Group-work therapeutic engagement in a high secure hospital: male service user perspectives.

Abstract

This paper discusses a service user perspective of factors that influence engagement in therapeutic group-work within a high secure hospital environment. An opportunistic sample of eleven male service users were interviewed, using a semi-structured protocol. This was underpinned by social and psychological factors highlighted within the literature, and concepts drawn from the Health Belief Model (HBM, Rosenstock, 1974). In accordance with service-user led initiatives, interview questions were open-ended, designed to invite and encourage exploration of themes through general discussion. Research findings were analysed through an Interpretative Phenomenological Analysis (IPA) approach to identify emergent themes of apparent influence. Themes were identified, and which were categorised into emergent themes and related sub themes. Emergent themes were then considered in relation to the theories and concepts that underpinned and connected them. The most substantial theme was *culture of the environment*, closely linked to the concepts of choice, which stem from and are greatly influenced by culture. Participants highlighted additional influential areas, namely relationships, trust, motivation, group-work content and expected outcomes.

Introduction

This paper reports on a qualitative study that explores factors influencing male service users' engagement in therapeutic group-work within a high secure hospital environment. Given the complexities of need presented by service users within high secure settings, professionals recognise a range of approaches and treatment modalities incorporating individual therapy, occupational and vocational engagement and therapeutic group-work. Examples include relaxation, Mental Health Awareness, Anger Management, to criminogenic / offence focused group-work encompassing Victim Empathy, Arson, Sexual Offending and Homicide. It is

specifically service users' views of engagement in such group-work that is considered within this paper.

Engagement has become a well researched area within health care. However, it predominantly encompasses medication adherence, treatment compliance and outpatient appointment attendance. The broad literature demonstrates great variability in the factors influencing treatment compliance within any realm of healthcare, potentially reflecting its complexity and multidimensional nature. Within forensic mental health settings, the focus has tended to be on 'compliance' rather than active service user engagement in therapeutic interventions (Lowry, 1998). Terms such as 'compliance' and 'engagement', are at times used interchangeably yet should convey distinct differences in their meanings. For the purposes of this paper, 'engagement' will be utilised; by this, we imply active participation, in preference to obedience and attendance. Before considering the wider engagement literature, we would note findings that point to the environmental influences upon engagement (Keilhofner, 1995). These could be of specific resonance in the treatment and rehabilitation within high secure hospitals where the delicate balance between security and therapy can have an impact on rehabilitative activity.

In exploring the influences on therapeutic engagement in high secure hospital settings, this study draws on Hochbaum, Kegels & Rosenstock's theoretical framework of the Health Belief Model (HBM) (e.g. Rosenstock, 1974, Conner & Norman, 1996). This framework encompasses individual perceptions of illness, general health values and the perceived importance of health and consequences. Related social and psychological factors also thought to influence health behaviour and choices have assisted in shaping the interview framework. Such factors include specific influences of cultural contexts, individual knowledge and understanding, socioeconomic status, past experiences and therapeutic rapport (McCormack Brown, 1999, Cameron, 1996, and Ley, 1988). It is thus these key factors that we drew on in designing interview protocols that sought to draw out participants' views. In

particular, the research considered past experiences of therapeutic group-work and the impact / influence of the participants' previous relationships with practitioners on their choices regarding engagement.

Ethics and Methodology

Ethical approval for this study encompassed approval from the host University, the Hospital Research Committee and the NHS Ethics Committee. In addition to these, additional governance safety and security issues were addressed through security management and ward management processes.

The research was conducted according to the ethical guidance of the BPS Ethical Standards prevailing at the time (The British Psychological Society, 2000). The protection of participants' welfare was fully considered and addressed through the involvement of participants' Responsible Clinicians; they provided assessments of fluctuating mental state, degrees of participant risk to themselves and others, and capacity for informed consent. Participants were provided with information regarding informed consent, data protection (anonymity and confidentiality), and their rights and procedures for withdrawing from the study. Specific consideration regarding debriefing was required given the context of the research environment and included information regarding internal Advocacy Services and a point of contact for the first author.

Materials

A semi-structured interview protocol was designed and adopted. In accordance with service-user led initiatives, interview questions were open-ended, invited and encouraged exploration of themes. It is not possible to include the full research protocol; however copies are available from the primary author and some example items from the questionnaire are included here: *Can you describe your previous experiences of group work? How would you*

describe your relationship with members of your clinical team? What hopes and fears do you have about groups?.

Participants

A sample of eleven male service users with a primary DSM IV (Diagnostic and Statistical Manual of Mental Disorder, 4th Edition) diagnosis of Mental Illness provided a proportionate representation of the hospital's acute and rehabilitation wards at the time. Interviews were recorded and transcribed for analysis. It was felt important to include both those who were actively engaged and those who were not, to fully explore both positive and negative influential factors involved in service users' engagement.

Participants with a dual diagnosis were also included. Service users on both the Admission ward and Crisis Intervention ward were excluded due to the acute vulnerability and ill health of these groups. Personality disordered offenders were excluded from this study, recognising the different needs and challenges posed within treatment and potentially having a higher prevalence of presenting unreliable data (McMurran, 2002). Female service users were also excluded from this research, due to such small numbers making it impossible to assure anonymity. It was also acknowledged that female service users present different therapeutic and treatment needs and challenges, and which were beyond the scope of this research.

Analysis

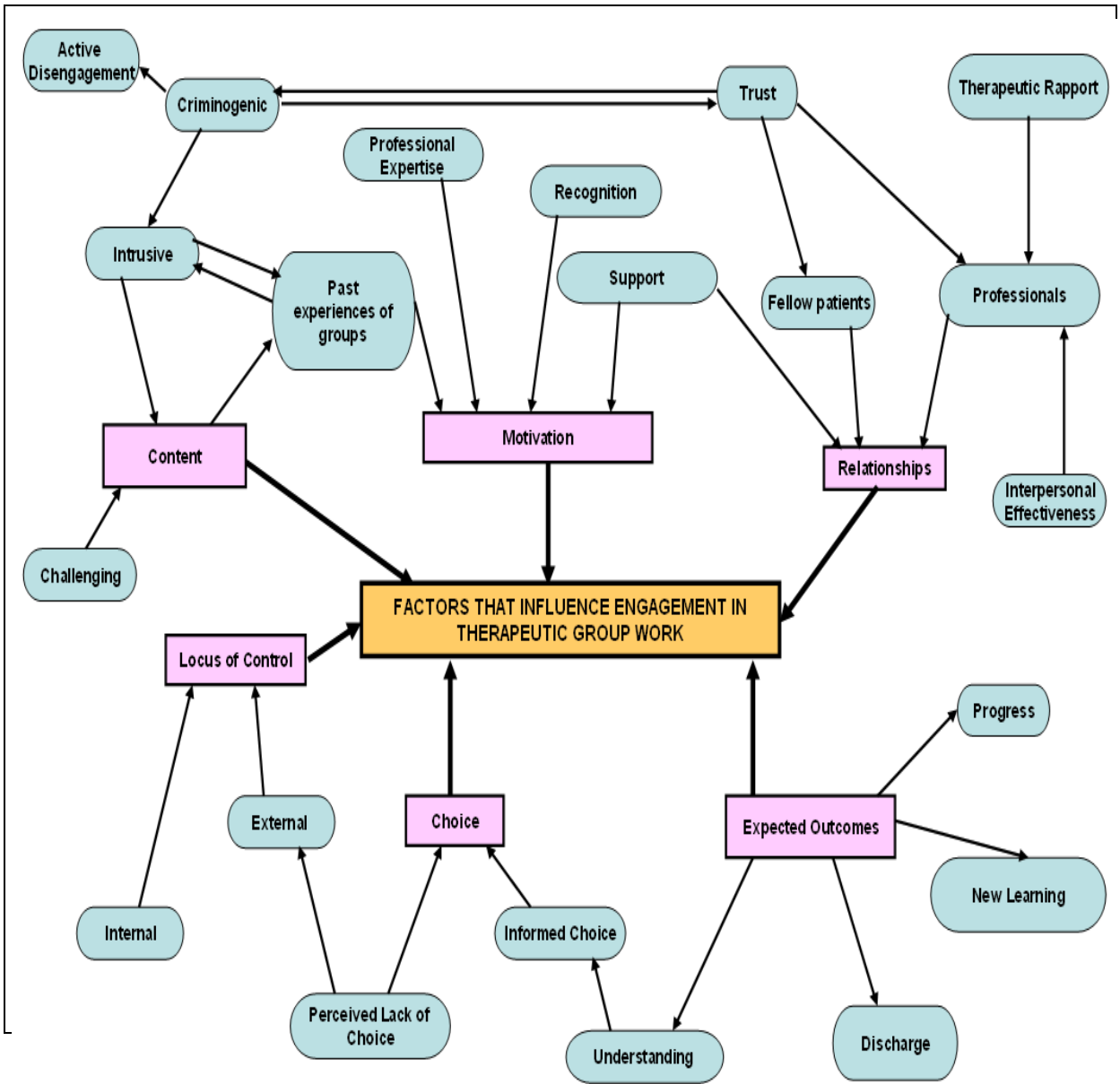
An Interpretative Phenomenological Analysis (IPA) approach was taken to identify emergent themes. IPA is interpretative and theory building, primarily concerned with understanding lived experience and how participants make sense of their experiences (Smith, Jarman & Osborne, 1999). Themes identified within findings, were ordered and categorised into emergent themes and related sub themes. Emergent themes were explored, coded and re-organised and considered in relation to the theories and concepts that underpinned and

connected them; relationships, motivation to participate, content of group work, perceived locus of control, choice, and expected outcomes from engagement.

Results

All names referred to here have been replaced with identification letters unrelated to the participants' actual names. A wealth of themes initially emerged from the transcribed interviews, with six key themes associated with engagement in therapeutic group-work evolving through analysis. These were: motivation; content of group-work; choice; expected outcomes; external locus of control and relationships.

Figure.1. below illustrates key themes and related sub-themes. The emergent themes will be discussed in turn with illustrative verbatim extracts from participants.



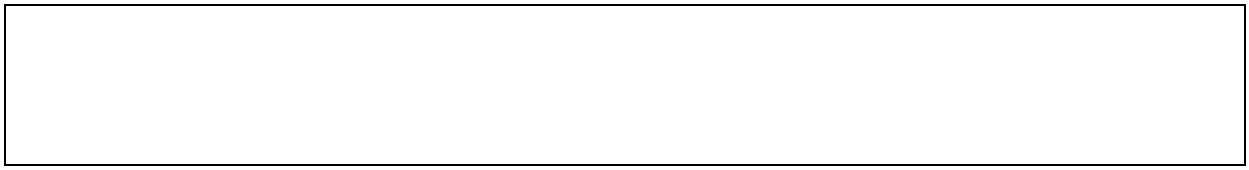


Figure 1. Emergent Themes

Motivation

Participants described a need and desire for external motivation, consisting of support and recognition on behalf of the facilitators and hospital at large. Participants described feedback as a measure of their progress and an acknowledgement of facilitators' interest and concern.

A – ***"Just a few words of encouragement / feedback from the facilitators, so you know where you're at and you're heading in the right direction."***

Group-work interventions were characterised as being difficult but incentives and rewards for completion were felt to demonstrate recognition for participants' efforts and contributed towards their motivation to engage.

B – ***"I was more interested in doing groups when you got paid as it represented the degree of work you had to put into them, they're not easy."***

Participants also identified the importance of previous, largely negative, group-work experiences.

C – ***"I'd already done it before and I'd find it boring. It's going over old ground."***

One participant also drew specific attention to the facilitators' backgrounds as influencing his willingness and motivation to engage.

D – ***"I'm worried about this whole bunch of people that you use to run groups, whether they're qualified or not to do them."***

Content of Group-work

Participants described both past experiences and personal assumptions that group-work was difficult, challenging and intrusive when focused on personal and criminogenic issues, affecting their engagement. A differentiation was identified between skills based groups in comparison to those focusing on criminogenic issues, which raised issues of trust within the context of group-work. Most participants stated a preference to address these issues / areas within individual interventions.

A– ***"If I had a choice between groups that's directly related to my index offence and one that's about communication skills, it would be communication skills, as I might learn something. Cause I wouldn't like talking about my index offence. And not being sure if I can trust people or not."***

The degree of perceived or actual difficulty and complexity of group-work was also identified by participants as influencing their decisions to engage. It appeared a delicate balance relating to level of content and duration; with most feeling that when the content was pitched too high or low and the duration of groups was too long, they would disengage.

E – ***"It's tough and you have to concentrate. I'm tired, not being able to concentrate and not up for the hard work."***

Locus of Control

Participants identified both sources of internal and external control with respect to decisions regarding engagement in therapeutic group-work. Participants described the importance of autonomy in decision making;

D – ***"I think you should be the important person, you should decide for yourself."***

F – ***"You need the freedom to choose."***

However, the majority did not recognise this as a current reality in their world. Instead, most participants conveyed learned helplessness, highlighting a lack of choice as a result of a perceived hierarchy of power / control within the high security hospital environment.

B - How much choice do you have about your engagement in a High Secure Hospital?

"None, you have to do it or you won't go to your RSU."

G - ***"……. if they insist upon it you have to do it."***

Those participants who stated they felt they made their own decisions also highlighted the perceived forces of the institution and their situation affecting their autonomy and perception of choice.

E - ***"You have got a choice, but it's not the right way to go about it if you want to get on and progress. It's part …of the way to get out. If you didn't want to do it you couldn't really say no."***

Choice

Participants placed value on being informed, understanding requests to engage in group-work and the nature of group-work itself, both of which were felt to enable an informed choice of engagement.

F – ***"They normally explain the groups and it does help in choices…as I need to understand it."***

Participants also reported a lack of choice, which they linked with a perceived external locus of control, the hospital and institutional culture of a high security environment, previously discussed.

H – ***"Not much, I've done most therapies for my CPA and the doctor said if we do the programme I will move forward. I'm stuck here; I don't want to be stuck here anymore, so I've no choice. It doesn't feel like a choice."***

A – ***"It's always been chosen for me."***

Expected Outcomes

Participants described a desire and expectation for positive outcomes from group-work engagement. Outcomes identified as valuable included understanding; both themselves and their illness better:

I – "*I expect help and awareness about your illness so you can stay well.*"

Participants' expectations of progress towards discharge:

H – *"Groups are what I need to do to get out of here and to an RSU. I hope that doing groups might help me live in the community."*

E – "*I hope doing groups will help me get out of _____ Hospital. So I don't get embarrassed with things and describe myself as a loser. It's the next step to moving on, you hope for progression and getting out of _____."*

Participants' expectations of new learning gained from participation in group work:

D - *"Family Awareness, that was interesting and helpful. I could do it and learnt something I needed to learn. I also gained awareness."*

<u>Relationships</u>

Participants identified relationships with two key populations; fellow service users and professionals, as most influential. Participants highlighted the importance of trust, vulnerability and therapeutic rapport:

J – ***"You don't know whether you can fully trust the other patients, you know there's a worry that if you say something it'll end up all around the hospital."***

C – ***"I felt I wasn't in the right company, I felt awkward and unsafe."***

H – ***"Good communication makes good relationships. It would need to be very truthful. Neglectful-ness makes a poor relationship."***

G – ***"…she (doctor) has proven by her word and she has proven by her actions that she does care and so I treat her with the utmost respect. I trust her fully now, I wouldn't go against a word she says."***

D - ***"…….Yes it makes a difference if they tell me, so that impacts on me as well, as it's nicer to be asked you know."***

Components of therapeutic rapport identified by participants varied, however most conveyed a belief that an honest, caring and helpful attitude, sense of humour and healthy respect would enable a positive relationship and foster trust.

D – ***"I think if they understand what problems you have, They'd need to be sensitive."***

F – ***"Being patient with each other. Respect for each other, being able to talk."***

Discussion

The findings suggest that the majority of participants felt unable to be autonomous in their engagement choices, struggling with perceived hierarchies of power and issues related to learned helplessness. Despite these predominantly negative group-work experiences, and examples of active disengagement from offence related group-work, participants were able to describe potential supportive mechanisms and an awareness and belief in positive concepts derived from group-work. Within the context of the close working relationship between service user and professional, many distinct areas of potential positive influence were also identified. In addition to the six primary emergent themes, the culture of a high secure hospital environment was interwoven within most dimensions of the research. Similarly, it is recognised that no single theme stands independently, as illustrated below.

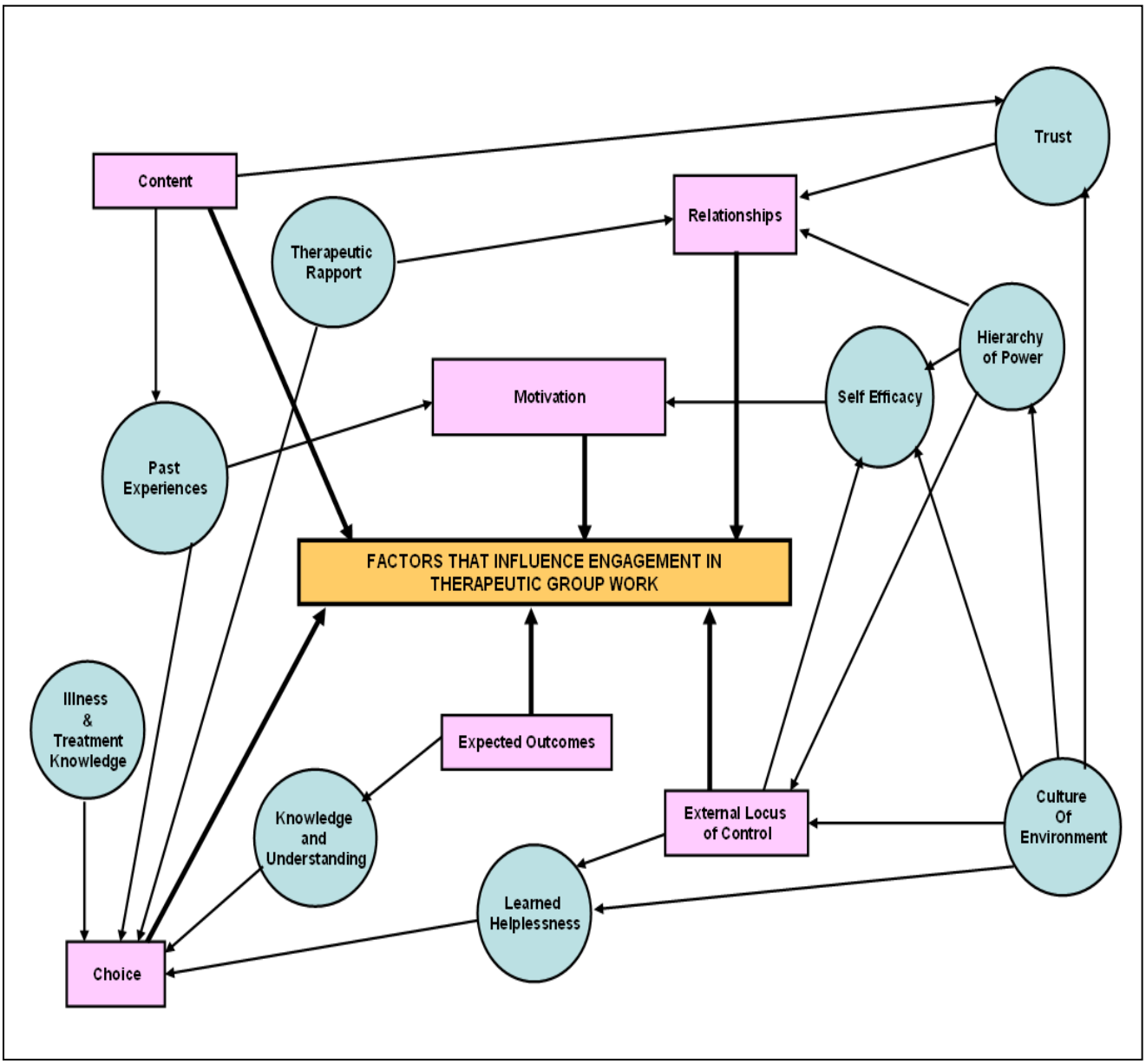


Figure 2. Theme Linkages

However acquired and perpetuated, the participants seem to describe a culture within the environment that fuels service users' feelings of disempowerment, de-motivation and feelings of distrust and helplessness (Goffman, 1961; Keilhofner,1995). Thus explanations of these findings could begin with potential links between self efficacy, social learning theory (Bandura, 1997), choice and behaviour, grounded in the broader environmental and social context of the setting within which the participants were held (Keilhofner, 1995). In common with much previous work, these findings would indicate that secure environments have an impact upon individuals' choice, autonomy, goal attainment and levels of competence (Coid, 1993; Flood, 1997; Lloyd, 1988; Powell et al, 1989; Whiteford, 1997). It is no surprise that the influence of a high security hospital culture is infused within almost all themes highlighted in this research study.

Participants attributed increased motivation to external origins e.g. staff support and the recognition of effort. Participants' perceived importance and influence of external sources of motivation appeared to correlate with both environmental context of the research and several relevant theories. Keilhofner & Lyenger (2002) and Lefcourt (1991) highlight that social and physical environmental constraints and less responsive milieus influence individuals perceived connections between their efforts and outcomes and negatively affect motivation for engagement over time.

Self efficacy, although difficult to measure, also influences motivation (Bandura, 1977) and is assumed to be situation specific; attributed to direct experiences, and/or influenced by the events and others surrounding you. Within the current context, participants seem to have been recognising the hierarchical structure of power and to have demonstrated poor self efficacy, thereby prompting service users to seek direction and approval by those who are perceived to be powerful (and on whom they rely for progression). This idea is congruent

with the conclusions drawn by Rosenstock, Strecher and Becker (1988) when they argued that self efficacy can be used to enhance uses of the Health Belief Model (HBM).

The findings also indicated that significant motivation stemmed from past group-work experiences. This finding too, is on par with the literature on the HBM considering underlying belief patterns. Given most participants had negative experiences of group-work, finding interventions to be repetitive, boring and unhelpful, it was no surprise to find that motivation and choice of engagement for future group-work interventions was lacking.

Findings highlighted the significance of group-work content as influential in participants' engagement choices and in their past experiences; typically described as being difficult, challenging, intrusive and unpleasant. Of note, participants described actively disengaging from offence related group-work, primarily due to its intrusive nature and issues of trust within the group setting and hospital culture. Findings were congruent with literature relating to illness and treatment knowledge within the HBM framework, suggesting that choices are influenced by individuals' experience and perception of complexity and challenge and by potential side effects such as anticipated emotional upset.

Participants struggled to see real and positive outcomes from engagement in what they perceived / experienced as complex, challenging and negative group-work, as for them their desired outcome, reward and result would be represented by progression and discharge. This is in line with expectancy theory of motivation (Vroom, 1964), and self efficacy relating to the quantity of effort and the willingness to persist at tasks (Bandura & Cervone, 1983, 1986). It also sits well with Rosenstock, et al.'s 1988 conclusion that "true therapeutic alliance", is when both therapist and patient are "involved in choosing goals that the patient feels personally capable of achieving within the time limit."

Trust within the context of group-work also has an impact on participants' motivation to engage and their engagement choices. The harsh realities of a sub-culture where such information is an effective tool for manipulation and bullying by peers means that a healthy degree of distrust was acknowledged. Considering both the challenges and potential risks participants faced through engagement in group-work, specifically relating to criminogenic issues, it was no surprise that group-work presented significant obstacles to individuals' motivation and or consistent engagement.

It is recognised that many influences affect individuals' choices of engagement including the significance of therapeutic rapport, sufficient information to enable informed choice, past experiences, observations of others individual beliefs and emotions. Participants recognised the importance of choice within healthcare (Department of Health, 2000, 2002, 2003) however were also aware that this concept was encapsulated in an environment which automatically restricted choice, and autonomy.

Participants recognised concepts representative of a good therapeutic rapport and the importance such a relationship has upon their choices of engagement (Cameron, 1996., Munetz, 1998., Manfred-Gilham et al, 2002., Russell et al, 2003). However, most described experiencing negative interactions with professionals at some point during their admission which had negative impacts on their choices to engage. Participants intimated sufficient knowledge of group-work requests. Yet, beliefs based on past experiences and individuals' perceived degrees of control and learned helplessness were also highly influential in participants' choices.

Potentially one of the most important origins of an individual's choices is held within an individual's emotions, beliefs and thought processes. Rational Emotive (cognitive) Behaviour Therapy (Neenan & Dryden, 1999, Ellis & Dryden, 1999) is linked with social learning theory and posits that activating events initiate beliefs which result in choices (Dryden, 2000).

Considering that findings implied a mixed picture of participants' group-work experiences, it seems logical to conclude that service users observed both the side effects and outcomes of their peers' engagement in group-work in addition to their own experiences, shaping their views and ultimately their choices of engagement in group-work as a less attractive and beneficial intervention.

Participants described an expectation of gaining understanding and new learning as a desired outcome of group work engagement, which was felt to lead to progress and ultimately discharge. Participants' realities of past group-work experiences neither reflected nor reinforced the correlation between effort and performance and attainment of such desired goals. Instead, negative experiences of group-work challenged participants' beliefs in such desired positive outcomes, de-motivating and reinforcing poor self efficacy. These findings draw parity with the expectancy theory of motivation in which expectancy is the belief that one's effort will result is achievement of desired performance goals. As found within findings, when individuals perceive that the outcome is beyond their ability to influence, expectancy motivation decreases (Vroom, 1964). When considering the theories of Lewin (1935, 1936) (and their relationship to the Health Belief Model) it is understandable that participants' choices were heavily influenced by the realities within their world despite recognising the possible, optimal and desired outcomes of group-work engagement.

Participants' perceived locus of control and their belief in their ability to influence or reach their goals of discharge, were found to be greatly influenced by the institutionalised culture of security and confinement and by hierarchical power structures. Participants were left feeling they had no 'real' choices. Aspects of both internal and external control within participants' decision making were highlighted within findings. However, internal locus of control was described as valued and important; an aspirational gold standard. In parallel, a learned helplessness (with external locus of control) was described by participants as representative of their current reality.

In contrast to theories of learned helplessness, it is also recognised that service users' non-engagement could potentially be one of the few ways individuals feel able to exert a degree of control over their circumstances within a predominantly restrictive and coercive environment (Couldrick & Aldred, 2003). Such choices to disengage potentially represent attempts to gain a degree of control through displays of wilfulness (Linehan, 1993). Although the evidence here is muted, such correlations could be representative of participants' choices to disengage and are worthy of future investigation.

Relationships are recognised as an integral and influential component of the therapeutic process and highly influential within service users' care and treatment. Perhaps even more so within a high secure environment where a power imbalance exists between service users and professionals; professionals having control over the most valued life decisions of freedom and liberty. Despite this obvious power imbalance, participants identified several qualities required for a positive and therapeutic relationship. They highlighted humour, honesty, and respect and most importantly, trust, despite the obvious pulls towards circumspection. Some participants described good relationships with professionals whilst others described a lack of mutual trust, feeling unheard and their views and choices not being fully respected. Such mixed results reinforce the importance of therapeutic rapport in engaging service users, highlighting this as an ongoing challenge for professionals to overcome within the rehabilitation and recovery of mentally disordered offenders, specifically those with a diagnosis of mental illness in this study.

In addition to the research question, this study aimed to explore differences in influences between acute and rehabilitation participants. From analysis, two significant differences were highlighted. Firstly of note, the decreased level of engagement in group-work interventions of rehabilitation participants; potentially symbolic of the 'seen it, done it and got the T-Shirt' attitude encountered within the first author's clinical practice within this environment.

Secondly, an acute participant's great sense of hopelessness, despite his short admission at the time of research, in comparison to those rehabilitation participants with a greater longevity of admission was highlighted. Related to the theories of social learning and self efficacy, observing the hopelessness of admission and engagement from an acute viewpoint compared with the degree of acceptance of circumstance and learned helplessness of those with longer admission stays within the rehabilitation participants was yet another obstacle of this challenging environment.

The findings of this study must be considered in light of several limitations. IPA is not designed to facilitate generalisation of findings, concentrating as it does on lived experience. However, we would acknowledge that a relatively limited sample size, the narrow range of participants and the specific environmental context combine to form a need for circumspection in conclusions (Dawson, 2002). The necessary involvement of Responsible Clinicians' within this study due to the specific environmental context is also acknowledged as a potential source of bias, as are the researchers' personal and professional experiences (Banister et al, 1994). It is also recognised that this study represents a 'snapshot' of service users experiences highlighted through a single semi-structured interview. If timescales allowed, further follow-up interviews could have elicited more detailed information to inform findings. Lastly, this work was initially submitted in partial fulfilment of a post-graduate qualification. Although within such work the option of involving other researchers is not common practice, involving a fellow clinical peer in the analysis of results would have decreased the influence of the researcher's biases and assumptions (Marshall, 1997).

Conclusion

This study aimed to explore potential influences on the engagement in therapeutic group-work from a service user perspective. Findings consistently highlighted two significant themes of influence. The first of these were the far reaching influence and pervasive nature of the culture of the environment; required to precariously balance security and public

protection with therapy, rehabilitation and recovery of those it confines. The second significant theme related to concepts of choice which are greatly influenced by the first. It is concluded that the perceived intrusive nature and content and issues of trust precipitated some participants to actively disengage from criminogenic / offence related group-work.

Our findings have been set within the wealth of literature recognising therapeutic rapport as an integral component of healthcare yet also demonstrate that it can be plagued by the context of the very culture within which it is set. Concerns regarding the skills and competence of group-work facilitators were also raised by participants within this research. Professionals need to demonstrate greater awareness of the therapeutic use of self in building and maintaining therapeutic relationships, promoting autonomy and choice for service users within the constraints of security implications and requirements.

Given the imposing, controlling and pervasive nature of a high secure hospital, it was expected that the institution would feature more directly within results. However, the degree to which the environment creates and influences other theories reinforces the need for further research into understanding the environmental impacts within high security hospital environments. A possible follow up to this work, may be to include similar questions as part of structured service reviews and to try to illuminate institutional impact.

The tenuous balance, of duty of care and public protection, for all professionals working within high security hospital environments is a fixture of such treatment settings. Continued exploration of the challenges posed through the context of such environments will reduce the risk of complacency and institutionalisation of all involved, including professionals, whilst endeavouring to create a healthy tension to enable effective rehabilitation, recovery and risk management.

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