyzing qualitative data to construct theories 'grounded' in the data themselves"* (Charmaz, 2006:2).

The aim with this approach is to begin with rich qualitative data, and through the process of systematic analysis, finish with a number of themes and lower-order categories and subcategories. These themes and the relationships between them illustrate my interpretation of the data. I aim to tell a story within and between each theme, and this process thus provides theory that is based on – or grounded in – the data.

Grounded theory was initially developed by sociologists Glaser and Strauss (1967). Glaser emphasised that the predominant strength of this method was that the researcher was not trying to force their data into preconceived categories based on their own assumptions (e.g. the significance of demographic variables) before beginning the data collection. Charmaz (2006), on the other hand, accepts that the investigator is part of the world we are studying and therefore our reflections and reactions are important and should be considered to be part of the process. Different grounded theorists adopt different styles of data collection. For example, Glaser (1995) advocates not

transcribing interviews, while others, such as Charmaz (1983, 1990, 1995, 2003, 2006) and Henwood and Pidgeon (1992), value the transcribed text.

This study used a grounded theory approach to analyse and interpret the data from the semi-structured interviews. The systematic process of analysis proposed by Charmaz (1995, 2000, 2001, 2003, 2006) was adopted for this task. The stages of analysis with examples used in this study are further illustrated in this chapter under the heading Procedure Part III (Analysis).

Issues of Quality

There are no methodological criteria capable of guaranteeing the absolute accuracy of research. A number of good practice guidelines have been suggested by qualitative researchers, such as Elliott et al. (1999), Henwood and Pidgeon (1992), Silverman (2000) and Yardley (2000). These can be used to guide the progress of the study and its ultimate evaluation by researchers and their peers (Henwood & Pidgeon, 1992). The main good practice guidelines are as follows:

1. Sensitivity to context (Yardley, 2000). This refers to the researcher having awareness of previous theories and research in the area of study. This study incorporates a relevant literature review of past research and refers to existing psychological theory to discuss the results of the study.
2. Owning one's own perspective (Elliott et al., 1999) and being transparent (Yardley, 2000) in the research process are crucial components for all qualitative research. This is the communication of the researcher's values and assumptions, and decision-making processes. It is helpful for reviewers and readers of the research to understand how the researcher interpreted their data (Elliott et al., 1999; Yardley, 2000). Henwood & Pidgeon (1992) termed this 'reflexivity' and, as they suggested, I documented my reflections throughout the research as memos. I also declared my position in terms of this research earlier in this chapter.
3. Documentation (Henwood & Pidgeon, 1992) and grounding in examples (Elliott et al., 1999) are necessary for both the researchers and evaluators to see the process from analysis to theory. Thorough documentation was kept throughout this study and examples from my process notes, memos and other analytical notes and diagrams will be reported throughout the analysis section of this

chapter, as well as the examples given throughout the narratives in the Results section.

4. Being 'sensitive to negotiated realities' (Henwood & Pidgeon, 1992). This concept refers to the possibility that the researcher and the participant may not share the same understanding as each other. According to Henwood and Pidgeon (1992), the researcher should validate their interpretations by checking them during the process of interviewing. Also see the section on Interview Processes.
5. Internal consistency (Stiles, 1993) refers to methods in which the researcher aims to achieve a greater level of coherence and internal consistency in their analysis and interpretations. In this study, the researcher attended an organised qualitative research support group, where researchers coded sections of each other's data and discussed any discrepancies in interpretations.
6. Transferability refers to the extent to which you can apply the findings of one study to similar contexts, or other similar studies. Henwood & Pidgeon (1992) place great importance on reporting and documenting the contextual features of the study, bearing in mind the risk of treating the context as an adjunct theory which is contextually sensitive to abstraction (Jaeger & Rosnow, 1988). In this study, this refers to having awareness of the prison environment where data is being collected. This will be referred to during the Data Collection, Results and Discussion sections of this report.
7. Sampling methods are used to ensure that the data represents a broad spectrum of views and experiences from participants (Silverman, 2000). These include theoretical and purposeful sampling. Where purposeful sampling refers to choosing a case to analyse deliberately because it illustrates a feature or process relevant to the topic of investigation (i.e. the initial decision to interview prisoners on D-wing), theoretical sampling involves choosing cases relevant to the emerging theory, and choosing negative cases that oppose any emerging theory. In this study, for practical reasons, all cases were selected on the initial notes and memory of the interview process. In the section on 'Selection of interviews for analysis', I have clearly outlined criteria for inclusion in the study, where I gathered as many different views and reported experiences as possible.

Summary of the Design

The aim of the study was to explore the experiences of those receiving treatment on a DSPD treatment unit in a high-security prison in order to gain insight into these experiences from the point of view of those residing on the unit. The study explored the anxieties and experiences of those on such a wing at HMP Whitemoor. This aim was addressed by interviewing volunteer participants using a flexible, semi-structured interview, and subsequently analysed using a grounded theory approach suggested by Charmaz (1990, 1995, 2000, 2001, 2003, 2006).

Procedure: Part I (Collecting the Data)

Ethical Consideration and Confidentiality

This research was submitted to the following committees for ethical approval: The Central Office for Research Ethics Committees COREC, the Cambridge and Peterborough NHS Research and Development (R&D) committee, Whitemoor Prison Ethics committee, and the R&D committee set up by the Home Office to monitor and co-ordinate all research being conducted in the UK into DSPD. All committees approved the research, which was designed in line with British Psychological Society guidelines. (For a copy of the documentation, please refer to Appendix Three.)

The study was introduced to prison and clinical staff on D-wing through a presentation that outlined the aims of the research and explained how the results would be fed back to the team. Time was also spent discussing the implications that the research might have, such as unintentional disruption to the wing routine, the request for flexible prison staff to provide security support during the interviews, and preparing for questions about the research that may be asked by prisoners on the wing. Prison staff spent time discussing how best to help me proceed with the interviews, and there was a positive and helpful reception from all prison staff. Information sheets were given to all D-wing staff summarising the aims and procedure of the research (see Appendix Two).

The ethical procedure demanded that all volunteer interviewees were given the opportunity to be interviewed. Before these interviews began, each volunteer read the participant information sheet and signed a consent form, on the understanding that they could withdraw their consent at any time (see Appendix Two). I was available to answer any questions about the research and the interview procedure. Participants were given

the opportunity to have a member of the prison staff present during the interview; this was taken up by only one participant. All interviews were conducted on the prison wing and recorded on tape. Only myself, my academic supervisor and a professional transcriber heard the interview tape. It was agreed that the tapes would be destroyed by December 2007.

Individual participants are not identifiable in this report. Audio tapes of the interviews and the typed transcriptions were kept anonymous. During analysis and reporting of the results, each research participant was referred to by number only. To protect the identity of the volunteers, only general descriptions are given in the section Selected Participants.

The Interview Process

All staff on D-wing were helpful and supportive in making sure that the interviews ran smoothly. Clinical staff organised timetables for the interviews, to avoid clashes with any other organised activity or therapy session. Informed uniformed staff managed the prisoners' excitement and anxiety that was caused by my presence on the wing. Staff were able to answer questions from prisoners regarding the interviews. The interviews were disrupted on two occasions due to a prison lockdown, where prisoners had to return to their cells to be counted. Prison wings are noisy, and at times the interviews were interrupted by loud shouts and door slamming on the wing.

The staff on D-wing wanted the interviews to occur over a short space of time to minimise the disruption to the prisoners' normal routine. All interviews were conducted over the space of two weeks in December 2005. The interview questions themselves did not change significantly during this time, and all interviews lasted no more than 55 minutes. Overall, participants spent more time talking about their difficulties, expectations and experiences than about their understanding of the term DSPD.

The length of time spent exploring the different topics varied between participants. For example, those on Blue Spur wanted to talk more about their day-to-day life on the wing and less about their expectations. This was probably because they had been resident on the wing longer than those on green spur, and their initial expectations were not so prominent in their minds. The flexibility of the interview format allowed for this.
On the issue of quality and in accordance with Yardley (2000), concerns with 'transparency' and what Henwood and Pidgeon (1992) referred to as 'reflexivity',

I made notes after each interview. These incorporated how I felt in terms of both my vitality and that of the participants. I also recorded how at ease I thought the participant felt, the general topics discussed, and how I felt in terms of the relationship with the participant. For an example, see Process of Analysis in this chapter.

Henwood and Pidgeon (1992) also advise that it is good practice to be 'sensitive to negotiated realities', and during the interview I made sure that when I was unclear about the meaning of what a participant was saying, I would check this with that participant. For example, in the first interview with the pilot participant:

> Participant: *"I don't fare well in group work, 'cause I end up rolling around the floor with people because I can't take on board..."*
> Interviewer: *"What do you mean, rolling around on the floor with people?"*
> Participant: "*Fighting.*"

I initially thought he was metaphorically rolling around, when he meant physically. Clarifying a shared understanding was also important as prisoners would use a lot of prison terminology and language that was unfamiliar to me.

Procedure: Part II (Selection)

Selection of Interviews for Transcription and Analysis

Ethical clearance demanded that all prisoners on D-wing were invited to be interviewed. It was not expected that I would have more than 10 participants. However, 24 prisoners were interviewed (this included the pilot participant). This research was limited by the time restraints and resources available to the clinical psychology doctorate thesis. It was considered that eight interviews would be needed for transcription and detailed analysis. After selection using the criteria below, there were a number of 'spare' interviews, which were put to one side to allow for further transcription, should more interview data be needed to saturate the emerging themes and categories. The pilot interview as well as a follow up interview with this participant were also included in the selection.

1. The aim was to collect data from prisoners who were at different stages of their treatment at HMP Whitemoor. It was expected that I would get a higher uptake of participants from Green Spur than Blue Spur as the clinical team on the wing thought that those on Green Spur tended not to feel comfortable with the amount

of time between structured therapy. 15 participants from Green Spur were interviewed and nine participants from Blue Spur.

2. The interviews had to be clear enough to transcribe and it seemed that some participants found the process quite difficult and uncomfortable, and they spoke very quietly. I thought this would make transcription difficult. Some participants spoke with a strong regional accent, as well as mumbling. The quality of the recording would have made such interviews hard to transcribe. The two most difficult interviews to understand were excluded from the study As long as the transcriber could accurately transcribe, an interview was considered for selection.
3. I remember that some interviews felt difficult. By this I mean it was hard to engage the participant in the interview process, and he may have given one-word answers. In two cases, I found the interview unpleasant. There were a few instances where I felt that the participant was changing the agenda of the interview and this resulted in the interviewer feeling intimidated or uncomfortable. An ideal situation would have been for a different researcher to do the analysis of these interviews, to avoid further distress. For ethical reasons in this study, such interviews were not transcribed or used in the analysis. I appreciate that it can be in the nature of this population for interpersonal interactions to be difficult and this is a limitation of this research. I must note, however, that only two out of the 24 participants were excluded for this reason.
4. One participant who agreed to be interviewed later felt anxious about the content of the interview (up to 10 days after). This participant was excluded from the study. No participants stated that they wanted to withdraw their consent. Those who found the interview difficult because they had a learning difficulty and could not read – they had the consent form and participant information sheet read to them – were also excluded to avoid any risk of future complications for this research. Only one participant met this exclusion criterion.
5. Exclusion criteria were used when I felt that other interviews covered the same material to a greater degree, or that a large amount of the content of the interview may have put the participant's identity at risk.
6. Participants were selected so as not to exclude any key features of the population on D-wing, whilst maintaining a selection which was broadly representative of the population as a whole. Indicators of difference were used to deliberately include participants such as: a range of PCL-R scores, a range of personality disorder diagnosis as measured by the IPDE, index offences and ethnicity.

The interviews I chose for this study I believed to be good examples, with a range of opinions (positive, negative and balanced), and a range of ways used to express opinions (having an officer present, using role-play, being confident and assertive or being anxious and reserved).

Description of Participants Selected for Analysis

In order not to include any potentially identifying information on the participants, a brief description of the seven selected participants is included here.

All participants met the DSPD criteria. They were all male and aged between 32 and 52. Six were Caucasian, with one Black British. Three of the participants were Category A prisoners, while the others were Category B prisoners. Participants' prison terms ranged from life sentences (six participants) to a determinant sentence of eight years (one participant). Many of those on life sentences were 'over tariff', which means they were considered too dangerous to release on licence after they had served the minimum time recommended by the judge at their trial. Their offences were all violent and/or sexual in nature, and included rape, murder and assault. All participants presented with complex interpersonal problems associated with the characteristics of more than two personality disorders, as measured by the International Personality Disorder Examination (IPDE). Participants had been diagnosed with a broad range of personality disorders, including antisocial, borderline, narcissistic and schizoid. Their Psychopathy scores (as rated by the PCLR, Hare, 1991) ranged from 24-37. At the time of interview, four participants had been engaged in treatment for approximately one to two years and the remaining three for approximately two to three years.

Transcription

Transcription of the selected interviews was shared equally between myself and a professional transcriber. A list of transcription conventions used are available in Appendix Four (Turnball, 2003). I checked the professionally transcribed interviews by listening to the interview tapes and reading the script. This enabled me to re-familiarise myself with the tone and content of the interviews, and check for accuracy. Any initial thoughts were made in the margin of the script. For example, if I thought the interviewee felt anxious and as a result I deliberately moved the interview on, I made a note of this.

Procedure: Part III (Data Analysis)

First I will outline the methodological steps taken, from initial coding towards deeper analysis and development of theory. I will then describe in more detail some of the methods used during the more complex phases of analysis.

Analytical Steps

It must be noted that the process of analysis was not a linear one, with memos providing the main route through the earlier steps in order to investigate and develop newly emerging ideas. However, the analysis can be summarised by the following steps:

1. Initial line-by-line coding of all transcripts was conducted. Each line of transcribed text was given an individual, descriptive code, which concisely defined that line of text in the context it was said.
2. Detailed analysis began initially for five of the transcripts (the first five to be transcribed).
3. Focused coding: the most significant/frequent initial codes were selected and refined, synthesising larger sections of text and highlighting emerging themes.
4. Focused codes were raised to conceptual categories. Comparison of the focused codes revealed which ones best described what was happening in the data. Each resulting 'theme' required a narrative description clarifying its form, content and relationship to other themes.
5. Diagramming was used to help with initial theme formation.

The analysis above was repeated for the remaining three transcripts. Both sets of data were integrated using the following methods.

1. Clustering was used to visually scatter thoughts, focused codes and categories that made up a theme on a page. Ideas could be visually moved around and links made in order to help group, formulate and organise the story within a category (an example is given in this section).
2. Diagramming is a development of clustering. It is a tool used to visually organise my thoughts and to see the direction the categories are going within and between themes (an example is given in this section).

3. Memo writing: memos provided prompts to elaborate processes, assumptions and actions covered by the conceptual categories. They also served as a record of the sequence of thinking that had been made when developing and refining the categories.
4. Constant comparison involves comparing codes and categories. Examples from the text would be compared within the same interview transcript and across to examples from other interviews. The names of the categories would be frequently revised in order to ensure that they remained close to the concept they were describing.
5. Category saturation: this was reached when no new information regarding the themes and categories was found in the data. At this stage, no further transcripts needed to be analysed (Strauss & Corbin, 1998).

Process of Analysis

Reflections

Thoughts and feelings about the data were recorded as memos. These were made throughout data collection and analysis. An example of such a memo is given here from a reflection made straight after interviewing participant 5.

> *"Participant seemed incredibly anxious throughout the interview – he was physically shaking all over (visible through his clothes). His speech was shortened and he spoke quietly. At times I moved the interview on quite quickly when his anxiety levels raised further. The participant's body language was remarkably clear – his body was almost facing the other way from me, and his eyes would look around intermittently to give me some eye contact. His chair moved slowly further away from me so he was almost backed in to the corner of the room by the end of the interview. I attempted to help the participant become more at ease, saying that he could leave whenever he had had enough and that he did not have to give an explanation etc... [verbally]. Considering his obvious levels of anxiety, the interviewer was surprised that he had volunteered to participate and was impressed that he managed to control his anxiety levels enough to tolerate this interview process."*

Memos and reflections were considered in writing the narratives and informed the more reflective elements of the results section.

Coding

The process of coding was made using the software package Excel. Each transcript was imported into a spreadsheet, with columns for each stage of coding and space for making initial memos (an example can be found in Appendix Five). The first stage of coding involved giving each line of transcript a descriptive code to concisely define the line of text. As an example, eight lines of transcript from the interview with the pilot participant – interview one (ppi) – are included below:

Text line number	*Text from transcript*	*Line-by-line code*
61	*and that's not what I'm looking for, because group therapy, although*	*Not looking for group therapy*
62	*it is run by the inmates, erm, if you don't or if you're not initially*	*Group therapy is run by inmates*
63	*straight with the inmates, erm, then there are a lot of things that you*	*You can choose not to be initially open with inmates*
64	*can hide and there's a lot of things that you can mask. Whereas one-to-*	*You can choose to hide from inmates*
65	*ones, the clinicians here have got it so that, it's all there, everything*	*Perceives clinicians as seeing through mask*
66	*about you, it's there, it's in black and white and you can't get away from*	*Perceives clinicians as having his history in print*
67	*it. And when they ask the questions and they want an answer you've got*	*Perceives having to answer truthfully to clinicians*
68	*no choice but to answer, that no matter how, how, harrowing or hard it*	*Perceives no choice; hard and harrowing experience*

Table 1: Extract from pilot participant (interview I) transcript with line-by-line coding

These line-by-line codes were then raised to focus codes. Here, sections or blocks of transcript were synthesised by the most relevant initial line-by-line codes. Essentially, this process reduced the text into manageable sections.

Using the example above, the eight initial lines of text were synthesised into three focused codes: 'You can choose not to be initially open with inmates', 'Perceives clinicians as seeing through mask' and 'Perceives it being harrowing having to answer truthfully to clinicians.'

Broad topics began to emerge from these focus codes and questions were asked and noted as memos. Again, in the same example, a memo was made: "Is his understanding of the treatment here based on his past experience of therapy?"

Sections of text were then examined individually and given broader initial theme names. To follow this example, the section of transcript was originally given the theme name 'Understanding of DSPD treatment'. When possible links to other emerging themes were made, a link was noted. In this example, there was a tentative link made to an initial theme, 'Past experience of therapy'. It was only tentative as it was not explicit.

This process was frequently repeated as the emerging themes developed. Names of the themes would change repeatedly to make sure that they represented what was being incorporated in that theme. A process of constant comparison (Madill, Jordan, & Shirley, 2000) occurred where codes and themes were compared to one another. Examples from the text would be compared within the same interview transcript and across to other examples from other interviews.

Clustering

A number of methods were used to establish categories and subcategories within themes. A clustering approach was used for the development of categories within the theme 'Expectations', with phrases based on the focused codes and the relevant issues for that theme clustered together into groups relating to similar topics. These groups then formed the initial categories within the themes. The groupings were rearranged several times to find the groupings which best reflected the data.

The first set of categories that were formed, while not dissimilar to the final categories, were felt to reflect an interpretation of what the participants had said, rather than taking their comments at face value, and the clustering process was useful in highlighting any bias that may have occurred.

The final grouping is shown in Figure 1, below. The earlier grouping had been based on the view that the subcategory 'Expectation of a programme that can do something for them' did not include the topics now in the subcategory 'Expectation to gain an understanding of themselves, their difficulties and crime'.

Instead, these topics were put together with those reflecting anxieties about the intervention, because it was felt that this was something the participants were anxious about and did not really want. This was clearly an interpretation and not something that was actually said. The clustering process helped to identify and remove this bias.

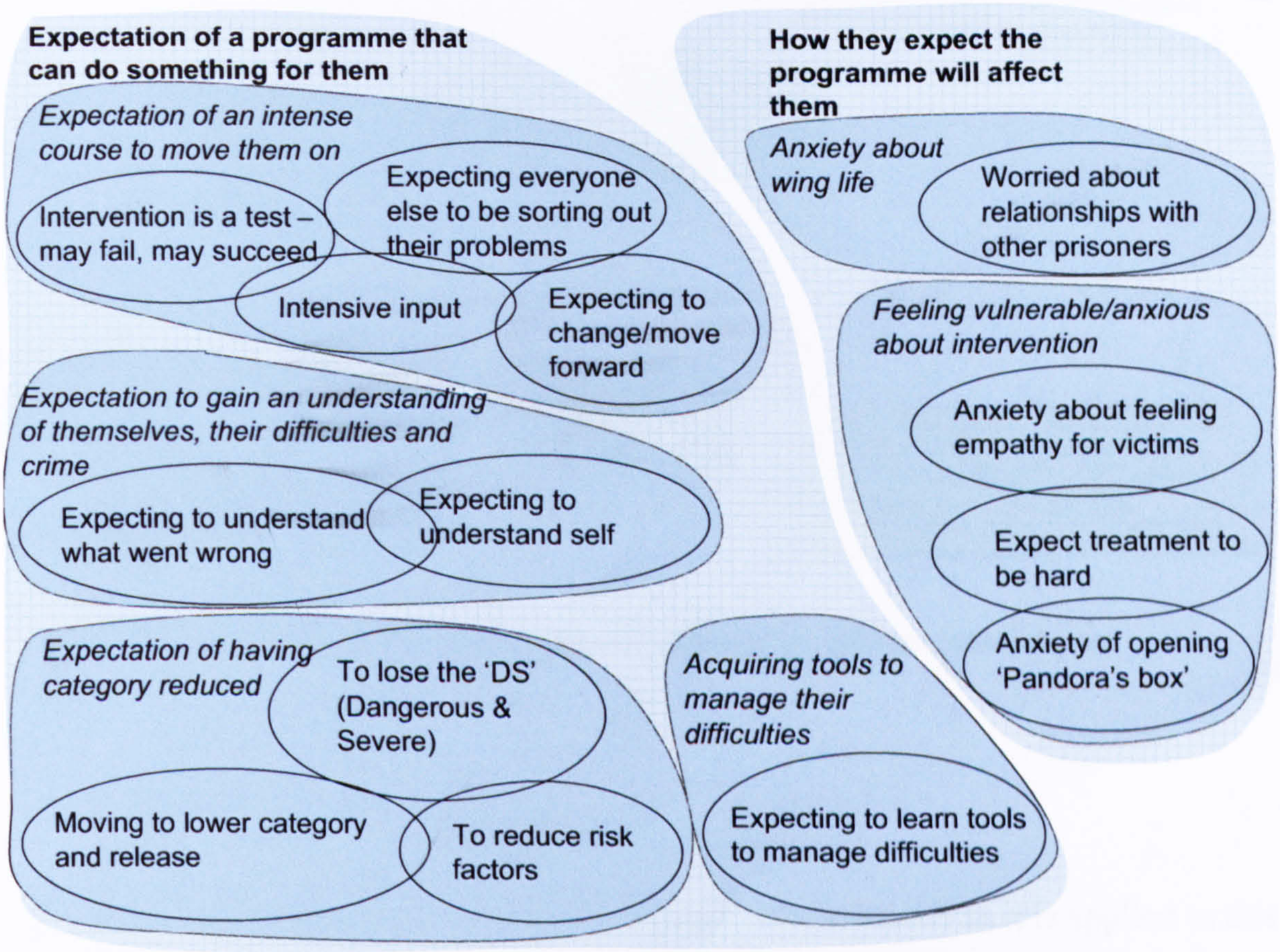

Figure 1: Clustering of preliminary categories for the theme 'Expectations'

Diagramming

Diagramming was used to understand the links between themes as they developed. This model was constantly updated as new links and themes were added, and as themes merged. Figure 2 shows one such diagram at an intermediate stage of the analysis after the first five transcripts had been analysed, but the subsequent three had not. Not all links are in place, some themes are not yet integrated, and others have started to form into groups, which in turn form larger themes such as 'Expectations' and 'Experience'.

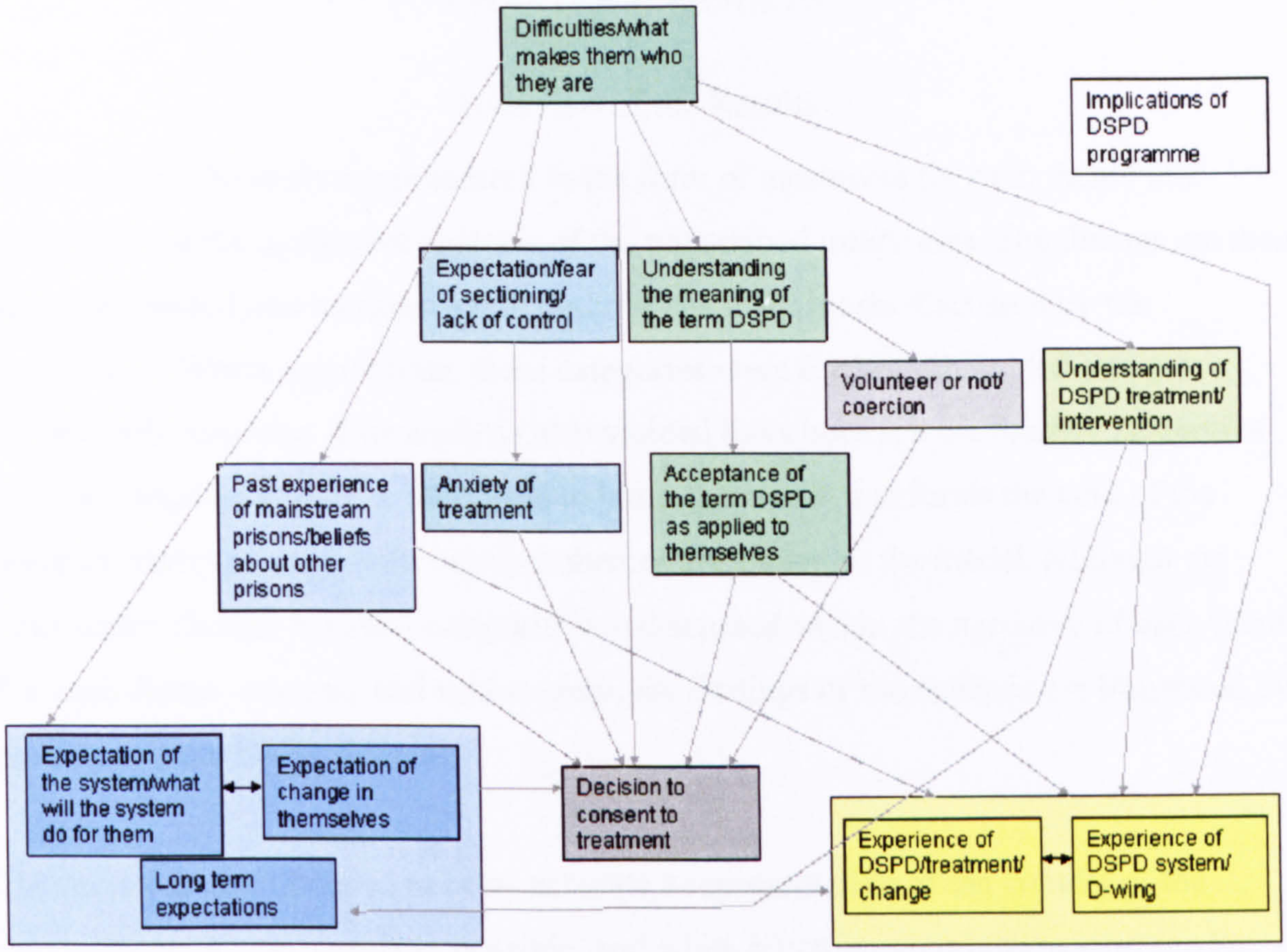

Figure 2: Example of diagramming used to explore relationships between initial themes

Summary of Chapter

In this chapter I have provided an overview of qualitative research as it is applied to this study. This has included outlining quality standards for qualitative research. I have also introduced my position as the researcher. I then provided details of the participants and the process of data collection, along with issues of confidentiality and ethical standards. The method of analysis, grounded theory, was finally described, with examples of the analytic procedure used.

CHAPTER 3: RESULTS

Overview of the Results

The results of the study are presented in the form of narratives for each theme that emerged from the qualitative analysis of the transcribed interviews. The themes are then further expanded into categories that describe the main issues discussed by the participants. Where appropriate, these categories were further subdivided into more specific subcategories. This analysis also yielded links between the themes, categories and subcategories that have been used to build the model that forms the core of the research. Only the main links between themes are shown in the model, although the links within themes between categories are discussed within the narrative of each theme. For each theme, category and subcategory, the findings of the analysis are illustrated by quotations from the participants.

The narratives are intended to be as accurate a representation of the content of the interviews with participants as possible, and while much implicit information can be interpreted from these results, this is saved for the discussion.

The analysis of the transcripts of the interviews with the participants from the DSPD programme yielded five main themes:

1. Difficulties (what makes individuals who they are)
2. Expectations
3. Experiences
4. Implications of the term DSPD, both perceived and real
5. Consent

The theme Difficulties was determined to be the single most important theme around which the model formed, and as such, this is termed the 'core' theme. This describes how the participants see their problems, how they feel that they became the way they are, and how this affects their life and interactions with others. The second theme, Expectations, is formed from the participants' current recollections of the expectations they had of the DSPD programme and D-wing prior to enrolling on the programme, in terms of how they believed they could be helped, and what they expected the programme and wing life to be like.

The third theme, Experiences, covers the participants' ongoing experiences of the DSPD programme in terms of their feelings about the treatment programme, how they see themselves and relationships with others changing, and how this matches up to their expectations. The fourth theme, Implications of the term DSPD, relates primarily to the participants' worries that others will view the association they have with the DSPD programme in a negative light. This theme could arguably be seen as being a category within Expectations, but it was deemed sufficiently important to the participants to warrant a separate theme. However, when viewing the model, note that the links from Expectations also apply for Implications (these links are omitted for clarity). Finally, the theme Consent details the participants' views on the importance of volunteering for the programme, and feeling that once there they could leave if they so wished.

These five themes are brought together in the outline model below in Figure 3. This model is further expanded at the end of this section to include constituent categories and subcategories. There is a pull-out copy of the full model in Appendix Six (page 147) that may be viewed alongside the text at any point.

Quotation Conventions for the Results Section

Quotations taken from the interview transcripts are identified by being in italics and between quotation marks. Following each quotation, the location of the excerpt within the transcripts are shown in brackets. The letter 'p' followed by a number indicates the selected participant interview, followed by the corresponding line numbers extracted from the transcripts. Selected interviews were from: pilot participant interviews one and two (ppi, ppii), and participants one, four, five, eight, nine and twenty four (p1, p4, p5, p8, p9, p24). When an excerpt contains a dialogue between the interviewer and participant, the words Participant and Interviewer are used to indicate who is speaking. An ellipses (…) signifies missing, confidential or potentially identifying text. At times, the excerpts contain names of staff or prisoners; when appropriate these have been changed to a pseudonym in order to maintain the flow of speech and to aid clarity.

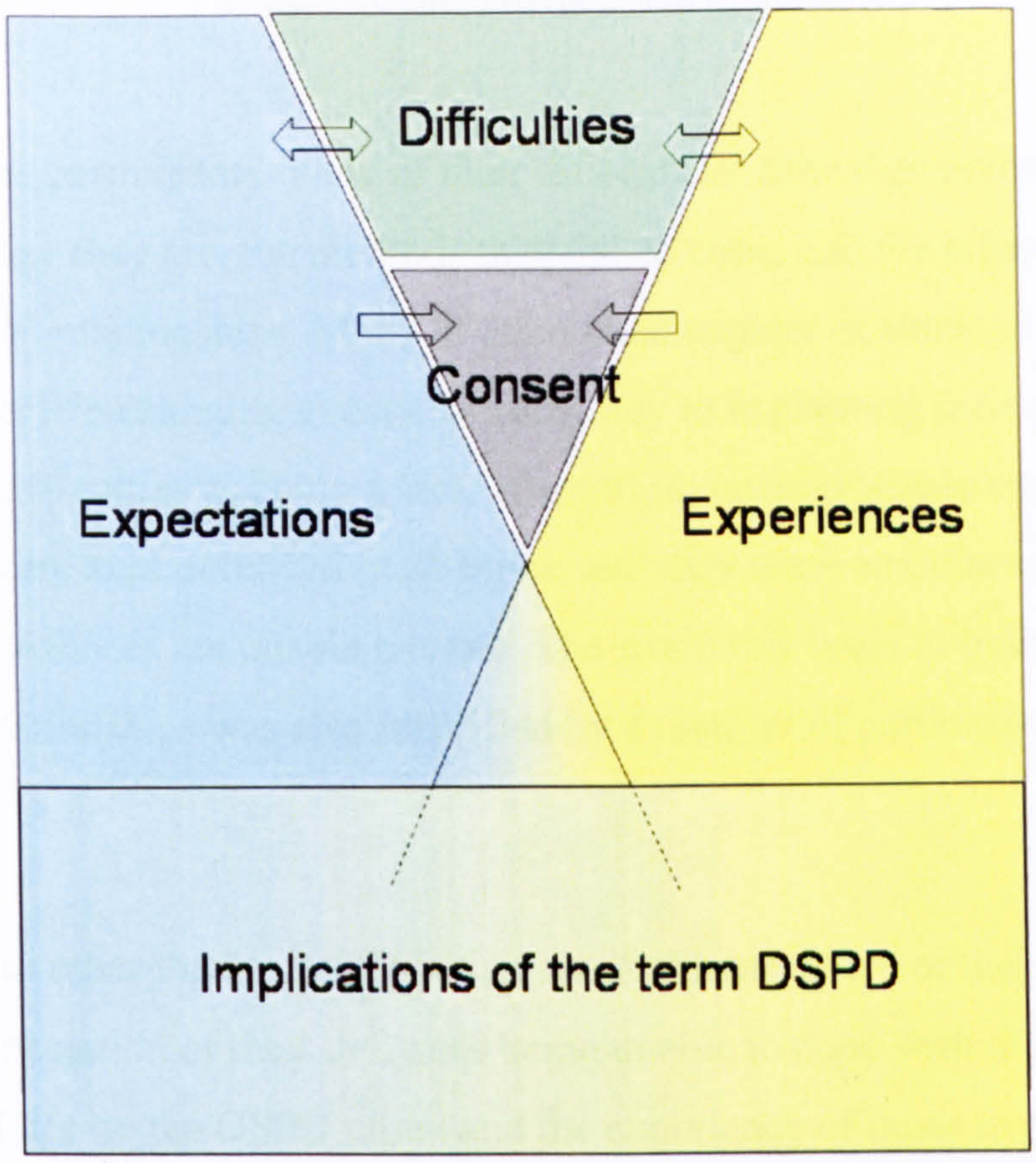

Figure 3: An overview of the model linking themes

The structure of the model will not be discussed in detail at this stage, but its inclusion here is intended to frame the following narratives and their relationships to one another. Being the core theme, Difficulties sits at the top of the model, and it influences both the participants' Expectations and Experiences, while their experiences of the DSPD treatment serves to modify their difficulties. The discrepancies between the participants' expectations and their subsequent experiences are, in part, a function of their difficulties.

The participants' Consent to enrolling on the DSPD program is initially based on their expectations, and their ongoing consent on their experiences. The theme Implications is predominantly an extension of their Expectations, but is also linked to their Experiences, where these expectations are realised. Each theme and its constituent categories will now be addressed in turn.

Theme 1 (Core Theme): Difficulties

This describes the participants' view of their difficulties: how they perceive that they came to be the way they are, the methods they use to cope, and the effect this has on their interpersonal relationships. Many of them cited neglect or abuse as a child, or significant earlier life-changing events, as being key to explaining their problems. They identified their difficulties as being a lack of emotion, uncontrollable emotion, or that their emotions were kept defended at all times, and they were anxious as to what might happen if these defences are unable to cope. The strain this leads to in their interpersonal relationships was also identified by a number of participants, and implied by others.

The main links to other themes are Expectations and Experience of the DSPD wing. The participants' expectation of their defences being unable to cope with the treatment programme and life on the DSPD wing, and the experience of those expectations being met, leads to anxiety. Anxiety is central to maintaining their difficulties and their anxiety is related to any change of the status quo.

Category 1: Childhood Nurturing/Neglect/Abuse/and Significant Life Events

A strong thread running through the interviews is that of the influence of the participants' upbringing in the development of their difficulties. Many talked about specific instances of abuse they endured as a child. During the interviews, participants disclosed events such as growing up in poverty, being abandoned by a parent, individual instances of sexual abuse, and sometimes a whole childhood of persistent and violent physical and sexual abuse. For example, Participant 9 revealed:

> *"Now, I was abused as a child – from five years of age I was raped and continued to be raped from five right through to my 16th birthday when I* left [name of children's home]" (p9 95-99*)*

Participant 24 talked about the anger he felt as a child when his mother died, and how he felt he had not progressed developmentally in some respect from that age, having missed out on years of parenting. This, he felt, went some way to explaining his violence – he described feeling as if he were a two-and-a-half-year-old boy throwing a violent tantrum.

"... like I say, most of my offences... been about violence... I was thinking about the violence... I think the people before were saying I was very unpredictable and I think a lot of people are wary of me because... sometimes I can be laughing and joking with somebody and the next minute I could punch their face in, you know what I mean? So I think that... because like my mum, my mum died when I was two and a half yeah, and what happens, like, when a two-and-a-half baby is angry yeah, he just lashes out and throws something like yeah and what happens is, like, because when I can't deal with a situation in my life, yeah, and what happens, suddenly a child who is two and a half yeah and mixes with a thirty-year-old man yeah, and that's where the prognosis of my violence comes from..." (p24 26-44)

One participant (ppi), identified the time that he had spent in the armed forces as being a factor in explaining his difficulties, but still cites his childhood as the main cause:

"... the way that I am today is because of the kind of childhood that I led and the life that I led, er, although the military has added to it..." (ppi 561-564)

The main categories of difficulties that participants identified as stemming from their upbringing and childhood were emotional and interpersonal, the emotional difficulties being that they had no gradient of emotion – they employed defences to keep their emotions under control, and were anxious of the consequences of feeling emotion.

Category 2: Defending Their Emotional Core

Many participants identified that their past has an effect on their present and have linked protective behaviours they employed as children to the defence mechanisms they have put in place to survive as adults. They have referred to these coping strategies as, for example, *"closed boxes"*, *"masks"* and *"lead coats"*. As a child, Participant 9 said he developed a coping strategy to minimise his further abuse. He learnt that adults did not believe him whenever he tried telling someone about being abused, and he was then punished for something he hadn't done. He learnt it was safer to stay in some control and and minimise his suffering by not telling anyone about the abuse.

"... when you are taught something as a child, it becomes part of you, or if you have to survive as a child, and I mean in my case, I was raped, I couldn't talk to adults

because when I talked to the adults, they referred me back to the persons who abused me and I got abused... I got chastised for supposedly telling lies. So I found that by talking to adults I got more pain and more suffering, so instead of that I reverted by closing to myself, sitting in my lonely room I became an isolated, lonely person, sort of, because I couldn't talk to anybody..." (p9 178-187)

The defence mechanisms are intended to protect the participants from being hurt and sometimes they appear to serve to hide difficult and painful memories of abandonment or abuse from the past that they don't want to remember. Some participants believed that they didn't have emotions, but comments they make elsewhere would seem to indicate that this was part of the defence mechanism.

"... you could be sat in the group and you could be explaining something extremely traumatic and to me it would be like, sat in the park eating an ice-cream, watching the dogs running round. I don't show and I'm not, I can't get in tune with the group when they're talking like that... I just brush it off the shoulders, it doesn't bother me..." (ppi 304-314)

"Since being here, some of the emotions that have come out, er, and some of the feelings and stresses, I think sort of shocked me a bit... and I think that it's going to get harder as it goes on." (ppi 122-125)

Participants described their defences as being used to protect them from experiencing strong emotions. Their experiences in earlier life have led them to develop coping strategies to protect themselves from a similar experience in the future. Participants talked about having no emotion, or no apparent emotion, as a result. Participant 1 in particular talked about when these strategies failed, and that the emotion felt was overwhelming, a bit like having an *"on/off switch"*.

"It went from sort of no emotion, I can, I can deal with each of these little problems, then all of a sudden they all sort of came into focus at once and the emotion just switched on instantly... there isn't a sort of, 'oh I'm annoyed', it's either it doesn't affect me, or bang – there's a major explosion..." (p1 69-82)

The idea that these defences may not be able to contain their emotion led to anxiety in many participants. Participants spoke of their anxiety that the therapy would uncover unknown parts of themselves, thereby penetrating their defences, and they feared coping with the emotions that were released.

> *"... if they open up Pandora's box, are they going to be able to shut it then? When they do open up Pandora's box, are they going to be able to understand it enough to help me understand it and maybe move forward... When I say Pandora's box, what I am talking about is me as a character, me as a person, my beliefs, my core beliefs, and how I think, and how I feel, and what makes me do the things I do, and what makes me say the things I say, and basically what makes me tick."*
> (ppi 138-147)

Another participant was worried that should he develop the emotional capacity for empathy, he would not be able to cope with the emotional impact of his crime.

> *"The day when I can actually fully realise what I have done to someone, and feel their pain, then how am I going to have the capacity to deal with that? That's what the worry is."* (p4 150-154)

Having such defended emotions is not just an issue in terms of the anxiety it causes the participants, but the fear of anxiety also affects relationships with those around them.

Category 3: Interpersonal Relationship Difficulties

The fear of allowing someone too close leads some participants to put up their defences to avoid getting hurt, and this causes difficulties in their relationships.

> *"It might be maybe a bit too desperate, a bit too needy, so then I can maybe cling too much or if the person is showing me too much then I might put a barrier up, and so sometimes it's quite contradictory 'cause I might put a barrier up if they try and get too close or I will hurt them and push them away. Or I might be too involved and too intense that they'll reject me, and that reinforces my sense of abandonment..."*
> (p4 33-38)

The defence mechanisms placed around their emotions have an impact on their relationships and several participants cited these difficulties as a contributing factor in the crimes they had committed.

> *"I suppose my difficulties are interpersonal relationships, maintaining them and maintaining the correct level of intensity involved in relationships with people, and social skills, and personal skills, and sense of identity. And I suppose a sense of belonging – feelings of alienation – I suppose outside, which lead to the difficulties and to me being violent."* (p4 11-16)

Some participants indicated that their survival mechanisms in the prison environment may reinforce and strengthen these interpersonal defence strategies.

> *"... you see, when you first get here you put all your barriers up, all your masks go on and you are somebody different and you are somebody different every day that you come out of your cell, because you have to be because it's a new environment... it's an extremely dangerous environment – umm, what I mean by that is because there are so many different people on the wing with different personality disorders and different characters... and you never know what you're going to meet and you never know who you're going to talk to, erm, so and it's a, it's a dangerous environment for yourself because you are always learning about yourself and there might be things that you learn about yourself that you didn't know before that you might not, you might not like."* (ppi 531-546)

As with their emotional defences being unable to cope, for many, interpersonal relationships are a source of anxiety, and the two are closely linked. The DSPD program involves, among other things, group work. Participant 1 expressed anxiety about this part of the programme, and indicated that his anxiety about interpersonal relationships even extended to this one-to-one interview situation.

> *"...well one of the major problems that I have is anxiety, and group work is a major contributor to that. I mean, even sitting here with one person is, I mean I'm actually sweating here."* (p1 28-30)

In summary, the participants have identified their main difficulties to include having no gradient of emotion, not being able to feel empathy, and difficulty with interpersonal relationships. These problems are found to stem from unresolved traumatic experiences in earlier life, which have led to individuals forming defence mechanisms that they employ in their interactions with others, resulting in difficult interpersonal relationships. Any change to the status quo results in anxiety, and these participants are anxious about what the DSPD programme may have in store for them.

Theme 2: Expectations

This theme describes the expectations the participants expressed that they had of the DSPD programme before they joined, and their ongoing and developing expectations of the programme while on the DSPD treatment unit at HMP Whitemoor.

The participants described their expectations of the DSPD programme in terms of what they hoped the programme could do for them and how they expected the programme to progress. In general, they predicted a difficult and intense process, viewed by several as a test. The majority of participants appeared to regard it to be the responsibility of those running the programme to get them through it. Many participants initially expected that this process would lead to their category of dangerousness being lowered, and ultimately to them taking a step closer to release.

There was some considerable anxiety, however, that this process may involve exposing psychological parts of themselves that had been locked away for a long time, and some were reluctant to engage in this way.

Category: Expectation of a Programme That Can Do Something for Them

The category 'Expectation of a programme that can do something for them' reflects the participants' wishes to take part in a programme that they believe will move them towards release (subcategories 'Expectation of an intense course which can be passed or failed' and 'Expectation of having category reduced and a life outside prison'). This category also reflects their stated aims of gaining a better understanding of themselves and obtaining tools to manage their difficulties (subcategories 'Expectation to gain an understanding of themselves, their difficulties and their crime' and 'Expecting to acquire tools to manage their difficulties').

Subcategory: Expectation of an Intense Course Which Can Be Passed or Failed

Many of the participants described their initial expectations of the DSPD programme in terms of what they hoped to get out of it. Several of them initially viewed the programme as being similar to a course that they could either fail or pass, with success enabling them to progress through the system. For example, participant 8 discussed his desire to succeed.

> *"... There are gonna be people who fail... we ain't all gonna succeed – we know that – but I'll be praying... that I'll be one that does succeed."* (p8 689-696)

A number of participants commented that in the past they had experienced therapy or courses that they felt had not addressed their problems. Many initially expected the DSPD wing to be something different from anything they had previously experienced, and they had high expectations of the programme. Participants expected to have their time filled with intense therapy.

> *"I thought, err, from the information I got, I was actually here like 24-hour groups – you gotta know that you can't have groups for 24 hours – but sort of like all your time on the wing is covered so there wouldn't be any boredom."* (p9 52-61)

Participant 8 expressed a belief that some of the other participants viewed the programme as a *"magic cure"* for their difficulties (p8 69-70), while many of the participants seemed to feel as if the responsibility for addressing their problems within the DSPD unit lay with the programme. Their language was often passive: for example, Participants 8 and 9:

> *"If they let me out, and I hurt someone again, then I'll be pissed off right, because it means that there is still a chance of me hurting someone, and THEY let me out."* (p8 488-490)

> *"There are certain situations I can get into where the temper is uncontrollable. It's like a red mist came down on you and you just don't see anything and you go pounding away. That's a problem that they've got to solve."* (p9 199-202)

Most of the participants, however, stated that their main personal objective for coming into the programme was to not harm anyone again; that it did not matter how long they had to remain in prison, so long as they were no longer a danger when released. Most of them used more or less the exact same phrase. Here I have given examples from participants 4 and 8:

> *"... it's an important thing to try to, at least, try to attain that, to make sure that I don't hurt anyone again. You see, that's the main thing. So I am not particularly concerned about the length of time in prison..."* (p4 66-69)

> *"We've all come here 'cause we want to change. I don't want to get outside – I don't want to hurt somebody again."* (p8 483-484)

In addition to not wanting to hurt anyone, several participants wished to gain both an understanding of why they had committed particular crimes, and also of their general difficulties in life. They then wanted to develop skills that would enable them to improve their interpersonal relationships and lead a more normal life.

Subcategory: Expectation to Gain an Understanding of Themselves, Their Difficulties and Their Crime

All participants spoke about the expectation that the intervention would consist of therapy to learn more about themselves. Participants seemed to gather that by better understanding themselves and their difficulties, they would be able to better understand their crimes. Ultimately, they described a hope that this understanding would reduce their risk of committing another crime in the future. Participant 5 answered a direct question on what he expected from intervention:

> *"... I suppose an understanding of my crime. You see, I don't understand yet how I committed and why I committed it. There's no answer yet there. Now there's a possibility that through intervention, doing one-to-ones and all that information, then maybe an answer will come up and I will come up with the answer of why I went that way and if I can find the answer to the question I've got, which is why I committed the crime, then the chances of it happening again is practically zero, innit?"* (p5 84-90)

He went on to relate a story of the process of exploring his childhood in his one-to-one therapy sessions.

Another example of the participants' expectation to learn about themselves is in relation to gaining personal understanding, which they expect will help them make sense of their difficulties and, in turn, enable them to cope with these difficulties better. This is illustrated by Participant 4:

"I suffer from borderline personality disorder, schizoid-type personality disorder, narcissistic personality disorder... Paranoia personality disorder – er, I wouldn't really say that it's like a full-blown – I don't have heavy serious feelings that people are out to get me and things like that, but it can still affect my perception of which I perceive somebody's doing of someone's motives. So all these things form an inevitable defence around me in the way that I've acted in the past and the way that act, which is like I say – almost self imposed. But then this is what I have to do – the more I understand it, the more I'm able to cope with it. So the more I'm able to cope with it then the more it's easier to understand. They're not gonna go away but I'm gonna be able to cope with it." (p4 168-181)

In contrast to the extract above, where Participant 4 seems to use insight and examples to explain his current understanding of how his difficulties affect his thinking and behaviour, the following example demonstrates how someone earlier in the programme (still in assessment and not yet in intervention) is expecting to gain some understanding of himself, but as yet cannot effectively articulate how this understanding will benefit him. This participant hoped he would gain a greater understanding of himself and his difficulties, and that although he expected the process to be hard, his subsequent understanding would somehow make his life easier:

"I'll be able to cope and I'll be able, I'll have a better understanding of myself. Erm, I'll know more about myself, er, and I suppose I'll know more about who I am and what I am. Erm, it'll be hard but it will be easier, and I think that, er, [pause] *I'll be able to achieve more, 'cause I'll have a better understanding, if that makes sense?"* (ppi 592-597)

This subcategory of expectations of a programme that can do something for them has emphasised the perception that participants expect to address the difficulties associated with their personality disorder and their violent or criminal behaviour.

Subcategory: Expecting to Acquire Tools to Manage Their Difficulties

Several participants have the expectation that intervention on D-wing will involve learning tools or coping strategies to manage their difficulties, and therefore reduce their risk. The pilot participant, who at the time of the first interview had not entered intervention, had the expectation that the process of treatment would involve almost rebuilding his character, developing coping mechanisms to help him with life and move forward towards release:

> *"... when you go into a one-to-one, you need to go into that one-to-one understanding that you know when you come out you're going be a mess because that's what this is all about – it's about breaking you down and building you back up again, but while they're breaking you down, they're giving you the tools to move forward, to see that, that if you ever get into this predicament again that brought you into prison in the first place, you've got the tools to stop, and if you've got the understanding, your can identify, err, certain aspects, certain traits that made you commit crime in the first place."* (ppi 216-225)

Participant 8, who has been in the intervention spur for longer, spoke at length about his expectations that intervention would give him tools to manage his difficulties, rather than cure him. He described this process as acquiring more appropriate tools to replace the survival strategies he had previously learnt:

> *'Right, we grew up in a* [pause] *in all our individual homes and places and the acts we did when we was younger made us what we are today. Now this is how we are today – when somebody spites us, that's it – oh don't want nothing more to do with you. That's what men do. Right, and that's what we're learning here, to change the style of living we had... to get rid of the rubbish we learnt in the past and learn the new tools. If you don't use them then you're not gonna change."* (p8 229-239)

He went on to clarify that the tools could help to manage his difficulties but that they weren't a cure for the disorder. He began by explaining that his personality disorders

were responsible for his behaviours and him being a danger to others. He used an example of an alcoholic to make his point:

> *"If you can deal with these personality disorders and find the tools to deal with them, you don't get into those scenarios* [the ones that lead to offending]... *But that means that you have to use your tools all the time... if you use the tools you're safe – by you being safe, other people are safe... Take an alcoholic. An alcoholic is an alcoholic for all times. A PD is a PD for all times. But an alcoholic stops... doesn't stop being an alcoholic, he stops the danger by not drinking. So he doesn't drink so he is no longer a danger. My PDs are there right – all I can do is find the tools to deal with it and so long as I use those tools, I'm no longer a danger."* (p8 385-400)

There seems to be a running thread that participants describe the acquisition of tools being an integral part of DSPD intervention. They seem to understand that the tools or coping strategies manage the negative consequences of having a personality disorder and therefore reduce their risk.

Subcategory: Expectation of Having Category Reduced, and of a Life Outside Prison

The decision to consent to be on the DSPD programme was, for several participants, influenced by an expectation that the programme would ultimately lead to a reduction in their category, and even release.

> *"... I mean, for example, the main reason that* [psychiatrist's name] *had me over here was to try and get me off Category A, and to get me onto to Category B and through the system."* (p1 134-137)

Participant 9 is even more explicit in his expectation that the DSPD programme is a route to freedom through lowering his category.

> *"... my goal is for freedom and this unit is the only way I'm gonna get it* (p9 578-579)... *I am a medium high risk. They said when I do it* [the programme], *it will bring it down to low risk, and I thought, well, if it brings it down to low risk then I am ready for release."* (p9 18-25)

Many participants would like to 'lose' the DS (Dangerous and Severe) from the term DSPD when applied to them. Participant 4 viewed the DSPD programme as a forum to convince people that he was not dangerous.

> *"Well, I'm hoping that I'm gonna learn a lot from it and then I'm gonna be able to show people that – and it's going to take a long time for me to convince people that – I am not dangerous."* (p4 501-503)

Some reported an expectation that when they are released, they would finally feel part of society. Participant 4 was expecting the programme to have the effect of helping him achieve what comes naturally to most people:

> *"... I'm gonna be in my sixties/seventies so I won't have much time to sort of like really put it into practice in society, but it will be long enough won't it for at least to say that I've done it – something that to someone else it has just come natural to them so it is relative. Not that I'm trying to make it sound as though I'm sorry for myself – it's just that contentment, that sense of belonging, is particular to me and if that's what my life is culminating then that's what it is. There is not really much more I can hope for..."* (p4 519-526)

Category: How They Expect the Programme Will Affect Them (During the Process)

This category refers to the emotional aspects of the participants' expectations. It has been divided in to two subcategories: how participants expected their environment (D-wing) to feel ('Anxiety about wing life'), along with the vulnerability they recalled expecting to feel during the intervention process, and a fear of failing the treatment ('Feeling vulnerable').

Subcategory: Anxiety About Wing Life

Participants were expecting the wing to feel different to other prison wings, and there were some concerns about who else would be on the wing. Some were worried because of the nature of offender who would be present on the wing, particularly sex offenders. Others shared their worry that there may be dangerous people on the wing who could be violent. However, more participants spoke about the general anxiety that they expected to feel when they first came onto the wing. Participants were worried about the types of

disorders their peers may present with, before they got to know them. For example, participant eight remembered thinking:

> *"You're obviously worried about who's around you. Not so much what they're in for as what kind of damage can they do. Have they got a personality disorder that I got to watch out for? Are they schizoid? You know, worries like that."*
> (p8 110-113)

The pilot participant stated:

> *"... It's an extremely dangerous environment... what I mean by that is because there are so many different people on the wing with different personality disorders... and different characters... you never know what you're going to meet and you never know who you're going to be talking to."* (ppi 543-547)

Others recalled how, despite knowing that it was a therapeutic wing with supportive staff, they still felt uneasy about the informal and friendly nature of the prison officers. They recalled that this was unexpected: it raised their guard as they were unable to predict how people were going to behave towards them. Participant 8 stated: *"... you don't know what's coming next."* (p8 108)

In the first interview with the pilot participant, he spoke about how he felt about his upcoming move onto the intervention spur, his expectations for intense treatment, and also how this might affect the wing atmosphere. He expected the wing to feel intense and withdrawn as people begin to *"go into themselves"* and focus on their own therapy and difficulties:

> *"When they do start or when we start the intervention, err, the wing is going to change, it's going to become very withdrawn and very intense... when I say intense, I don't mean intense in the way that you're going to be bickering at each other, it's just going to be intense 'cause everybody is going to be studying themselves, everybody is going to come out of their one-to-ones with their head bad, battered, messed up, confused... so it will, the atmosphere on the wing will change because of that fact, that everybody's got their own problems to sort out."* (ppi 208-227)

Participants were quite aware of what other people outside of D-wing may feel about the wing, especially with regard to the negative connotations the term DSPD had. This will be addressed in the narrative implications of the term.

Subcategory: Feeling Vulnerable

Again, I begin with the pilot interview. This participant is referred to frequently in this section because he was first interviewed in the assessment unit, before moving over to D-wing's intervention phase, and so his feelings regarding expectations about the wing were at the forefront of his mind at the time of the first interview. He seemed to describe preparing himself for intervention in a similar way to how one might imagine a soldier would be 'psyching' himself up for a battle. He was feeling anxious about the unknown:

> *"I know it's gonna get harder... though I am not sure how harder it's gonna get because I don't know what's around the corner... So I suppose I wouldn't say that I've mentally prepared myself for it because I can't – but I have physically prepared myself for it..."* (ppi 433-445)

He described the psychologists as having the skills to ask deep, poignant questions that he did not know how to hide from. He described this as positive, and almost as a relief that he didn't have to wear a mask with the team, as he had previously with inmates. He had an anticipation that the clinical team were going to give him some sort of revelation in the intervention and he expected the process to be frightening. I am assuming that he felt exposed and vulnerable, sensing that the professionals knew more about him than he did, as he carried on to say:

> *"It is hard, it's frightening because it's y-y-you're basically airing your dirty laundry out... that's what you're doing, er, and it's embarrassing.* (ppi 67-69)*... now we all know its going to get harder, from here on, because the psychologists have done their homework, they've collated the information and now they're just going to drop it on our toes."* (ppi 200-206)

Despite having faith in the clinical team, the pilot participant was worried about what the psychologists might find when they looked deeper into his mind. He used the metaphor 'Pandora's box' and he described a fear of opening this unknown box of horrors in his head, along with an anxiety because he did not know what might happen

in the process. He seemed to be worried whether during the process of exploring his difficulties, and letting his own controlling defences down, the psychologists would be able to interpret things clearly and accurately, and contain any resulting feelings he may experience.

> *"I have an expression... which I call Pandora's box... if they open up Pandora's box are they going to be able to shut it... are they going to be able to understand it enough to help me understand... When I say Pandora's box, what I'm talking about is me as a character, me as a person, my beliefs, my core beliefs, and how I think and how I feel, and what makes me do the things I do and what makes me say the things I say, and basically what makes me tick... it's going to be hard, it's going to be frightening but the biggest thing that scared me that I'd heard was that, err* [pause], *the reactions from them, when I talk about the things that I talk about or when I talk about certain aspects of my life, you know?* (ppi 138-151)

Other participants spoke about the process of changing. They had an expectation that this was something they would have to do themselves; it wasn't something that could be done for them. Participant 8 remarked:

> *"I'm the only person who can change, they can't make me change. Only I can change, right?* (p8 356-360)

The process of changing their way of thinking, however, was described by one in quite unpleasant terms, as if he was being forced to change.

> *"It will change my way of thinking for a start, because I mean, I have a rather stubborn way of thinking things through, such as, 'I will not budge, I ain't gonna budge from this, I'm glued to the spot, I'm cemented down. No one is gonna move me.' Oh yes they are gonna move you* [name], *they are gonna drag you screaming into the future."* (p9 641-646)

Participant 4 expected that the process of change involved becoming and then convincing people that he was no longer dangerous. He expected that part of the intervention would involve understanding his crime from an emotional perspective. He

spoke about having to learn to have empathy and learning to feel the pain he has caused others, and he seemed apprehensive and afraid about whether he could face this:

> Participant: *"To face – to face the things that I have done. To actually look at what I've done and to actually recognise and feel what I've done. 'Cause it doesn't – I can't recognise what I've done in terms of emotional feeling and talking about what I've done and things that I've done. I've done some terrible things to people – violent things. But it almost becomes academic when you're talking about it – I've talked about it so many times with different people, you know, with different prison sentences that I've had and reports that have been done. But when you're in here you've got to actually try to come face to face with it, what you've done, for it to mean something to you – not just say 'Oh yeah, I've done that and accept the punishment' – there's more to it than that. I have to actually feel what I've done to them people and look at it from that person's point of view and that's what I can't – that's what's difficult, being able to feel the empathy. These are the things that are gonna be difficult, these are the things that might break me down. The feeling of being afraid, of being broken down, broken down."*
>
> Interviewer: *"Do you mind if you give me an example of what you mean by broken down?"*
>
> Participant: *"All my defences, all my defences even in terms of talking about crimes that I have committed... I can sit here and talk about what I've done in graphic detail but that's not the same."* (p4 121-145)

Participant 4 continued to talk about his worries and expectations extensively, without interruption. He seemed to be saying that talking about his crimes, as he had done so many times in the past, trivialized them in a way, whereas talking about them in the programme was impossible without being aware of the emotional reactions he had, and he finds this difficult to deal with.

Other participants spoke of an expectation that they would explore their motives to commit crimes in an endeavour to make sense of them. For example, one participant was still contemplating a question he was asked by his psychologist four months previously.

"Who did I do my crime for? Now I'm in here 'cause I killed a guy that raped a member of my family. I know why I did it, but who did I do it for? Now it would be easy for me to turn around and say, well the answer is there – you know I did it because he raped a member of my family. But then when you actually look at that question, 'Who did you kill him for?' – that's a different question and it needs a different answer and that I can't answer. Not because I don't want to, not because I wouldn't want to incriminate myself any further. I can't answer it because I really don't know. Because no one has ever asked me that before and when you get asked those kind of questions then you have to sit back and you have to say, 'Well, wow, where did that one come from?'... Will I ever be any closer to answering that question? I really don't know. I want to say yes but then what would I achieve by answering it? I don't know – I can't answer that question at this time." (ppii 293-313)

He was expecting to continue to think about these questions during his treatment on D-wing.

Theme 3: Experience of DSPD Wing

This theme details the participants' descriptions of their experiences of life on the DSPD programme. They described their developing relationships and improving interpersonal skills, in terms of relationships with other prisoners on the wing, other members of therapeutic groups, clinical staff and prison officers. Participants discussed the process of personal development and the changes in their understanding of – and feelings about – themselves. They also revealed their feelings about the programme in general and how it compared with their expectations. Three of the interviews focused more on the Experiences theme than the other interviews.

Category: Developing Relationships

Participants' accounts would suggest there is a process of personal development during which their experiences and feelings change. When asked about life on D-wing, participants introduced different examples of interpersonal encounters. The relationships they have on D-wing were central to their discussions about life in the programme.

They described a structured environment in which they were able to explore emotional difficulties with others. For many, this could be both anxiety-provoking and frustrating

at times. Some described having gained an understanding and tolerance of others they did not previously have, which has helped them to resolve arguments without resorting to violence. A few participants' comments suggested that they were beginning to develop a sense of self, and an understanding of themselves, particularly through the experience of their one-to-one therapy.

For the participants, developing relationships consists of first building an understanding and tolerance of others, and then learning to build trust and support, and to be supported by others (described in the subcategories 'Understanding and tolerance of others' and 'Experience of trust, safety and support').

Subcategory: Understanding and Tolerance of Others

Participants talked of the relationship difficulties they had had in the past and often reported that these had led to conflict or violence. Some participants described experiencing anxiety about their relationships with other prisoners on the wing, specifically because of the nature of their personality disorders and offences. The pilot participant in his first interview described being wary of the other inmates:

> *"...It's an extremely dangerous environment... what I mean is that there are so many different people on the wing with different personality disorders..."* (ppi 537-540)

Participant 1 described feeling that the prison environment made it necessary to have an *"aggressive side"* in order to survive, and that it was a matter of *"survival of the fittest"* (p1 274-293). This implies that the prison environment may be maintaining some of their difficulties.

A small number of participants made it clear that they were unable to tolerate people who they knew had committed sexual offences. They were struggling because they believed these crimes *"crossed a line"* (p24). Some stated that they found it difficult to ignore their strong, negative feelings about sex offenders, which included anger, disgust and, at times, fear. They predominantly coped with these feelings by refusing to acknowledge such prisoners in any social interactions. The same participants also tended to experience frustration at their perception that staff and the system in general served to protect sex offenders.

Fear and anger came across strongly when participant 24 spoke about a previous therapeutic unit where disclosures about crimes were shared. He reported that he still suffered nightmares about the sexual abuse of others.

> *"... a lot of people who are not sex offenders don't feel comfortable being with them... I had to listen to it* [details of their offence] *day in, day out, and even listening to some people even having murdered somebody... listening to like why they've done it, yeah... no, it's a nightmare when I'm asleep."* (p24 281-292)

In the interviews, the small number of participants who felt uncomfortable around sex offenders seemed to want me to agree with them about their views, as in the interview with Participant 24. As the interviewer, I heard anxiety and desperation in his voice:

> Participant: *"... compared to a sex offender I'm a really nice guy, but I... what I will say to you is this, like yeah, now if I'm gonna ask you a question now – answer honestly now, yeah – now would you rather have, say you lived on a council estate, right, yeah, would you rather have a drug dealer live next door to you there, yeah, a paedophile, yeah, or maybe someone like me – who's more likely to assault you?"*
>
> Interviewer: *"I really don't want to think about it."*
>
> Participant: *"But, but it's..."*
>
> Interviewer: *"I've never had to think about it."* (p24 203-213)

Participants indicated that they found relationships confusing, and this elevated their anxiety. Participant 4 recounted his nervousness at approaching a fellow prisoner who had not been addressing him by his first name, despite this being normal on D-wing, and despite the individual in question addressing others by their first names. He seemed to feel anxious about asking the other prisoner about the reason for this, perhaps fearing that challenging them would lead to conflict. Ultimately, he discovered that the reason for the other prisoner's behaviour was simply that he (Participant 4) had never introduced himself, and the other prisoner did not know his name.

Others experience discomfort and pain when there is an unresolved disagreement. Historically, conflict resolution had frequently been sought through violent means. A number of participants' accounts indicate that they now had the insight to understand this about themselves.

Many of the participants stated that their relationships had improved since being on the programme and that they had begun to develop the skills necessary to interact with others in a more 'healthy' manner. They described how they were able to avoid situations of conflict, and better understand others' comments and actions.

> *"I know everybody – I know their ups, their downs. I know when they're in a mood or when they're not in a mood. You can't judge it all the time but 90% of the time you can judge how somebody is feeling – if they're likely to fly off the handle or anything, and so it gets more relaxed, and the more people know each other, the more you can say to each other without anything getting untoward."* (p8 124-130)

A number of participants felt that they had developed an ability to defuse conflict when it occurred.

> *"Erm, arguments with er…* [name] *Me and* [name] *had a bust-up, right. And it should have been settled the next day but it wasn't – we let it drag on and on and on and on and we're fucking mad 'cause we like each other, we get on with each other, but this silly little incident, it, phew… split us apart, right. I was coming out of my cell and I said, 'Oi, I want a word with you," so he said, 'Yeah, I want a word with you as well, this is bloody stupid.' And I said, 'That's what I was gonna say,' and again, it's a positive and a negative. We both realised we'd been stupid over a negative incident… It's all a learning process. It might sound silly to you hearing these bits and pieces, but this is the way we grew up and this is the way we are and this is what we are trying to change."* (p8 213-226)

The participants said they felt they were making progress, and compare their current behaviour and way of thinking with how they acted previously. There were many examples of participants describing apparent improvements in interpersonal skills, and a few are presented below.

> *"I've only had one incident of violence to another inmate since being on unit… I've only had one adjudication… only assaulted one person… in two years… that's, that's that's, that's brilliant for me… Now had I not been here, I'd have been down the coves… so it's obviously done me some good… I've not assaulted one prison*

officer... now that was an everyday occurrence... so it's obviously done me some good." (p5 575-582)

I've realised now that if you treat people with respect like, yeah, erm, and you know they'll do the same back to you and they'll try and help you, and you'll probably get more help that way than by spilling a punch." (p24 66-69)

"I've been in this prison... 12 years, staff who have known me since I came here have said that I am a completely different person now to what I was then... The fact that they can actually talk to me is a major difference. Because back then they'd have just got a mouthful of abuse and told in no uncertain terms where to go... you know, now I'm more inclined to actually have a conversation." (p1 255-262)

Participants seemed surprised and proud of their achievements in managing interpersonal relationships and tolerating both staff and other prisoners on the wing.

Subcategory: Experience of Trust, Safety and Support

Due to the nature of the difficulties people on D-wing have, it could potentially be an environment that feels threatening and unsafe. Mainstream prison wings in high-security prisons have been described as such by the participants. Participants suggested that on D-wing they are working towards trusting prison and clinical staff, as well as their peers.

Participants discussed the importance of trust on the wing, particularly with respect to its relevance to their own physical safety, although some participants may not be able to articulate their need for safety directly. Participant 4 chose to have his personal officer present during our interview. He was relating a story where two other prisoners were having an altercation and he referred to how the prison officer (who was in the room with us) had intervened. I felt Participant 4 was indirectly telling the prison officer in the interview room how vulnerable he sometimes felt, and his need to be protected by staff.

"One person has a laugh with that person, a practical joke; he gets upset and tries to attack him. [Prison officer's name] *has to step in, put himself on the line, instinctively put himself in between that person and this other person. This other person was a big bloke as well. He's got weight behind him, he's at least five stone heavier than* [Prison officer's name] *and* [Prison officer's name] *put himself in between that person. I've seen that – I appreciate that – 'cause that's what he'll do for me."* (p4 311-317)

There was a general sense among participants that D-wing staff were supportive of their difficulties and that this was appreciated by prisoners, especially in the instances where they could have been disciplined in the past. For example, participant 1 explained that there was a week when he had to cope with a number of changes to his routine, including a change of therapist. As someone with Asperger's Syndrome and a clinical presentation associated with schizoid personality disorder, he found this particularly difficult, and as a consequence he self harmed and inflicted damage on the property in his cell. Instead of being punished, which was what he was expecting, the staff supported him by staying with him through the prison disciplinary procedure.

"I mean, they actually arranged after the incident, where I'd sort of stressed out down there, they'd actually arranged for someone from the wing to go down with me." (p1 304-309)

It seemed prisoners noticed small details that meant D-wing felt supportive, such as staff being considerate and polite. At the beginning, when they arrived on the wing, this increased their anxiety as they were not used to people being 'nice' to them. I have changed the names in the following example to illustrate this point:

Participant: *"The first officer I met here, Jo Smith, diamond of a person, but we just come from a regime where you don't use first names. And Jo asks, 'What are your names?' 'Jones.' 'Christian name?' 'Jones.' 'No, no, what's your name" – are we thick or what! 'My name's Jones.' 'No my names Jo – what's yours?' Dah! That's how I felt – just bang me up, 'cause it's just not done in other prisons, you know, especially high-security prisons. There was a bit of a, 'Whoa, what's this!' A bit of a shock to the system, and everybody was the same – they were all plum nice."*
Interviewer: *"And that made you anxious?"*

Participant: *"Oh yeah, you don't know what's coming next."* (p8 97-108)

Participants described the process of learning to trust and accept support from others as both anxiety-provoking and difficult, as this was something they were not accustomed to. In the past, the best survival strategy had been to depend on no one but themselves.

> *"I suppose the reason why I find groups hard is because I don't – I'm not used to having that support. I'm a very – I work on my own, I did when I was in the forces and I did when I came out of the forces... I worked on my own because it's much easier – I don't have to depend on anyone else and nobody else has to depend on me and I like it that way... I'm used to it that way and it's easier. You see now, the good thing about the group is I'm having to learn how to integrate with these people and so it's a massive learning programme"* [memo – sounded genuinely surprised by this] (ppii 101-110)

The process of learning to trust others was often achieved through working in a therapeutic group. It was highlighted that having a 'strong group', founded on trust and support, enabled prisoners to help one another work through some of their feelings about past abuse, or issues that had come up for them in personal therapy. It would seem that some of the trust in this group could be harnessed therapeutically, with prisoners feeling able to challenge one another, without the fear of repercussions, such as physical harm.

Participants seemed genuinely pleased when they were able to resolve a conflict without violence.

The benefits of beginning to trust others was felt outside of the structured therapy time by some participants, who shared experiences of supporting their peers though emotionally difficult times. Participant 8 reflected on the process of supporting others both from the point of view of the supporter and the supported. He described people coming out of a one-to-one therapy sessions in distress, and while they said and felt that they wanted to be alone, he thought that being alone could be too painful and dangerous. He described his own experience of an emotional one-to-one, explaining that if he had been left alone for too long, it could have led to depression:

"I lost my dad and had a bad one- to-one that same week. I just wanted to bang up – get me out of here. Not out of the wing, but just leave me alone... in your cell by yourself. This is the way I deal with stress and problems. I was banged up that night 'cause they let me alone that night, and the next morning, two of my mates turned around and said, 'Now get him out of that fucking cell,' and that's the way you help each other. They didn't want me behind my door 'cause your head just keeps thinking and thinking and thinking, and it just gets worse and worse and worse, and you go down with depression. Depending who your mates are, they'll get you out of your cell by saying, 'Come and have a game of cards,' or 'Come in and have a game on the PlayStation,' whatever. Just to keep you moving so you don't get into a rut and stay there..." (p8 146-170)

In the excerpt above, the participant described the supportive relationship of his fellow inmates. This may have helped him manage the intensity of some of the emotional reactions that therapy can generate.

Category: Process of Developing a Sense of Self

The process of developing a sense of self refers to the parts of the interviews where participants reflected on the process of their own personal development. Participants were sharing experiences from their personal therapy with their psychologist or psychotherapist, and sometimes experiences from their interpersonal group therapy. Participants disclosed times when they allowed themselves to feel vulnerable, or when they had had a 'revelation', when an event in their past made meaningful sense to them. There are descriptions of the discomfort and pain in this process, but also admiration and/or frustration with regard to the therapists.

What was clear was that all of the participants shared an aim or desire to begin to make sense of themselves, to understand how they had become the way they are, and to make sense of their difficulties. Some participants spent a greater proportion of the interview talking about their experience of developing a sense of self in therapy.

There was a general consensus that a person's past was key to understanding how they are in the present. There seem to be many unanswered questions for these participants. Some had a clear idea that they 'needed' to deal with 'what went wrong' in the past before their crime could begin to be understood. Participant 9 described how his experience of learning about his past had affected his personality:

"In my case, I had no love, no affection, I had nothing at all right through my childhood – all I suffered was from abuse and from physical, mental and psychological torture – that's all I ever did. I cannot mention, I cannot describe to you any happy incidents in the whole of my life. I haven't had any happiness and because of that my personality is one of destruction. It's like you've got a toy better than mine so spitefully I go up and I stamp on it and smash it to pieces because you shouldn't have that toy – if I can't have it, you can't – and that's the way my personality has been brought up – it's destruction..." (p9 385-392)

Several participants described the reflective experience of exploring their past and finding the part of them that may have been abandoned, neglected or abused. Two of the participants interviewed on Blue Spur (the treatment spur established for the longest time) described the experience of recognising the needs that weren't met when they were a developing child, and related this to their current difficulties.

From those interviewed, accounts of one-to-one interventions were described as "*hard but worthwhile*" (p4); a stressful but often necessary part of their intervention. The process was also described as supportive and, at times, "*hard and intense*" (ppii). This latter account was not necessarily perceived by the participant to be a criticism of the one-to-one: in the second interview with the pilot participant, he described the experience of his one-to-one therapy, saying he felt that the process of moving forward and understanding himself was supposed to be hard:

"I want them to be hard and I want them to be difficult. I want to come out of these rooms with my head smashed to bits. I want to come out of these rooms mentally, physically and emotionally drained because otherwise I'm not gonna change, I'm not gonna learn anything, I'm not gonna understand what makes me tick... I suppose when it comes down to it, you've got to hurt yourself mentally and physically hurt yourself to be able to break yourself down to build yourself back up. You build it up into a person that you have had hidden away for so long." (ppii 166-193)

The relationship participants had with their therapist was noted as being particularly important for them to be able to explore and progress through often frightening and

painful issues. Participant 9 describes the positive relationship with his therapist, which helped him address issues from his past.

> *"When I sit in here with* [psychologist] *and talk, I feel alright, I don't feel scared, I don't feel frightened. Alright, I'm gonna get really scared and I'm gonna get really frightened and I'll get really nervous as we get closer and closer to the actual, er, crimes – that's the crimes which was committed against me, not the one I committed against the other person..."* (p9 404-409)

Participant 5 described the experience of processing some painful parts of his history. He clearly felt some sense of achievement at developing an ability to experience and express painful emotions in one-to-one therapy sessions:

> *"... I mean, certain parts of my life have been quite painful, you with me? Now, when you want to tackle that and you get into a one-to-one session... you can get, I can get. I can even get, I mean this, my one-to-one, she's that good I can even get emotional with her... I can just start, I've cried in front of her..."* (p5 262-268)

Participant 9, among others, described this process of learning about himself as being painful. Participant 9 talked about how his therapist was helping him manage his own anxiety. Some alluded to a worry that the process of therapy could become frightening, especially those in the earlier stage of intervention. The pilot participant (interview two) revealed that the process of learning about himself was akin to opening Pandora's box – he was anxious as to whether he could cope with what explorative work might find, but also as to whether his therapist would be able to 'close the box'. Others described bringing past abuse into their minds, which they would rather not think about (e.g. participant 1). Other participants who were at the early stages of the intervention, talked about how they could feel exposed by the process. The therapists were perceived to ask difficult questions that to one participant felt like a *"character assassination"* (ppii). He seemed anxious of the powerful potential of talking therapy.

Some viewed therapy as an opportunity to learn about correct emotional responses. They could read the emotional response from the therapist, but not have a sense of the feeling themselves. An example of this occurred when the pilot participant was discussing his history with his psychologist, and sharing a feeling of sadness with him.

He was unable to feel the emotion, but believed that was how he should feel. He related his struggles with the process of gaining awareness of his feelings, and was upset at his lack of emotion regarding his mother's diagnosis of cancer. He was so shocked at not being able to feel that he became a danger to himself and was put on suicide watch (ppi 350-355). His learning about himself at this time was that he must be a cold and callous person not to have an emotional reaction to the possibility of his mother dying, a view he found very distressing.

Category: Expectations (Not Being Met) – Disappointments and Difficulties

Participants who were more recently introduced to the intervention spurs on D-wing often felt disappointed by the amount of intervention available to them. They frequently used the word 'shock' to describe their feelings about not having as much clinical input as expected. One participant who had experience of other therapeutic prisons explained that at HMP Grendon, the whole day would be structured by therapeutic activity, and he felt shocked when he discovered that D-wing was not organised in this way.

The newest arrivals to the intervention wing complained of boredom, and that there was not enough guided exploration of their difficulties. For some, there seemed to be a sense that they had been waiting a long time for all the intervention activities to be organised, and sometimes there was almost a sense of hopelessness, as illustrated by Participant 5, when he stated:

> *"...for the first 18 months, I was sitting here doing nothing, nothing, nothing at all."* (p5 238-239)

Participants described spending time on the wing alone as being boring, and seemed to be struggling to come to terms with the time they had in between interventions. Some participants who had been on the intervention wing longer were still finding this unstructured time hard.

> *"It was a shock when I got here to find out it's just a group you've got. I've got two groups a week in the afternoon, I've got a one-to-one on the same day that I have the group... and the rest of the week I'm practically on my own... I'm afraid I'm bored..."* (p9 62-68)

There were a few participants who seemed to experience strong feelings of betrayal and a lack of faith in the system. The second interview with the pilot participant described these feelings passionately. Whereas others stated that they were bored and disappointed as they had hoped they would be getting more input (e.g. p5), he recounted scenarios where he was sent to do craft activities, when instead he had hoped to be actively guided towards an understanding of his crime and himself.

> *"... we just kept getting put in the creativity rooms, sticking stars on the paper – well that's not therapy, you know that's not helping to learn about ourselves. They made promises and they couldn't keep those promises."* (ppii 32-46)

He seemed anxious to move forward, and expressed this frustration by being angry at the clinical team for letting him down:

> *"My expectations of intervention were certainly not as they've been portrayed... all that faith has been smashed to bits... they are not delivering what they said they were going to deliver."* (ppi 4-5 & 58-60)

In relation to the actual organised intervention, some participants were surprised that they were able to tolerate group activities, where they had expected high anxiety. They found that they were bonding with their peers and feeling a sense of belonging. Others found the group intervention easier than expected, and had hoped for it to be harder. Participant 9 seemed particularly frustrated by a perceived lack of motivation among some of his group members. He indicated clear ideas about how the groups were meant to work and his feelings that the staff should be more disciplined with the prisoners, making them work harder:

> *"... I was expecting it to be a lot... harder and a lot more of it... I mean, we don't discuss the things on the group that we should do, for a start. They say you can talk about anything you want, but most of the people don't wanna talk about their childhood because they're frightened... I was expecting it to be stronger in the fact that you had to talk about your childhood – no ifs, no buts, no questions – this group is about you talking about your childhood, so start talking, you know – if you don't talk then what's the point of you being here, this sort of thing – stronger..."* (p9 124-135).

There seemed to be an annoyance that the staff were not facilitating this particular group properly, resulting in this participant feeling that he wasn't getting enough out of the therapeutic process.

A particularly strong thread running through this subcategory was difficulty with the limit of 50 minutes for the one-to-one therapy sessions. Many participants said that they were not expecting this strict time restraint. They described the emotionally upsetting experience of building up to difficult disclosures and then having to work through the after-effects of therapy unsupported, and alone. Participant 5 described this experience, which is in many ways typical of the experiences of other participants:

> *"It takes about 40 minutes for that build up, to get it all out at the start, getting emotional, you with me? And 10 minutes later you are kicked out of the door, so then you've got to go back to your cell. You with me? And bang up, yeah, and your head's a mess, you're upset, you are physically and emotionally drained..."* (p5 268-274)

This category reflects the participants' frustration with the time spent on the wing in between organised therapeutic activities. They seem to find this time hard, both cognitively and emotionally.

Theme 4: Implications of the Term DSPD

The theme 'Implications' is defined by how the participants perceived and experienced the effects of having spent time on D-wing. There are two categories in this theme: the practical implications, which are more about how they may be treated differently by the prison system, and the emotional impact of feeling labelled by the term DSPD.

Category: Practical Implications of the Term DSPD

Participants felt that many prison personnel did not understand the term DSPD, and some said that other prison officers were not educated on the term. They heard from the officers who spent a shift working on a mainstream wing what other officers thought of those being held on D-wing:

> *"We've had our officers go off the wing and they have gone to other wings and they've been told, 'Oh, you working on D-wing, with the nutters, the crackpots, the*

dangerous ones – you know they'd rather stab you in the back than look at you... "
(p9 533-541)

As a result of this reputation and the lack of understanding of the purpose of DSPD treatment wings, the main implication is that prisoners on such units are treated differently than prisoners the participants would class as being equally dangerous. This has the perceived consequence that prisoners may not be granted release at the end of their prison tariff, and may not have their security category reduced. There was a general frustration that the people making decisions on their lives had not come to find out what DSPD was about, and were not looking at what prisoners on D-wing were trying to achieve. Many participants have made this point and Participant 8 illustrates this well.

"The Board of Visitors – they've no understanding of this place and its very hierarchy. Someone's on an A Cat... Now they go on their board and they say, 'Oh he's on DSPD, we can't reduce him.' Why don't they look at his progress while he's on here – look at the progress he's made instead of just automatically saying, 'Well he's on DSPD, we can't reduce him.' Yeah, and they don't understand what it's really like... they don't know what it is. They don't... even some of the staff on the wing, you know – they just don't understand what's going on in here. Yes, we are in here for serious crimes – we wouldn't be here otherwise, right. But A-wing – you go down to A-wing, you've got more nutters down there than you have up here. Because they're in for serious crimes, but the difference – I'm going to blow my own trumpet here – the difference between them and us is we want to do something about it, that's the difference, and we get called nutters for that... " (p8 648-683)

There is a sense that participants feel there is an immediate negative association with the term DSPD. This has the consequence that some feel they are treated unfairly when compared to mainstream prisoners who have an equally serious security category.

Participant 24 continues to develop the theme by saying it is the 'label' DSPD that frightens the people making decisions about their release, because they would not want the responsibility of releasing someone who has been categorised as being 'dangerous'.

"I mean, I was speaking to [name] *officer yesterday and I said, like, well, you know, it's like, erm, he said, 'Erm erm, other people said to me," he said, "the biggest problem you've got is that label because, you know, they said, it'll be a very brave guy who signs that release form, knowing that you'd been labelled with that."* (p24 136-141)

Participant 5 has described an experience of prejudice that he felt was due to being associated with the term DSPD, despite reassurance from staff on the wing. As evidence supporting his perspective, the participant explained that he had applied for accumulated visits. This is a system whereby a prisoner can save up unused visits, often in circumstances where it is difficult for family members to visit regularly because they live a long way from the prison. After a time, a prisoner can apply to move to a prison close to his family for a short period of time. This participant was experiencing difficulty with his application to move because no prison close to his family would accept him, and he believed it was because of the DSPD term.

"But I was just told by staff on the wing, psychologists, yeah? That it ain't what it sounds, it's just a name, DSPD. Yeah? But it is what it sounds, it is what it sounds, because if you was running the prison and you, you got 10 inmates coming from other prisons and one's coming from a dangerous and severe personality disorder unit, you don't want it. You're not gonna [pause]... *Anyway, it's been so difficult for me to get my visits when it's an entitlement, you with me, I've got them! But its been a, a big, big struggle."* (p5 508-518)

Participants have also thought about the implications of the term DSPD in the event that they are released. There were a few who hoped that because they had spent time on an intervention unit, there would be specialist support in place to help them with ongoing difficulties they may experience on the 'outside'. Another participant hoped that the term wouldn't disadvantage him, but that it would instead be recognised as an effort to address his difficulties:

"I hope that it won't have any disadvantages and people will see that I have made an effort to sort my life out and they'll take me for me and not as a label, you know what I'm saying – and that's what I hope for. And if people don't do that then that's their problem, you know what I mean. [15-second pause]" (p24 178-184)

Other participants seemed to be worried that the term DSPD would 'stick' to them on their criminal file. Participant 5 worried about the police making a routine check and how they may react on finding out that he had spent time on a DSPD treatment wing:

"Now for when I get out... I know I'm gonna have to carry this DS for the... rest of my life. I know I'm gonna have to carry that, yeah? But... I mean, you know, I mean, every time I'll get pulled up by the police when I get out, that's the first thing that's gonna flash up, that's the first thing that's gonna flash up." (p5 520-522)

Category: Emotional Impact of the Term DSPD

This category summarises participants' emotional responses to the term DSPD. Most felt that the term was punitive and unjust, as other mainstream prisoners who had committed serious crimes did not have an official 'label' of being dangerous. The participants felt punished for trying to help themselves address their difficulties and make themselves less dangerous. There was a hope that the Dangerous and Severe part of the DSPD term would be dropped once progress was made, but there is little clarity as to how this progress will be achieved, and this heightens their anxiety.

Most participants felt that to be associated with the term DSPD was a negative consequence of receiving treatment for their personality disorders. Many felt devastated and betrayed because they did not recall being made aware of the dangerous and severe part of the term. One participant felt that the term would make people stay away, and that it could have been worded better as it frightens people.

"DSPD – it's not a nice label 'cause when we leave here, other prison mates who are not used to it will say, 'Dangerous, severe – what's this for?' It's there, you see it in their faces at the time... They get wary – they get scared..." (p8 420-425)

Participant: *"I think severe is a bit harsh... it sort of makes out we're all nutters who haven't got a brain, do you know what I mean... And you know the thing, that DSPD label is just like – it's made to look just, just* [three-second pause] *you know it could have been worded a lot better without making us to look like, erm, sort of like monsters, you know what I mean."*

Interviewer: *"How better?"*

Participant: "[Nine-second pause] *I would say yeah, I think this is what it should be called, Emotionally Developed Personality Disorder.*" (p24 72-76 & 86-90)

Other participants described feeling hated and uncared for, and that the term DSPD only made this worse.

"Joe Public thinks that most of us should be took out into the yard and shot, yeah. Joe Public doesn't like prisoners, they don't like – they don't like people who are violent, yeah, and that's – they'd rather think that way." (p24 214-218)

In the long extract below, the pilot participant explained how the act of labelling would make someone feel. He questioned why humans should be labelled like food. He appeared to be questioning who benefited from the label, and wondering whether society deserved to know who or what they were dealing with. I understood from this interview that although he had distanced himself by talking in the third person, the DSPD label exacerbated his feelings of being almost subhuman, held in low esteem and unemployable. He drew the parallel of not meeting certain criteria, and he could be referring to being 'good' enough.

Participant: "... *How can I say this* [four-second pause] – *having a DSPD label is just another way for society to say that you are an outcast. Because at the end of the day, erm, why do we have to label everything, why do we have to give everything a label, you know. Now you could say, well, 'You know every type of food's got a label," yeah, but that's because then you know what you're eating, but we're talking about characteristics, we're talking about people, so why do we need to give somebody who already has, like, an inferiority complex or a shy complex, why do we then need to add to the problems that they've already got by saying, 'Well, they've got a label,' because that's what it is– it's just an added burden, isn't it."*
Interviewer: *"You said it's society's way of making someone more of an outcast?"*
Participant: *"Well, erm* [five-second pause], *as you know yourself, you've got to climb the ladder, haven't you, to be recognised, to get any kind of recognition in every walk of life, in every job, you've got to try and prove yourself, right. Now if you've got an office of 50 people and one of them – I don't know, but for whatever reasons – can't meet the criteria, right, erm, not only does it get ostracised and pushed to the side but, you know, it falls to the bottom of the barrel. Now that's what*

I mean – he's been labelled, you know, 'Oh he can't do his job right, blah, blah, everybody's talking about him." (ppii 491-529)

In the above example, this participant seemed angry not just at the term DSPD; he seemed to feel that he was somehow not good enough, and expected to be regarded negatively. It seemed that the term DSPD just acted to compound this affect.

Category: Fear of Sectioning

Some participants either directly stated or alluded to a fear that because they were being treated for personality disorders, at the end of their prison sentence, they might, if their difficulties weren't fully addressed, be threatened with sectioning under the Mental Health Act. Some said it was this fear that stopped other prisoners on mainstream wings from volunteering for therapeutic intervention on D-wing.

"A lot of the other lads on C-wing, who would benefit from coming over here, won't volunteer because the one worry they have is that they're going to slap a compulsory section on them and they'll end up in a hospital somewhere and never get out." (p1 157-160)

Participant 1 seemed to have a fuller understanding of current mental health legislation. He explained that you could not receive compulsory treatment for a personality disorder under the Mental Health Act as it was not deemed a treatable mental disorder. At the time of interview, he was aware that the government was attempting to remove the treatability clause from the act, which could make it possible for personality disorders to be treated involuntarily.

"... it's currently going though as a draft bill... the 2005 act... removes the treatability clause from the old 1983 act, which then means that personality disorders will come back into the compulsory sectionable conditions. Up until '83..., with a personality disorder you could be compulsorily sectioned under the Mental Health Act. '83 took it out of the system purely because the government at the time wanted to save money on the health service and the easiest way was to say, 'Oh, personality disorders are untreatable so we don't need them in hospitals, we can kick them all out. Well, now the, err, scapegoat cycle has come full circle and, err, and

personality disorders are now going back into the compulsory sectionable category ((laughs)).*"* (p1 102-113)

This participant implied that he considered personality disorder a treatable condition, whereas the government decided whether personality disorder was treatable or not for purely strategic reasons. It is important to consider that at the time of interview, a draft mental health act was being considered by the House of Lords, which has since been permanently rejected.

There is a considerable fear among participants that they are at risk of a compulsory section at the end of their tariff or sentence (for discretionary sentences). Some were anxious that their efforts to address their problems would then be futile. As this was a predominant view, a number of quotes are included to illustrate this point.

Participant: *"The one thing that frightened me the most because again, I'm doing life and it's a mandatory life sentence. Er, so to go this far in my life and think that the problems that I've got can be dealt with, then to be sectioned off."*
Interviewer: *"Can you tell me what 'sectioned off' means?"*
Participant: *"Yes, it's, er, when you end up in a mental hospital"* (ppi 156-174)

Participant 5 was asked about any worries he had about his expectations from D-wing:

"...What they can do to you at the end of it, that was another concern... how you can be sectioned at the end of it... If you are diagnosed with personality disorders, yeah, and, erm, come the end of your sentence they move you on and instead of getting released, they move you on to Broadmoor, Rampton, RSU's regional secure units, you with me here? Instead of getting released." (p5 84-102)

Participants were worried that the system would have the power to make them do more courses after the intervention on D-wing. They were concerned that the prison would hold them indefinitely, or that if they did leave the dispersal system, they would be sectioned by the Mental Health Act on release from prison.

Participant 9 seemed to worry that he volunteered to come onto D-wing in the hope that it would satisfy requirements to get him moving towards release. His perception was

that he worked slowly and he viewed the treatment intervention on D-wing as having a time limit. He was anxious that he may not 'pass' the course in the time allocated. He was also aware that the prison system could refuse his release or stipulate further courses for him to attend.

> *"I mean, it all depends on how long it takes these people here to – to move forward because I go forward slowly. Now they've got a set time, between three to five years, but you can overrun that, so I could be here for the next ten years – I don't know. At the end of this, after that, they might turn round and say, 'Look, I'm sorry Frank, but you need to do another course on this,' and that could be six months to a year or even more. And then after I've done that they could say, 'Sorry Frank, but you need to do this course, or you need to do that course to get out.' Erm, I don't know because life in here to me – well, it's in the prison system for the past few years now – has been nothing but courses, doing course for this, doing course for that, do this course, do that course and that's how it seems. I can – I can only – I volunteered to do the course, Miss, to try and see if I could get out, if in 10 years' time... It's when they decide that I am ready for release, they will release me."* (p8 622-638)

This goes some way to explaining the passive attitude towards change that some participants have. This participant perceives little autonomy in his life – for him, it seems like it is the institution that will decide his future.

Theme 5: Consent

Participants discussed their reasons for engaging in the programme. This ranged from a strong emphasis on volunteering to feeling that there was an unsaid coercion to consent. There was a general understanding that if they intended to progress and move towards release then they needed to accept and begin to address their difficulties. Since most of the participants were 'lifers' they were aware that ultimately the system had the power to detain them indefinitely, and therefore logically they would not be considered for release until they were considered less of a danger to the public. Some were aware that it was their difficulties that led to their crimes, and therefore it made sense to them to engage in a therapeutic programme.

Participant 9's account of his reasoning with a prison officer when deciding to come onto D-wing encapsulates the general experience of others:

> *"... Will I ever get out? Will I rot in prison because I mean, I have been inside 25 years now and I thought, 'What's happening, why am I here, why aren't they releasing me?'... It wasn't until I got here and they turned round and said, 'Well, because you've got personality disorders, we feel that if we release you, you'll go out and commit another crime... there's some problems out there you can't cope with and the reason why is because you've got personality disorders – these have to be addressed... you haven't been given strategies to cope with your personality disorders and as long as you haven't... you won't survive... you'll revert back to what you were before and the crime will happen again because you're not in control of it.'"* (p9 232-248)

There was an implicit message understood by this participant that unless he addressed his problems, he couldn't be released safely, and that this programme was suited to him addressing his problems. There was also a sense that once difficulties had been identified in the assessment phase of the D-wing package, prisoners were obliged to continue with treatment if they were to be seen to be addressing their problems. Regarding the same issue, another participant commented:

> *"Once you're here, you're stuck."* (p5 294-298)

One participant disclosed what seemed to be an extremely violent past within the prison system. He explained that no prison wanted him on the main prison wings because he was a danger to staff and other prisoners. It seemed that he was being permanently held in the segregation blocks in other prisons. This seemed to be a common scenario for some prisoners on D-wing. He said that when he was offered a place at Whitemoor, on an open prison wing, he was glad to be allowed out of segregation. Regarding his invitation to D-wing, he said:

> *"I mean, if they knocked on my door selling double-glazing, I would have bought it."* (p5 16-17)

He had an awareness that should he leave D-wing, he would return to segregation:

> *"I've been told... if I come off here... I could end up in any segregation unit in the country, and I don't want that."* (p5 300-306)

In this sense, I believe he felt that his options were limited. His choice to come onto D-wing was influenced by it being the only place where his anger and violence could be addressed and controlled without resorting to total isolation from other prisoners. I also felt, however, that the therapeutic atmosphere on D-wing afforded a quality of life no other prison could offer him, and it was in his best interests to be treated on the wing.

Several of the participants talked about past courses in mainstream prisons where they have felt persuaded to attend, including sex offender courses and courses in enhanced thinking skills. Participants explained that they needed to appear to co-operate with the system or their parole board would not look favourably on their case. This was described as *"hoop jumping"* or a *"bureaucratic exercise"* (p1). Participant 1, however, stated that although he attended such courses in the past, and had passed them, it was academic, and he did not feel that they had made any difference to him. He described a deeper emotional engagement in the DSPD programme, and he felt this was because the programme was relevant to him *"personally"*, and it was important that he'd had some autonomy in the decision to consent.

> *"... The difference is that on here we are all volunteers, and we want to be here, not because the system has said, right, you have to come on to it. I didn't have to come on here... It's a psychological difference... I am more a volunteer than someone who's been coerced."* (p1 95-121)

Others stated that the reason they came to Whitemoor was to take advantage of the specialist treatment programme:

> *"... It's the best opportunity for me to try and resolve these issues and so I am now taking advantage of what's on offer, you know, rather than just be negative and just say I'm not interested."* (p4 56-59)

Individuals stressed that they had spent time considering whether to come to D-wing, making sure that it was suited to their difficulties. For some, it felt like *"a big step"* because they had to admit that they had psychological difficulties; for others, there was an air of desperation, and it felt like *"the last port of call"* (ppi). The pilot participant said he had wanted to come onto the wing because he was afraid of his own behaviour:

> *"I knew there was something wrong, you know, before coming here I was willing to admit it, you know? You can have a laugh with your mates and say yes, you know I'm mad and crazy, blar blar blar, but there comes a time when you have to turn round and say, 'You know what? I am mad and I am crazy and I am off the wall and I am different – I am broken. I am this* [pause] *and I'd already accepted that, I already accepted that there was something not right – there was something going tick in my head that made me do certain things* [long pause]..." (ppi 442-449)

Others reasoned that D-wing presented an opportunity to take advantage of specialist intervention that was suited to their difficulties.

> *"It was these difficulties and issues which led me in the past to commit crimes which have then led me into prison. So you know, it's sort of like culminated in the depths somewhere and so now I am in this situation, then it's the best opportunity for me to try and resolve these issues and so on and so on. And so I am now taking advantage of what's on offer, you know, rather than just be negative and just say I'm not interested."* (p4 53-59)

The suggestion that prisoners have come from a system where they have had to show and convince people that they are changing and conforming may help to explain the common language they use in interviews. Most participants said they needed to address their difficulties in order to move towards release. In this last theme, there was an emphasis on the voluntary nature of their inclusion on the DSPD programme at HMP Whitemoor, although there was fear and confusion as to how much control they had over their future in terms of detention.

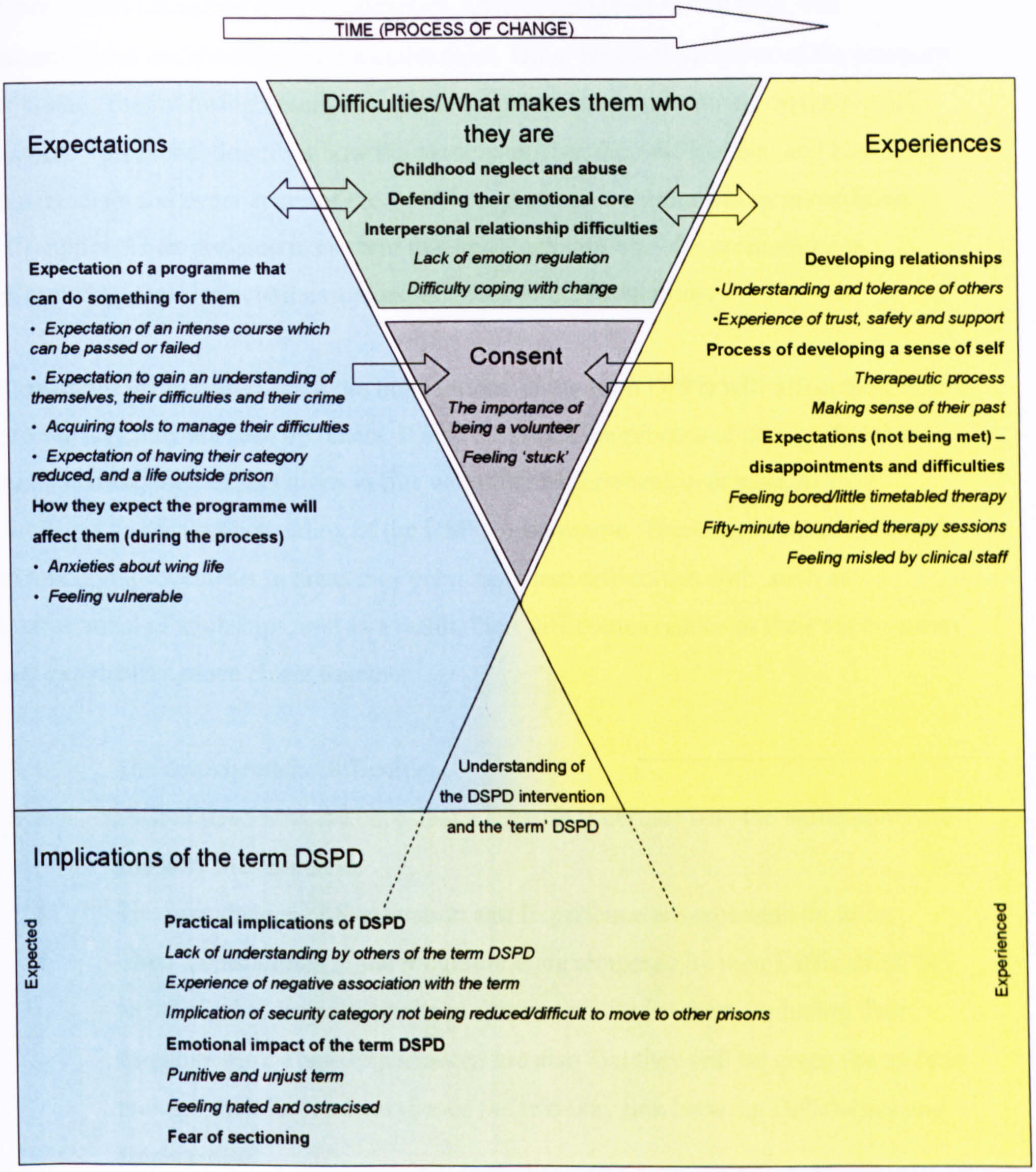

Figure 4: Extended model presenting the interrelating themes, categories and subcategories

The earlier model, Figure 3, which linked the themes, is developed in Figure 4 above, which shows categories and subcategories. Categories are shown in bold, and subcategories are identified with a bullet point. Other text is descriptive of the category or theme. The following description of the model serves as a summary to the results section. This model describes how the participants see their difficulties, and how their expectations and experiences of the DSPD programme are framed in terms of those difficulties. Their decision to consent to – and to remain on – the programme is informed by their expectations and experiences of the programme.

It describes their concerns that the implications of the term DSPD will affect their future and the way they are seen by others. It also describes the process of change that then starts to bring their expectations in line with their experiences over time, as they develop a greater understanding of the DSPD programme. Their experiences then start to reflect improvements in areas they previously had difficulties with, such as interpersonal relationships, and as a result, their difficulties reduce as their expectations and experiences move closer together.

1. The core theme is Difficulties.
2. Difficulties forms the core theme because it defines who the participants are and why they are here.
3. The twin themes of Expectation and Experience are separated by time.
4. Their Expectations of the programme are tempered by their Difficulties, in terms of what they expect the programme to do for them (reducing their category, etc). Their Expectations are also that they will be given the tools to manage their Difficulties (hence the two-way link between Difficulties and Expectation).
5. Their Experiences of the programme reflect that the nature of the programme is to address their Difficulties. With time, their Difficulties should be reduced by the programme, and we see some evidence of this in their statements (hence the two-way link between Difficulties and Experiences).
6. The discrepancies between their Expectations and Experiences mirror their Difficulties.
7. The overlap between Expectation and Experience indicates an understanding of the programme, which grows with time. This understanding extends into the theme Implications.

8. The theme Implications of the term DSPD, is an extension of the two themes Expectation and Experience (and is thereby linked with both of them), in that it covers the Expected and Experienced Implications. However, unlike Expectations and Experience, which deal with the intervention/programme, this theme deals with the perceived Implications of the term.
9. The decision to enrol on, and remain on, the programme is reflected in the theme Consent. The initial decision is driven by the participants' Expectations of the programme, and their ongoing Consent by their Experiences of the programme (hence incoming links from Expectations and Experiences).
10. There are other implicit links that logically should be present and can be inferred from what the participants discussed, such as from Implications to Consent. However, these links were not discussed directly.

This model serves to describe and explain the perceptions that the DSPD programme's participants have of the programme itself, and of life of D-wing. However, it also raises many interesting avenues for further work, some of which will now be highlighted in the discussion, together with a more interpretive stance on the model and data.

CHAPTER 4: DISCUSSION

Summary

The aims of this study were as follows: to use grounded theory methods to explore the expectations and experiences of prisoners who were engaged in the DSPD treatment programme at HMP Whitemoor (D-wing), and to develop a theoretical model that was grounded in the data; to hear the views of those receiving treatment on D-wing in order to gain a better understanding of this population; and to provide feedback from this research study to the service on D-wing.

The focus of the approach was to address the perspectives of those being detained on the wing. A semi-structured interview format provided the basis for asking participants about their experiences of their difficulties and the treatment process. Eight interviews were selected for a detailed analysis, using a grounded theory approach. Five main themes encapsulated the results from the interviews and these were subsumed into a theoretical model.

The main findings will now be outlined and discussed in detail, highlighting their contribution to the existing literature. The implications of these results for the DSPD programme will also be discussed. These implications, together with the results themselves, will be the focus of the feedback to the team on D-wing. The study's limitations and directions for future research are also presented. Measures taken to address the quality of the research are addressed, along with my own reflections.

Review of the Research Findings

Summary of the Main Findings

The main findings of this study are:

1. From the perspective of the participants, their experience of difficulties is consistent with those we would expect from the theoretical literature.
2. Participants' expectations of – and objectives for – joining the treatment are not entirely concurrent with those held by the DSPD programme. However, the objectives of the participants and of the service appear to become more congruent with the experience of positive change through treatment.

3. Participants fear the implications of negative association with the term DSPD; in particular, the misunderstanding of the term's meaning among people outside the unit. This conflicts with their prime objective for engaging in the programme.

Discussion of the Main Findings

The three main findings will now be discussed individually in more depth. These will be addressed in terms of how they agree and contradict the literature. The implications of these findings will be addressed in more detail later in this chapter.

1. Participants' Experiences of Their Difficulties

Participants' perspectives of their difficulties will be outlined before relating them to the existing theory. Their views concern how they perceive their problems, how their upbringing and life experience contributed to their difficulties, and how their personality disorders and the difficulties associated with them currently have an effect on their lives.

In terms of the participants' risk factors for developing personality problems, the findings are consistent with Paris (2001), who proposed that the association between adversity and mental disorder was related to an individual's vulnerability and a number of risk factors. Participants in this current study described several of the same risk factors that Paris (2001) associated with the development of personality disorder: firstly, dysfunctional families, and secondly, traumatic experiences. There were no explicit references to social risk factors, such as social exclusion. However, as Herman (1992) argues, many children who are being ritualistically or persistently abused are often kept socially isolated by their abusers.

Participants' perceptions of their problems included interpersonal and emotional difficulties; a past history of trauma in the form of being abandoned, neglected or physically and/or sexually abused; and dysfunctional family dynamics. Incidences of high anxiety were also described. Participants' accounts of their difficulties would therefore seem to validate, in part, the existing theory on the nature and aetiology of personality disorder. Participants described their childhood experiences as invalidating; either by being silenced by their abuser or not being believed by other members of their

family or community (if living in care). Participants' reflections on the link between their past trauma and their current problems were revealed in different ways – for example, perceiving their current angry outbursts as being similar to those of an angry and abandoned toddler; or stating that they had built up 'defences' that were created to cope with events in their past. Participants also perceived a relationship between the style of parenting they had experienced and their early engagement in criminal activity. Criminal behaviour was discussed in relation to their difficulties, not in relation to reform, punishment and acceptance of responsibility.

Participants' presentation of their difficulties may reflect an understanding they have gained through the stages of the D-wing model of treatment. Interestingly, a number of participants described the defensive and aggressive persona that had been adopted by many as an adaptive strategy learned in mainstream prison to avoid being judged weak or vulnerable by other inmates. The question as to whether mainstream prison environments maintain interpersonal difficulties has not been addressed in the literature.

In terms of the existing theory, the perceived interpersonal and emotional difficulties that participants described were consistent with the literature on attachment and trauma reactions. Emotional reactions seem impulsive and unconsidered, which is consistent with Siegel's (2001) theory which emphasises that in the absence of secure, healthy attachment relationships in childhood, fear and anxiety responses are more readily triggered than the higher order cognitive processing. Participants seemed to present with insecure and disorganised patterns of attachment styles, recognised by attachment theorists as resulting from neglectful, abusive and insecure childhoods (de Zulueta, 1994; Herman, 1992; van de Kolk, 1996). Participants had not generally made the link between how their current behaviour is maintaining these styles of relating. They did understand, however, that their trauma had had an impact on their developing personalities, and they also recognised that they had difficulties in the present, which they perceived in terms of everyday difficulties and personality disorder.

Unlike previous literature, none of the participants commented on what personal characteristics they had which may have made them vulnerable to abuse. They did not describe a negative self-image, nor blame themselves in any way for their abuse. They did not choose to discuss in detail their shame or guilt associated with past trauma.

Instead, they seemed to intellectualise the connection between being abused and subsequent personality development. Herman (1992) has described some abused children feeling guilty that they didn't stop the abuse occurring. She rationalised that these children were not able to dissociate from the pain and abuse, and instead adopted an attitude of self-blame, where they would seek faults in their own behaviour to make sense of the reason for them being abused.

Herman (1992) would explain the findings in this current study by continued use of the defence strategy dissociation. Dissociation in this case is the ability to alter reality by imagining that abuse is not occurring to an individual. A potential consequence of the pervasive use of dissociation is impoverished emotional development as adults. However, participants in this current study did not explicitly reveal this survival strategy. They did not verbally disclose or self-reflect feelings or absence of feelings experienced as children. Participants did, however, relay their current confusion with emotions. They described emotional outbursts (anger) they could not understand, predict or control.

An explanation for how these maladaptive defensive strategies are maintained in the present treatment regime is explained by Butler et al. (2006), who adheres to theories suggesting that individuals survive by adopting coping strategies to protect them from painful realities (Herman, 1992). Psychoanalytic theory suggests that when enduring emotionally stressful environments that are not recognised and contained in childhood, the defence strategies used can become pathological in adulthood (Steiner, 1993).

One of the defences that was most evident among participants was the prevalence of anxiety. Anxiety and dissociation can result from a past coping strategy or defence adopted to survive traumatic life experiences (Butler et al., 2006; Herman, 1992). Participants were anxious and defensive when addressing their maladaptive patterns of interacting. This anxiety can be conceptualised within Young's schema theory (Young, 1994), which forms part of D-wing's treatment model (Butler et al., 2006), whereby any challenge to the individual's core beliefs or schemas relating to how the world works is uncomfortable and provokes anxiety.

The current study presents a much more complex picture of the importance of anxiety in the lives of these participants. Although some participants perceived the main problem to be an absence of emotions or feelings, anxiety was one emotion with which these

participants appeared to have problems. They saw anxiety as a difficulty that related to treatment on the wing. For example, participants described feeling anxious about first coming onto D-wing, when first experiencing the supportive nature of staff, and when exposing personal weakness to other inmates. They also described feeling anxious, worried or emotional about any change from the norm.

Participants discussed strong sensations of anxiety when they took risks in their interpersonal relationships – an example would be talking openly to a fellow prisoner regarding how something they said felt like a personal insult, or a threatening attack. They also talked about how violence towards themselves though self-harm, or towards others though physical means, would have been the normal coping strategy for many of the prisoners on D-wing. Participants reflected on their surprise and sense of achievement when managing to talk to a member of staff or a prisoner about a problem, and it being resolved without resorting to violence.

Participants also recounted their feelings of being overwhelmed by thoughts and emotion as a consequence of the therapeutic environment. This would become apparent through spending time in their cell alone for days, crying and wanting to isolate themselves from others; shouting at staff or inmates; fighting with other inmates; being physically abusive to staff (although many stressed that this was now a rare occurrence); and having an angry outburst and destroying property. The feelings of being overwhelmed were perceived as resulting from a difficult and emotional therapeutic intervention and/or unavoidable changes to their routine (e.g. changing their one-to-one therapist). It could perhaps have been expected that they would have viewed this as a necessary part of the therapeutic process to be endured. Managing these uncomfortable scenarios, however, was not generally described by participants as being part of the therapeutic process, and more as a consequence of it.

Participants did not discuss the link between gaining empathy, understanding others and being able to have adaptive relationships. The difficulty with regulating proximity in relationships was discussed in detail by only one participant, who described not having the capacity to regulate the intensity of his friendships. He perceived this as a difficulty that D-wing was there to address. There was a general understanding by the participants that they lacked empathy and that gaining empathy would mean they could feel for their

victims. Some participants discussed feeling anxious about this prospect. There was also a general perception that they had not yet developed empathy.

Participants' experiences of relationships concur with D-wing's treatment model, which adheres to de Zulueta's (1994) proposal that personality disorder could be better understood as a *"complex attachment disorder"*. D-wing's model states that:

> *"... the dysfunctional behaviours that are adopted by people with personality disorder are attempts to maintain relationships with others that have evolved in unusually adverse childhood relationships."* (Butler et al., 2006:6)

From participants' descriptions of their experiences of developing empathy, it appears currently to be in a passive or intellectual form. For some this could be a reflection of their movement towards stage three of D-wing's model – Exploration – whereby prisoners begin to acquire a psychological framework for their difficulties, begin to recognise sequences of events that lead to problem behaviours, and build up motivation to change (Butler et al., 2006). However, it seems that tremendous anxiety remains, which inhibits their ability to let down some of their defences, self-reflect on their current interpersonal style, and recognise the internal benefits of changing.

2. The Relationship Between Participants' Expectations and Experiences of D-wing

The findings of this study suggest that participants' expectations and objectives for joining the treatment are not entirely concurrent with those held by the DSPD programme. The participants' and the service objectives, however, appear to become more congruent with the experience of positive change through treatment.

The present study indicates that the participants' perceptions of what the DSPD programme can offer them can be divided into two separate treatment objectives:

1. The participants view the programme as a course on which they have to 'tick boxes' to meet certain criteria in order to be able to move on and achieve their goal of having their security category reduced.

2. The participants view the programme as a means of addressing their difficulties, gaining an understanding of themselves and their crime, and reducing their risk of re-offending.

The first of these objectives is strongly endorsed by many participants in this study. Unsurprisingly, it is not listed in the aims of the D-wing's treatment model, nor the objectives of the DSPD programme in general, and the participants' experiences reflect this. Reducing their category was a specific aim of many of the participants. They now felt as if their category had been raised by their acquisition of a DSPD label. Participants complained that there was no official feedback from the prison to suggest otherwise. Alongside this, some participants (particularly those who had only recently joined the intervention spur) expressed feelings that the programme was not moving quickly enough towards their goal; they felt that therapy was not intense enough, they felt 'stuck', and they felt that the clinical team was not delivering their promise.

Sainsbury et al.'s (2004) hospital-based study found that their participants valued being able to contribute to the content of therapy and were demotivated by the indecision from management regarding therapeutic input. The current study concurs with this. In fact, participants commented that they felt let down and betrayed by not beginning certain aspects of intervention when they were expecting to.

Prisoners' objectives may be an inevitable consequence of having spent time in mainstream prison, where it is beneficial for prisoners to attend short-term, less intensive and possibly less emotionally demanding courses. In this way, it seems that there is a mismatch in expectations between the DSPD programme and the participants of this study. A way of matching prisoners' and the DSPD objectives at this early stage would be to offer more advice and information to prisoners during the assessment phase, discussing the nature of change and the aims of the programme.

The findings in this study provide information about participants' overall perceptions of the programme when compared to situations where participation is not voluntary. Findings suggest that D-wing is experienced as being therapeutic and supportive by participants at varying stages of the therapeutic process. Participants commented that they would not have been able to address their interpersonal difficulties in mainstream prison.

Ryan et al.'s (2002) study on the perspectives of detainees in a high-security hospital found that some believed that the prison environment would not be therapeutic, would not validate their difficulties, would be punitive, and they expected their safety to be compromised by violence and bullying from other prisoners. This does not appear to be the experience of the participants in this study, however, some acknowledged similar views of the main stream prison environment. Most of the prisoners in Ryan's study had some experience of prison, and it is assumed that this would have been on mainstream prison wings.

Sainsbury et al.'s (2004) study found that positive experiences of treatment revolved around a safe and supportive therapeutic environment. A distinction should be made between what motivates male offenders with personality disorder to decide to engage in a treatment programme and what maintains their engagement in a treatment programme. Participants in Sainsbury's study would have been compelled to take part in the assessment and treatment. In contrast, those in the current study are volunteers and can leave at any time. Therefore motivating factors (in voluntary settings) may be different. Ryan et al's (2002) study suggested that some hospital detainees would prefer to have an expected release date believing that this would prevent them from feeling stuck in the psychiatric system. The present study highlighted the importance of being a volunteer but also a discrepancy between what the participants expect from treatment (i.e. they are still aiming towards release) and what their experiences actually are.

The second objective concerns participants committing to a programme of personal development and change. It is wholly aligned with the formal objectives of the DSPD programme. Despite the participants being involved in a voluntary capacity, assessing the participants' motives is difficult. It is interesting to note that a number of stock phrases are present in almost all of the narratives, such as, *"I don't want to be released before I am ready"* and *"I want to make sure I don't hurt anyone again,"* and, *"If I hurt anyone again, it'll be their* [the services'] *fault"*. There may be an element of the participants voicing what they think they should be saying to achieve their goal of moving on.

Participants were interviewed from both Green and Blue Spur and, therefore, have had a varied amount of experience of the DSPD programme.

The participants' experiences of D-wing appear to gravitate their expectations of the programme towards the second objective (addressing their difficulties) as they recounted positive experiences of improving interpersonal relationships within groups and in general wing life. Therefore, it is reasonable to hypothesise that participants' perceived expectations will change over time.

I would hypothesise that as participants experience the benefits of the programme, their anxieties lessen and their expectations come more into line with those of the programme, although they may have resigned themselves to not having their category reduced. In this study, participants reported their experiences as being more positive than their initial expectations as their fears and anxieties are allayed and they start to see the benefits of the programme. As previously mentioned, a further longitudinal study, interviewing prisoners at different stages of their treatment, would clarify this.

Fear of change associated with D-wing's model is addressed within Stage 1 of the treatment programme. At the same time as collaboratively formulating their difficulties, prisoners are encouraged to develop supportive and therapeutic relationships with the wing staff (Butler et al., 2006). The findings suggest that this stage of therapy is much appreciated and is incredibly important to participants on D-wing.

In the present study, participants valued the experiences of developing relationships, feeling supported and physically safe on the unit. These findings are consistent with Sainsbury et al. (2004) hospital study. The current study also revealed participants' perceptions of anxiety around initially building those relationships at the outset of therapy, and their surprise at being able to develop such relationships with prison officers.

One significant finding of the present study was that participants displayed a fundamental and profound anxiety at the prospect of attaining the second objective (i.e. the process and result of change through addressing their difficulties in therapy). Despite knowing that their current state was fraught with difficulties and anxiety, the thought of changing appeared to be more uncomfortable than maintaining their difficulties.

One participant stated that his defences would be drawn down, Pandora's box opened and empathy felt. It appears as D-wing's model predicted (Butler et al., 2006), that the participants are frightened by the thought of any changes to the status quo.

Interestingly, Sainsbury et al. (2004) found that a negative motivating factor for engagement in therapy was having to expose vulnerabilities to peers during group work. In the present study, although participants described this process as uncomfortable, difficult and fraught with anxiety, they recognised that it was a necessary component of therapy and it was necessary in order to move forward. Perhaps this difference could be explained by the stage of change of participants and the compulsory status of the various programmes.

3. Negative Association with the Term DSPD

Participants discussed their fears regarding the implications of negative association with the term DSPD, particularly among people external to the unit misunderstanding its meaning. This contradicts their aim of reducing their security category and moving towards release.

While DSPD is not intended to be a diagnosis or a label (Bell et al., 2003), it is often used as such. Participants commented on the term DSPD being used in relation to their difficulties, and to describe the treatment unit, but also said that it has been referred to as a label. Participants themselves at times used the term DSPD as a diagnostic label.

There is much confusion and contention surrounding the concept of DSPD as a term, rather than a label or diagnosis. Many of the participants viewed DSPD as a label and were particularly concerned that the 'Dangerous and Severe' (DS) part of the term represented an increase in their category, which they perceived as moving them further from release. They were unhappy about this as they felt that they volunteered to be part of the programme in order to actively address their difficulties, while others not on the programme who they perceived to have similar difficulties had no association with such a term.

One participant relayed the experience of negative association with the term DSPD when he requested a temporary stay in an alternative prison. He believed that other

prison governors did not want the responsibility of accepting a DSPD prisoner. This was the only experienced incident cited by a participant. Participants did report on their expected consequences of being a DSPD prisoner, particularly with regard to a negative attitude from other professionals in positions of power, such as boards of visitors and parole boards.

Participants suggested that their anxieties around labelling did not relate to the attitudes from officers or staff on D-wing – it came more from the lack of understanding among those who feared the term outside the programme. The implication here is that the findings from Bowers (2002) and Bowers et al. (2005), which stressed the importance of a positive attitude from staff, seem to have been taken on board.

In terms of feedback to D-wing, a positive, non-judgemental attitude should be encouraged and maintained throughout the treatment process. Attitudes from outside the programme may be contributing to a negative association with the term DSPD. There were suggestions from participants that they wanted more visitors on the wing to encourage a more positive attitudes. A further recommendation from this research would be to encourage a general awareness and education about DSPD during staff inductions.

Several participants expressed concerns regarding 'failing' at the DSPD treatment, or not being seen to address their difficulties. They were anxious that they would never be released, or be sectioned to a hospital unit. Some commented that they felt stuck.
In the study by Ryan et al.'s (2002) participants have commented on a similar concern with feeling stuck within the hospital psychiatric system. Ryan's participants supposed that in prison they would receive some protection from this due to having an expected release date. Most of the participants in this study have, however, surpassed their expected release date; they are not in mainstream prison and have chosen to engage in a therapeutic treatment programme. It would appear that the anxieties regarding moving towards release from both the therapeutic prison and the hospital environment are similar despite the voluntary nature of DSPD in prison.

Prisoners assume that engaging in the treatment will help them towards release. It may become clear in future documents from the Home Office and the DSPD programme whether this will be the case. There is some reference in the joint Department of Health

and Home Office paper (1999) that in the future, there would be lower-category DSPD step down units. Currently, there is an absence of such units and no indication of time scale for these developments.

The term DSPD is a new concept and, at present, it is unclear how it will affect individuals assessed as meeting DSPD criteria in the future, especially regarding the attitudes and actions of people in power outside the DSPD system. Participants in this study also commented on the longer-term implications of the term DSPD. They discussed the implications resulting from their perceptions of how others outside of the programme viewed and understood the term DSPD, and they were particularly concerned with how this may affect their prospects in later life, should the perceived stigma of the DSPD term remain with them.

In this study, participants seemed to make the distinction between their diagnosis of personality disorder and association with the 'dangerous and severe' part of the term. In relation to the label of personality disorder, participants seemed to accept it as a description of their difficulties. They did not comment on their experience of 'PD' (personality disorder) in isolation, nor whether it was stigmatising or a judgement of their 'treatability', as suggested in Castillo's (2000, 2001, 2003) research. Perhaps this was because they were actively engaged in a treatment programme to address those difficulties and felt supported and validated during the process.

Implications From This Study

One aim of this study was to provide feedback to the clinical team on D-wing. This has already begun in the form of discussions with the clinical director (my field supervisor). The results and potential wider service implications have also been discussed with a clinical psychologist working at the DSPD unit at Rampton Hospital. I intend to make a brief summary of the findings available (after consultation) for prisoners and other interested staff. I hope to publish this research, thereby making available my findings to a wider audience. Implications for the DSPD programme will be presented before outlining the potential for future research.

Implications for the DSPD Programme and Wider Services

In this section, implications and recommendations for both D-wing, the DSPD programme in general and the wider service will be presented.

1. The theoretical implication for this research study is that the experiences and understanding of people who have a diagnosis of personality disorder and meet the DSPD criteria for treatment appear to be consistent with the current theory of the aetiology of personality disorder. There has not been a great emphasis on hearing and understanding the perceptions of those individuals with personality disorder; this study therefore adds to this literature and can aid the DSPD service in their understanding.
2. The therapeutic treatment model adopted on D-wing seemed to be positively received by the participants of this study. Participants had an understanding of the theory of personality disorder, which is adopted on D-wing to educate prisoners into the nature of their difficulties.
3. Generally, the prisoners valued their experiences on D-wing, particularly the supportive and understanding nature of experienced staff. It seems important that this is encouraged and maintained throughout their treatment.
4. The subject of managing the therapeutic change process was discussed in the findings. For example, participants discussed their high anxiety, their boredom between organised therapeutic intervention, and feeling overwhelmed with emotion. It appears that some of these difficulties concerned problems with managing the process of change, and a lack of awareness of the self-reflective component to therapeutic change. This process would occur in and between organised interventions. Individuals seemed to require different types of therapeutic input at different stages of change (Honos-Webb and Stiles, 2002). This appears to be something that D-wing has already considered thoroughly, since their treatment system is based on a model of change.
5. Prisoners have a lot of input to the treatment through their consenting to assessment and engagement in the programme. It is important, however, for the team on D-wing to be aware of the discrepancy between the expectations of prisoners and the aims and objectives of D-wing. Generally, participants were anxious about wanting to move towards having their category reduced. They were also concerned about the possibility of indefinite detention though the

prison or psychiatric system. Participants were frustrated with the system delaying or not delivering the planned therapeutic intervention. The slow beginning may contribute to their belief that they are not moving through treatment towards having their category lowered. Perhaps the model on D-wing could address these issues by discussing the concept of moving towards release and the fear of indefinite detention both during assessment and throughout the treatment plan. The D-wing team could ask prisoners what they need in terms of feedback on their progress and could clarify to participants when and how treatment intervention is organised. These difficulties are also reflections of the developmental nature of the DSPD programme, because as yet, there have not been any outcome studies carried out on the programme.

6. Participants' voluntary status seemed crucial as the motivation to engage in the treatment programme on D-wing. Participants spoke about 'passing the assessment' and 'meeting criteria' as a positive aspect, as this meant they were eligible for specialist treatment. This may explain why they had high expectations. The results of this study should enable future prisoners who are considering joining the programme to have a full discussion as to what they are consenting to and what the implications of treatment will be.
7. The implications of being a volunteer do not apply to hospital-based services where DSPD 'patients' are compelled to be assessed and attend treatment. Individuals being treated at hospital sites will have less autonomy regarding their engagement. This study highlights the benefits of having the choice to engage in a treatment programme, and it makes sense not to be compelled when the treatment encourages positive therapeutic interpersonal relationships with staff. Perhaps other programmes could regard motivation to change as part of the assessment criteria for inclusion into DSPD programmes, and consider offering individuals detained under mental health legislation a choice of DSPD or mainstream hospital treatment.
8. The current contention and lack of clarity around the term DSPD perhaps also reflects the developmental nature of the programme. There is a need for agreement on what it means to be associated with the term DSPD, and what DSPD treatment aims to achieve. This study has highlighted the fears of those who have association with the term, and how, due to the lack of understanding of others, this may negatively affect them in the future. It seems prudent for all

staff who work in hospitals or prisons with DSPD units, and staff who will work in future DSPD step-down units, to be educated on the term during inductions.

9. The findings of this study will be of interest to the wider services working with personality disordered individuals, both in a detained setting and externally. One of the main findings from this thesis is that people with personality disorder may have inconsistent expectations throughout their treatment this is as a consequence of their interpersonal difficulties, which means that they find it difficult to marry their expectations with their experience of treatment. Therefore, clinicians may find it useful to re visit these expectations throughout therapy in a format which is sensitive to their difficulties. This is applicable in which ever service the treatment is offered.

Methodological and Ethical Implications

In this section, the implications for conducting further research with personality disordered and/or forensic populations in their own environment are considered.

1. Participants in this study seemed to positively engage in the interview process, they were able to provide balanced views and felt safe enough to disclose details regarding their difficulties. It appeared important to provide the participants with clear rules of the research process, including issues of confidentiality. It was also essential to be organised and punctual when visiting the prison and conducting the interviews.
2. While researching in a high-security prison environment, it seemed important to understand and acknowledge the range of professionals who run the service and the rules visitors need to follow. This may seem obvious, but there are a number of protocols to bear in mind when planning further research, including: health and safety, personal security protocols when working with prisoners, a Criminal Bureau check (if interviewing prisoners alone), ethical protocols, not having keys to move around the prison, organising escorts, and acquiring permission to take recording equipment in and out of the prison.
3. The psychological wellbeing of the researcher should also be considered when conducting research with this population. A researcher's role is very different from a therapist's role: they do not know the personal characteristics of the

participant, they have no remit to contain or address difficult and distressing subject matters, nor to challenge subtle behaviour they may feel inappropriate or abusive. Therapists have supervision and lines of management so they can discuss the content of interviews, while a researcher is not required to do this. In addition, the researcher is bound by confidentiality as to the content of interviews (apart from the exceptions noted in the Method section on confidentiality). I would recommend that researchers organise external debriefings when collecting emotionally-laden interview data. Occasionally, potential participants from this population may (consciously or unconsciously) use the interview scenario to abuse the interviewer – for example, by manipulating the interview format, or by discussing uncomfortable subject matter. Researchers should perhaps consider how to manage this scenario (for instance, by role-playing possible uncomfortable scenarios).

Limitations of the Research

A number of limitations became apparent during this interview process. I was in the unusual position of having a large response rate from prisoners on D-wing. From past research conducted at HMP Whitemoor, it was thought that the likely number of volunteers would not exceed 10. This study required only six participants. Eight interviews were analysed. All volunteer participants (24) were interviewed. This was a stipulation for ethical approval, and it was necessary to select participants from this potentially large sample for detailed analysis.

Were this study not limited by the size of a doctoral thesis, and were further resources available, a larger study could have been conducted. Analysing all 25 interviews within these constraints could only have been considered with the use of a content analysis approach.[8] Content analysis would require a set of precise categories to be developed, and the number of instances of these in each transcript would then have been counted. This study is a new area of research and it demanded a more explorative approach to develop new theories that were grounded in the data.

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[8] See Silverman (2000) for further details.

The selection of eight out of the total twenty five interviews was guided by the need to analyse interviews from as many different views as possible, as well as studying people with a range of difficulties and past offending behaviour, who were at different stages of D-wing's programme of intervention.

Further limitations of the selection process were that individuals who compromised the wellbeing of the interviewer (see the section on Methodological and Ethical Implications) were excluded from analysis. Another volunteer was also excluded after being interviewed because it was thought that he may withdraw his consent in the future. I felt I was right to exclude these people, because even though consent was not ultimately withdrawn in this case, it would have posed significant problems for completing the study. Ideally, with further resources, a different researcher could have analysed the excluded interviews.

For practical reasons, all interviews were completed, selected and transcribed before analysis began. A potential limitation within theory development was that a negative case analysis could not be completed. As I previously stated, however, the interviews analysed had a range of views and opinions and saturation was reached, meaning no new material was emerging from the interview transcripts.

One of the main findings indicated that participants had an understanding of personality disorder theory, when discussing their interpersonal difficulties. It is unclear how much the participants' understanding of their difficulties is an effect of their inclusion into the programme. It was not possible within the scope of this study or the chosen methodology to explore participants' use of familiar discourse (e.g. participants at times used words associated with psychological theory, such as *"core beliefs"*, *"early trauma"* and *"maladaptive schemas")* in relation to the language they used to describe their difficulties.

There are limitations that should be acknowledged when conducting research with this population. There may have been a certain amount of 'impression management', meaning that participants may have chosen to share the views they thought I would want to hear. It is also known that this population (high PCLR scorers) has a tendency for pathological lying (Hare, 1991).

This study, however, takes the stance that the views and experiences participants chose to share with the interviewer were relevant and important to them. There is also a need for this population to contribute to research that may affect their care (Coffey, 2006). This population has proven ability to participate in research and this has been addressed in other sections of this thesis.

Directions for Future Research

The following section summarises the main directions for future research.

1. How and when do individual participants experience change during treatment, and to what extent is the treatment itself socially conditioning individuals in their understanding and experience of their difficulties? A longitudinal study of individual cases would be worthwhile in gaining deeper insight to the above questions. The individual stages in treatment could be explored in relation to any changes in the participant's experience of difficulties associated with their personality disorder, and any developing personal insight. This should help discover whether it is the treatment that is socially conditioning individuals to describe their difficulties in a certain way, or whether at a certain stage in treatment they are able to integrate this understanding with their own experience.
2. Do individuals who believed they had made progress in addressing their difficulties on a DSPD unit think they would 'revert back to the way they were' in mainstream prison? It was not possible to explore this within this study. To what extent does mainstream prison maintain the difficulties associated with personality disorder and/or antisocial behaviour? A study exploring the experiences of prisoners being detained in mainstream prison, particularly the strategies employed by prisoners to survive in that environment, would contribute to our understanding of this.
3. To what extent is the perceived fear of negative association with the term DSPD likely to occur, and is there still confusion about the term DSPD? How is having spent time on a DSPD unit likely to affect a prisoner's future in the prison system from the perspective of people who make decisions about security and movement down the system? It would be interesting to explore how the decision-makers in prisons understand the term DSPD, and how they perceive people who have

received treatment on a DSPD unit. It would also be worth looking at whether the term DSPD had any effect in their decision-making about an individual whose history was similar, apart from time spent on a DSPD unit.

Measures to Ensure the Quality of the Research

I endeavoured to follow the quality standards recommended by Elliott et al. (1999), Henwood and Pidgeon (1992, 2003), Stiles (1993) and Yardley (2000). For further details, see the Method section 'Issues of Quality'. I adopted an interpretive stance throughout this research study, and have therefore aimed to own my own perspective, and to have situated the sample. The level of detail given regarding the individual participants was restricted to general information in order to reduce the possibility of individuals being identified by professionals working at the unit. The reporting of the analysis and results has been a transparent process ('transferability'), providing examples of coding, memos, diagrams, and verbatim quotes from the interview texts. I have also provided examples of the interviewer checking her shared understanding with the participants ('being sensitive to negotiated realities').

In terms of the quality criteria 'coherence' (Stiles, 1993), a qualitative research support group was attended, where coding and emerging theory were discussed. Results and interpretations were presented to my field supervisor and to an external clinical psychologist from Rampton Hospital DSPD Unit, who had not been involved in the research until the final stage. His distance from the research enabled me to discuss the research with renewed focus, particularly regarding how the findings could have implications for the DSPD treatment programme as a whole. The results of these two processes fed into the Discussion chapter, particularly with regard to the wider service implications.

It was not possible to return to D-wing to conduct a focus group with participants of this study. The idea of a focus group is to present the initial themes emerging from the interview data and discuss them with the participants. This is a useful quality method often adopted to both develop the richness of themes, and to ensure that the analysis remains close to the data (Silverman, 2000). In this study, interviews concerned participant's expectations and experiences of treatment. A focus group could have only

been conducted nine months after initial data collection. As the participants were engaged in ongoing treatment, it was thought that they may have been moving towards a different stage of intervention (resulting in different perceptions and experiences of the wing). A focus group was therefore not conducted.

Elliott et al.'s (1999) final quality criteria was that the research should *"resonate with the reader"*. Since I have been immersed in the literature and the data, it is hard to imagine myself reading this study for the first time. However, to some extent, my discussions with the clinical psychologist from Rampton Hospital helped me gain an 'external' perspective, and I hope I have been successful in bringing to life the perspectives and experiences of those detained at HMP Whitemoor D-wing.

Reflections: The Research Process

Reflexivity is related to quality criteria. Both Stiles (1993) and Finlay and Gough (2003) discuss the value of reflexivity in enhancing the quality and transparency of the research (see also 'Issues of Quality' in the Method chapter). The aim of a reflexive section is to acknowledge how the researcher's way of thinking (interpretations and emerging theory) is influenced by the research process.

In this section, I wanted to document some of my feelings and experiences of the research collection and analysis that were felt relevant. Primarily, I wanted to comment on the process of conducting research in a high-security prison environment. I admit to feeling anxious about meeting the participants. I was conscious about my personal safety and whether the participants would engage in the interview process. Despite my initial worries, the prisoners on the wing showed interest in the research and they seemed aware of my inexperience of prison life (the noise, the lack of independence regarding movement and prison language) and generally attempted to accommodate me. Bearing in mind that this population have interpersonal difficulties, I felt they managed to engage in the process extremely well.

As a therapist, I felt somewhat out of my comfort zone working as a researcher. I felt that I had the skills to actively listen, hold silences and attune to the sometimes terrible feelings of sadness or the high anxiety of some participants. I generally felt sympathetic

to their past experience of trauma and difficulties. It was very important to me that the participants felt safe and heard during the interviews, and my sense was that this was achieved.

I should acknowledge how exhausting and difficult it was completing so many interviews over a short space of time, especially given the emotional content of the interview material. It was important, due to the sensitive nature of this population, not to appear tired, nor show favouritism, nor disrupt the wing more than absolutely necessary.

At times during the interviews, I was aware that I was not part of the clinical or the security team, and as I spent most of the day talking to the prisoners, I could feel quite isolated. I was also aware that I was bound by confidentiality and although I was invited to the prison team debriefs, I was not able to share the content of the interviews (see 'Methodological and Ethical Implications' in the Method section). I was staying near the prison, away from my own home environment, and at times I felt incredibly sad. On reflection, I realise I was tuning in to the powerful transference communications from the participants. I sought support from one of my academic supervisors after four days of interviewing, which helped to validate some of my own feelings regarding the process. On reflection, I should have organised a daily debrief from an independent source.

The prison security staff challenged a prejudice I did not realise that I had. I had expected them to be quite stern and formal, but they were incredibly professional, while being interested, supportive and helpful, both on issues of security and managing the interview schedules. I was very dependent on them, needing escorts to move from room to room. This was not as easy as I had expected it to be since the prison was a very busy place. However, security staff made this as easy as possible for me.

An interesting reflection is that during the process of data analysis, when listening to the interviews and reading the transcripts, I noticed that at times, participants spoke fluently, and similar phrases were used by different participants. Perhaps this suggests that participants have used these phrases before. At other times, when participants were talking about examples of actual experiences, I noticed frequent pauses, and their speech was somewhat broken. Perhaps in these instances, participants were thinking as they were talking, it seemed unrehearsed.

As declared earlier, my personal stance is one of sympathy with this particular prison population. Due to this sympathy I am aware that during the analysis I became increasingly empathic to prisoners believing that the treatment was having a positive effect. Whilst I attempted to report the perspectives of the participants, I am retrospectively aware that the results do not directly criticise the treatment model and may in parts have reflected this personal stance.

It was a challenge after the analysis to re-engage with psychological theory, as I had deliberately attempted to remain neutral during this process. As a result, a break from research was taken. Most of the theoretical reading and enquiry into the treatment model used on D-wing was completed at this late stage. This enabled me to revisit the results from a fresh perspective.

Concluding Comments

This current study has broadened our understanding of how this population view their difficulties when engaged in HMP Whitemoor's DSPD treatment programme. It has generated theory as to the expectations and experiences of those who volunteer to engage on a DSPD treatment programme in a prison environment, and has emphasised that the current contention and confusion over the term DSPD seems to have a negative effect on the clinical population. The findings will feed back into the ongoing development of the DSPD service and provide insight into the perspectives of those receiving treatment at a prison-based DSPD treatment site.

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APPENDIX ONE

Definitions of the Subtypes of Personality disorder DSM IV-TR

Table 1 presents a brief description of the 10 standard personality disorders (DSM IV & DSM-IV-TR) and the two personality disorders under review in the Appendix of DSM-IV-TR. Table adapted from Siegal, Coolidge, Rosowsky (2006).

Personality disorder	Brief description
Paranoid personality disorder	A pervasive pattern of distrust and suspicion of others such that the motives of others are perceived as malevolent
Schizoid personality disorder	A pervasive pattern of detachment from social relationships and a restricted range of emotional expression
Schizotypal personality disorder	A pervasive pattern of social deficits marked by acute discomfort with close relationships, as well as eccentric behaviour and cognitive and perceptual distortions
Antisocial personality disorder	A pervasive pattern of disregard for, and violation of, societal norms and the rights of others, as well as lack of empathy
Borderline personality disorder	A pervasive pattern of instability in interpersonal relationships, self-image and emotions, as well as marked impulsivity
Histrionic personality disorder	A pervasive pattern of excessive emotionality and attention-seeking behaviour, with superficiality
Narcissistic personality disorder	A pervasive pattern of grandiosity, need for admiration, and lack of empathy and compassion for others
Avoidant personality disorder	A pervasive pattern of social inhibition, low self-esteem, and hypersensitivity to negative evaluation
Dependent personality disorder	A pervasive and excessive need to be taken care of, and a perception of being unable to function without the help of others, leading to submissive and clinging behaviours
Obsessive personality disorder	A pervasive pattern of preoccupation with orderliness, perfection and control at the expense of flexibility, openness and efficiency
* Depressive personality disorder	A pervasive pattern of depressive cognitions, feelings and behaviours
* Passive-aggressive personality disorder	A pervasive pattern of negative attitudes and passive resistance to demands for performance in social and work situations

* Under review for further empirical justification in the appendix of DSM-IV-TR

Table 2: A brief description of the ten standard personality disorders (DSM IV & DSM-IV-TR) and the two personality disorders under review in the Appendix of DSM-IV-TR

APPENDIX TWO

Appendix Two contains the following documents:

Participant invitation letter

Participant information sheet

Staff information sheet

Informed consent form

Interview schedule

Participant Invitation Letter

Katie Crews
Psychologist in Clinical Training
DSPD Unit, HM Prison Whitemoor
March, Cambridgeshire, PE15 0PR

Telephone 01354 602350

Your views on DSPD and reasons for taking part in the programme at Whitemoor

Information about the project:

There is little known about DSPD and the difficulties that people who are on the DSPD treatment programme experience. There is also little heard from the men themselves about how they feel about the term and the programme.

I am interested in how you make sense of DSPD, how you decided to go ahead with treatment and I would like to find out how you see your life in the future.

I will be asking everybody on the DSPD wing if they would like to be part of this study. I hope to be able to talk to about six to ten of you about your experience of DSPD.

What it will involve:

I would like to meet with you for about an hour to talk about your experiences of DSPD. We will meet in an interview room on the wing and you are welcome to invite your personal officer or a nurse to attend if that will help you feel more at ease.

You will not be asked about your offences and you can choose not to answer any of the questions if you would prefer not to. I will ask you about how you came to be on the treatment programme at Whitemoor and how you see your future. If you feel able, I may ask if I can meet with you again to make sure I have understood everything properly. You can also stop the interview at any time.

What will happen to the information?

Each interview will be tape recorded to help me remember what we talked about. The tapes will be kept in a locked place until they are destroyed. Your identity will be hidden. I will do this by giving each person a code (for example, 'participant 1', 'participant 2') and your real name will not be recorded on the tape.

Generally, information discussed during the interviews will remain anonymous. The only exception would be if a participant should disclose information causing the researcher to believe

that someone's safety was at risk. As normal in prisons, this would have to be reported to the prison team. Of course, if this happened, I would tell you about it before I told anyone else.

When the study is finished, I will be writing it up, every participant will be given a summary of the findings and a full copy will be given to the University of Leeds. Parts of it may be presented at conferences and published in journals, but your identities will be hidden and your name will never be mentioned, so no one outside the project will know that you have taken part. Members of your team will not be told about any of the things you have said, although the team will see the final summary.

Benefits of participating:

Participation in this research is voluntary and the choice not to take part will not affect your normal care or treatment in any way. People can find being asked their views and opinions rewarding and I hope you will too. People do want to know what you think.

I would be very grateful for any help you can give me with this research. If you wish to withdraw from the study at any time, your decision will be respected without further questions being asked.

Further questions:

Should you have any further questions or concerns about this research, please direct them to Jacqui Saradjian on site, at the DSPD unit (contact details below). All prisoners will be given the chance to have any questions answered by myself before agreeing to take part.

Jacqui Saradjian
Consultant Clinical and Forensic Psychologist
DSPD Unit, HM Prison Whitemoor
Long Hill Road
March, Cambridgeshire
PE15 0PR
Tel: 01354 602350

Thank you for your time.

Katie Crews
Psychologist in Clinical Training (Leeds University)

Participant Information Sheet

Your views on DSPD and reasons for taking part in the programme at Whitemoor

Information about the project:
There is little known about DSPD and the difficulties that people who are on the DSPD treatment programme experience. There is also little heard from the men themselves about how they feel about the term and the programme.

I am interested in how you make sense of DSPD, how you decided to go ahead with treatment and I would like to find out how you see your life in the future.

I will be asking everybody on the DSPD wing if they would like to be part of this study. I hope to be able to talk to about six to ten of you about your experience of DSPD.

What it will involve:
I would like to meet with you for about an hour to talk about your experiences of DSPD. We will meet in an interview room on the wing and you are welcome to invite your personal officer or a nurse to attend if that will help you feel more at ease.

You will not be asked about your offences and you can choose not to answer any of the questions if you would prefer not to. I will ask you about how you came to be on the treatment programme at Whitemoor and how you see your future. If you feel able, I may ask if I can meet with you again to make sure I have understood everything properly. You can also stop the interview at any time.

What will happen to the information?
Each interview will be tape recorded to help me remember what we talked about. The tapes will be kept in a locked place until they are destroyed. Your identity will be hidden. I will do this by giving each person a code (for example, 'participant 1', 'participant 2') and your real name will not be recorded on the tape.

Generally, information discussed during the interviews will remain anonymous. The only exception would be if a participant should disclose information causing the researcher to believe that someone's safety was at risk. As normal in prisons, this would have to be reported to the prison team. Of course, if this happened, I would tell you about it before I told anyone else.

When the study is finished, I will be writing it up, a summary of the findings will be available to participants, and a full copy will be given to the University of Leeds. Parts of it may be presented at conferences and published in journals but your identities will be hidden and your name will be never be mentioned, so no one outside the project will know that you have taken part. Members of your team will not be told about any of the things you have said, although the team will see the final summary.

Benefits of participating
Participation in this research is voluntary and the choice not to take part will not affect your normal care or treatment in any way. People can find being asked their views and opinions rewarding and I hope you will too. People do want to know what you think.

I would be very grateful for any help you can give me with this research. If you wish to withdraw from the study at any time, your decision will be respected without further questions being asked.

Further questions
Should you have any further questions or concerns about this research, please direct them to Jacqui Saradjian on site, at the DSPD unit (contact details below). All prisoners will be given the chance to have any questions answered by myself before agreeing to take part.

Jacqui Saradjian
Consultant Clinical and Forensic Psychologist
DSPD Unit
HM Prison Whitemoor
Long Hill Road
March
Cambridgeshire
PE15 0PR
Tel: 01354 602350

Thank you for your time.

Katie Crews
Psychologist in Clinical Training (Leeds University)

Staff Information Sheet

Individual's understanding of the term Dangerous and Severe Personality Disorder, and its implications for consent to treatment

Information about the project:
The overall aim of this project is to gain an insight into the understanding that those individuals who have consented to treatment have about DSPD. The study will focus on the two main issues: an individual's understanding and experiences of the 'diagnosis', and how this influences their consent and involvement with treatment. This understanding will inform the clinical team as to the most productive methods to focus on when trying to facilitate those individuals less motivated to engage in the programme.

What it will involve:
Each prisoner who engaged in the treatment phase of the programme will be invited to attend an hour interview with myself, where I will ask him about his views of the DSPD, what the term means to him, and about the implications that being on the programme have for his future. We will meet in an interview room and prisoners are welcome to invite their personal officer to attend if that would make them feel more at ease. Participants may be invited to a second interview to clarify or ask further questions about any points raised in the first interview. Most people like the opportunity to talk about their experiences and I hope that they will too. Prisoners will not be asked for details regarding their offences. Prisoners can choose not to answer any of the questions if they would prefer not to, and can withdraw at any time.

What will happen to the information?
Each interview will be tape recorded in order to aid my memory. The tapes will be transcribed and then kept in a locked filing cabinet until they are destroyed. Each prisoner will be allocated a pseudonym (e.g. 'participant 1', 'participant 2') and prisoners' real names will not be recorded on the tape. Generally, information discussed during the interviews will remain anonymous. The only exception would be if a participant should disclose information causing the researcher to believe that someone's safety is at risk. This information would be fed back to the multi-disciplinary meeting and the participant would be informed of this disclosure.

When the study is finished, I will be writing it up. A full copy will be given to the University of Leeds. Parts of it may be presented at conferences and published in journals, but prisoners' identities will be disguised and names will never be mentioned, no one outside the project will know which prisoners have taken part. Members of the multi-disciplinary team will not be told about any of the things individual prisoners have said, although the team will obviously be made aware of the overall findings of the study.

Further questions:
Should you have any further questions about this research, please direct them to Jacqui Saradjian on site at the DSPD unit (contact details are below). All prisoners will be given the opportunity to have any questions answered by myself before agreeing to take part.

Jacqui Saradjian
Consultant Clinical and Forensic Psychologist
DSPD Unit, HMP Prison Whitemoor
Long Hill Road
March
Cambridgeshire, PE15 0PR Tel: 01354 602567

Thank you for your interest.
Katie Crews
Psychologist in Clinical Training (Leeds University)

Informed Consent Form

Individual's understanding of the term DSPD and its implications for consent to treatment

The purpose of this form is to help us ensure that you are willing to take part in this study and so you can understand our willingness to accommodate you in any way we can. Because we need to keep a record of this, the language is rather more formal than we would like. Signing this form does not commit you to anything you do not wish to do.

Please circle as appropriate

- Have you read the participant information sheet? Yes / No
- Have you had the opportunity to ask questions and discuss the study? Yes / No
- Have you received satisfactory answers to your questions? Yes / No
- Do you understand that you are free to withdraw:
  - At any time? Yes / No
  - Without having to give a reason for withdrawing? Yes / No
- Do you agree to participate in an interview which will be audio taped and destroyed on completion of the study? Yes / No
- Do you agree to take part in this study? Yes/No

Signed..... Date.....

Name in block capitals:.....

Interview Schedule

Introduction:

- Aimed to help me and others understand your experience and how you have made sense of DSPD.
- There are no right or wrong answers – it is your personal opinion and experience that are important. INFORMED CONSENT FORM.

1. I was wondering if you could tell me when you came onto the wing? And where you were beforehand?

2. I was wondering if you could explain something about your own difficulties, and what made you decide to come onto the wing?

3. What were you expecting before you joined the wing? Prompts Hopes/Worries?

    a. Were there any worries?
    b. What kinds of worries did you have?
    c. Can you tell me more about (a story) an example of one of these worries?

4. Now that you are on the wing, how do you feel about being on the wing now?

    a. How have things been for you on the wing – examples?
    b. Have any positive things happened during your time on the wing – examples?
    c. Have any negative things happened?
    d. Sometimes things aren't what you were expecting. Have you had any surprises since joining the programme (positive/negative)?

5. Can you tell me what people on the DSPD wing are like generally?

6. Did the term DSPD have any impact on you when you decided to join this treatment programme? (Explore the term)

7. Thinking about your own character and life experience, how would you change the term?

8. Do you think you fit in with the term or are you different in some way?
    a. Can you think of a time when you felt you differed in some way?
    b. In what ways are you different?
    c. How does it feel to be different?
    d. Can you think of a time when you found yourself fitting in?
    e. In what ways did you fit in?
    f. How did it feel to fit in?

9. How do you hope that being in the programme will affect the course of your time in the system?

10. How might things be for you when you get out of the system?

Thank you for your time. If I find that I could do with asking you more questions, would it be okay to meet again to do this?

APPENDIX THREE

Appendix three contains the following documents:

Ethical Approval (COREC)

Approval from the local NHS Research and Development committee

Ethical Approval (COREC)

NHS

Northern and Yorkshire Multi-Centre
Research Ethics Committee

Direct Dial: 0191 374 4151
Facsimile: 0191 374 4102

Northern & Yorkshire MREC
John Snow House
Durham University Science Park
Durham DH1 3YG

10 May 2005

Miss Kate Crews
Psychologist in Clinical Training
University of Leeds
Academic Unit of Psychiatry & Behavioural Sciences,
15 Hyde Terrace,
Leeds
LS2 9LT

Dear Miss Crews

Full title of study: ***Individual's understanding of the term Dangerous and Severe Personality Disorder (DSPD) and its implications for consent to treatment.***
REC reference number: ***05/MRE03/27***
Protocol number:

Thank you for your letter of 20 April 2005, 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.

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.

The Committee has designated this study as having "no local investigators". There is no requirement for Local Research Ethics Committees to be informed or for site-specific assessment to be carried out at each site.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document Type:	Version:	Dated:	Date Received:
Application		21/02/2005	07/03/2005
Investigator CV Katie Eleanor Crews			07/03/2005
Investigator CV Dr Zazie Todd			07/03/2005
Protocol	1	21/02/2005	07/03/2005
Covering Letter		01/03/2005	07/03/2005
Letter from Sponsor Clare E Sumner, Research Grant Manager, Leeds University		11/02/2005	07/03/2005
Interview Schedules/Topic Guides Proposed Pilot Interview Schedule	1	21/02/2005	07/03/2005
Letters of Invitation to Participants	1	21/02/2005	07/03/2005
Participant Information Sheet Staff Version	1	21/02/2005	07/03/2005
Participant Information Sheet	2	29/04/2005	29/04/2005
Participant Information Sheet Prisoners version	2	29/04/2005	29/04/2005
Participant Consent Form Staff Version	1	21/02/2005	07/03/2005
Participant Consent Form Prisoners Version	1	21/02/2005	07/03/2005
Response to Request for Further Information		20/04/2005	29/04/2005

Management approval

You should arrange for all relevant NHS care organisations to be notified that the research will be taking place, and provide a copy of the REC application, the protocol and this letter.

All researchers and research collaborators who will be participating in the research must obtain management approval from the relevant care organisation before commencing any research procedures. Where a substantive contract is not held with the care organisation, it may be necessary for an honorary contract to be issued before approval for the research can be given.

Notification of other bodies

The Committee Administrator will notify the research sponsor that the study has a favourable ethical opinion.

Statement of compliance

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

08/M1RE03/27	Please quote this number on all correspondence

With the Committee's best wishes for the success of this project.

Yours sincerely,

G. Brunton-Shiels

Dr Simon Thomas
Chair

E-mail: sandy.brunton-shiels@durhamcdspct.nhs.uk

Enclosures *Standard approval conditions*

Approval from the Local NHS Research and Development Committee

Natércia Godinho
Kingfisher House
Kingfisher Way
Hinchingbrooke Business Park
Huntingdon
Cambs PE29 6FH

Our ref.
Your ref. 05/JRE03/27
Date 24 August 2005

Tel: 01480 398540
Mob: 07887760431
Fax: 01480 398501
E-mail: natercia.godinho@cambsmh.nhs.uk
Website: www.cambsmh.nhs.uk

Miss Katie Crews
Psychologist in Clinical Training
University of Leeds
Academic Unit of Psychiatry & Behavioural Sciences
15 Hyde Terrace
Leeds, LS2 9LT

Dear Miss Crews:

Full title of study: Individual's understanding of the term Dangerous and Severe Personality Disorder (DSPD) and its Implications for consent to treatment

Thank you for sending me a copy of your research ethics application form.

The Trust Research and Development team have reviewed your research submission and we are pleased to inform you that Trust is happy to approve your research and thereby accept responsibility as Sponsor.

In addition to obtaining Trust approval, I remind you that you must obtain full approval from the appropriate Ethics Committee before proceeding with the research (for further information consult www.corec.org.uk). **Please send me a copy of the Ethics Committee letter of approval as soon as you receive it.**

Please note that any adverse events relating to this research should be notified to me, or in my absence, to Sue Smith Associate Director Quality and Healthcare Governance (01480 398536). In accordance with the Trust Incident Reporting procedures you would also need to complete a risk incident form.

Research Governance requires monitoring and auditing of all research projects. I ask that you let me have copies of any annual and final reports as well as details of any papers published arising out of your research.

We wish you well with your research. If we can be of further help, please do not hesitate to contact us.

Yours sincerely

Natércia Godinho

Trust Research and Development Coordinator

APPENDIX FOUR

List of Transcription Conventions

The following list is based on Turnball's (2003) recommended symbols used in transcription. Symbols marked with an * were my own conventions.

Symbol	Meaning of Symbol
[pause sec]	Significant pause, and number of seconds.
( )	Missing speech, due to speech being unclear or a noise, which meant no guess could be made.
...	Material left out of transcription for brevity or confidentiality.
((sniff)) ((cough)) ((laughter))	Non-speech sounds
*[psychologist name] [prisoner name]	Should a transcript contain a staff, institution or prisoner name, they were replaced by a description in square brackets.

Table 3: List of transcription conventions

APPENDIX FIVE

Excerpt of an Interview Transcript with Coding

The next pages in Appendix Five contain an example of part of an interview transcript and the process of line-by-line focused codes and memos.

PARTICIPANT 5_ 23-09-03_9:00am

NOTES Straight after interview: Participant seemed incredibly anxious throughout the interview – he was physically shaking all over (visible through his clothes). His speech was shortened and he spoke quietly. At times I moved the interview on quite quickly when his anxiety levels raised further. The participant's body language was remarkably clear – his body was almost facing the other way from me, and his eyes would look around intermittently to give me some eye contact. His chair was moved slowly further away from me, so he was almost backed into the corner of the room towards the end of the interview. I attempted to help the participant become more at ease, saying that he could leave whenever he had had enough and that he did not have to give an explanation, etc... (verbally). Considering his obvious levels of anxiety, the interviewer was surprised that he had volunteered to participate and was impressed that he managed to control his anxiety levels enough to tolerate this interview process.

NOTES: What I remembered during analysis. Mood – high emotion when he felt he had to justify/prove himself – i.e. 'I don't have a problem trusting women.' Mood – low, sad, down when talking about suicide, despite the suicide attempt being framed as a positive event for him – perhaps this is linked with what is 'true?' and perhaps he does not really trust women (i.e. he doesn't trust me?) so anger is his defence so as not to ask or probe him further? Use of "you with me?" often. He stated at the beginning that he takes 40 mins to warm up to be emotional (interpretation: to speak from the heart).

INTERVIEW TRANSCRIPT

Text Unit		Text (script)	Line-by-line code	Focused code	Category	Memo
p5	8	What made you decide to come onto this wing?				
p5	9	I was involved in a very serious incident at Belmarsh. I took a hostage	Last prison involved in hostage taking, serious incident	Past violence, cutting room-mate	Past experiences – llnk to difficulties	
p5	10	situation and, erm, I cut another room-mate, and I was in the long-term	Past violence, cutting room-mate			
p5	11	block and, erm, this place was suggested, and I got interviewed and here,	Was staying in long-term segregation before being invited for assessment	Previously was serving sentence in segregation	Volunteer / consent	Felt passive in this process
p5	12	and here I am.				
p5	13	OK. Can you tell me a little bit more about the interview you had?				
p5	14	I felt I felt I was conned in the interview?	Participant felt conned by the interview	Felt desperate to move from segregation		
p5	15	Oh right. OK?				Saying anything would have been an improvement to the
p5	16	Erm, because the interview, said to me on the interview, I mean if they				

p5	17	knocked on my door selling double-glazing I would have bought it.	Would have been taken in by anything at the time			circumstances he was in at the time.
p5	18	Erm, because they promised, they didn't promise me, they said this	He was promised to by interviewers	Felt the system had given him promises	Expectation of system. Link to Volunteer/ Consent	
p5	19	happens when you get to there, that happens when you get to there and	Promised that this and that would happen on unit			
p5	20	nothing's happened.	Nothing happened		Experience	Was expecting more therapeutic work?
p5	21	What do you mean – what happened?				
p5	22	Concerning therapy wise, are you with me?	Nothing happened concerning therapy			
p5	23	So what were they saying would happen?				
p5	24	They were saying, erm, you receive therapy on a daily basis, erm, all	Believed he would receive therapy on a daily basis			
p5	25	them sorts of things, and you don't, so, once you're on here, you're stuck on	Once on unit, feels stuck		Expectation of system	
p5	26	here.				
p5	27	So you're saying that – I'm just trying to ask you to expand a little bit			Link to – Understanding of treatment	
p5	28	on that. So you had an interview process?			Link to – Decision to consent	
p5	29	Yes.	Decided to come to unit after interview		Link to – Implications of the programme	
p5	30	And it was after the interview that you decided to come here?				
p5	31	Yes.	Decided to come to unit after interview			
p5	32	Is that right?				
p5	33	Yes, yes.	Emphasises decision			

p5	34	OK, so can you tell me a little bit more about what made you decide				
p5	35	to come here?				
p5	36	Well. When I was in block, right in, there was an S.O. down there?	Decision also based on S.O. advice in seg			
p5	37	S.O.?				
p5	38	Yes, yeah, he's a Senior Officer, he's off the block. Now I knew him				Been in the prison system, in and out, since Borstal; a community; a way of life
p5	39	years and years ago, when I was doing Borstal training when he was	New S.O. since he was in Borstal			
p5	40	just a prison officer.				
p5	41	Uh huh.				
p5	42	He knew me and we've known each other for about 20 years, you with	Known S.O. for 20 years			
p5	43	me, and he says to me, he's the one who explained, he said look, I'll, I'll	S.O. explained about unit and put him forward for Whitemoor		Volunteer Linked to – Decision to consent Linked to – Finding out about programme (new category?)	
p5	44	put you forward for Whitemoor, yeah, this unit, he says think about it, so	S.O. officer told him to think about it			Possible new category – Finding out about programme
p5	45	I said all right then, and he put me forward for it, then, I got interviewed,	Participant agreed for interview			
p5	46	they came to see me and they interviewed me. That's how all this place came	People from Whitemoor came to interview participant			
p5	47	about.				

APPENDIX SIX

Pull-Out Version of the Model, Presenting the Inter-Relating Themes, Categories and Subcategories