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Exploring lived experiences of familial support in  
forensic settings using best-fit framework  
synthesis and interpretative phenomenological  
analysis: A portfolio thesis

Martha Gillespie

Doctorate in Clinical Psychology

The University of Edinburgh

May 2019

## Declaration of Own Work

**Name:** Martha Gillespie

**Title of Work:** Exploring lived experiences of familial support in forensic settings using best-fit framework synthesis and interpretative phenomenological analysis: A portfolio thesis

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## Thesis Portfolio Abstract

Existing research has evidenced the fact that maintained familial support can have positive outcomes for prisoners and forensic patients during a detention. Maintained familial support has been linked with reduced reoffending, improved mental health, and improved relationships following imprisonment or hospitalisation for the individuals receiving support. Despite this, visiting relatives in prison has been shown to have both positive and negative consequences for families of prisoners.

Given the available literature which has focused on families' experiences of supporting relatives during imprisonment, a systematic review was conducted to explore, collate, and critically analyse these findings. Drawing upon qualitative literature, a best-fit framework synthesis approach was used which allowed the researchers to identify the applicability of and expand upon an existing framework when considering families' experiences. Three superordinate themes were identified: *Experiencing a "parallel sentence" beyond prison walls*; *Shifting roles and relationships*; and *Ambivalence*. Twelve subthemes were encapsulated by these superordinate themes.

Whilst literature has explored families' experiences in this context, there has been a dearth of research exploring prisoners' perspectives of maintained familial support, and research exploring patients' experiences of familial support is almost entirely absent. Therefore, an explorative study drew upon the methodological principles of interpretative phenomenological analysis to investigate this phenomenon. Eleven patients residing in a high security forensic hospital who had maintained familial support via hospital visits were interviewed about their experience of familial support. Interviews were recorded, transcribed, and then analysed. Analysis revealed four superordinate themes: *Connection*; *Growth, Power*; and *Ambivalence*. Sixteen subthemes are subsumed by these superordinate themes. Results are discussed, along with clinical implications, study limitations, and suggestions for further research.

## Thesis Portfolio Lay Summary

Research has highlighted the fact that prisoners and forensic patients who receive family visits and support during time in prison or in hospital often show improved outcomes when compared with those that do not. For example, maintained familial support and connectedness in these populations can be linked with reduced reoffence rates, improved wellbeing, and improved relationships once back in the community. Furthermore, having the support of family may in itself give individuals a reason not to reoffend.

There have been a number of qualitative studies that have explored the experiences of families who continue to support imprisoned relatives during time in prison. However, there has been a lack of research exploring experiences from the perspectives of individuals on the receiving end of visits in forensic settings.

A systematic review was conducted in order to synthesise existing data looking at families' experiences of supporting a relative in prison. In absence of a similar review of its kind, this allowed for a comprehensive overview of research data whilst responding to the existing literature gap. This review constitutes the first journal article.

Given the absence of research exploring patients' experiences of familial support in forensic settings, the second journal article describes an empirical study which was conducted to explore how patients in a high security forensic hospital experience familial support in the form of hospital visits. This study was explorative in nature, allowing a "bottom-up" approach to data collection, as opposed to a "top down" design. Participants' accounts of familial support were analysed in order to identify appropriate themes resulting from the data, which were then discussed in relation to existing literature and clinical implications.

**The experiences of families supporting imprisoned family members: A systematic review and framework synthesis of qualitative research**

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<sup>1</sup> Written in accordance with submission guidelines for the International Journal of Forensic Mental Health (See Appendix 1 for author guidelines)

## Abstract

Familial support during imprisonment has been shown to predict prisoner wellbeing, recidivism, resettlement and familial relationships following imprisonment. However, maintaining family ties can be challenging. This review identified twelve qualitative studies which have explored families' experiences in this context. Using a best-fit framework synthesis approach, existing data was built on allowing for a coherent theoretical overview of families' experiences. The resulting framework was then analysed and interpreted. Following expansion of Granja's (2016) findings, the superordinate themes identified were: Experiencing a "parallel sentence" beyond prison walls; Shifting roles and responsibilities; and Ambivalence. Results, clinical implications and future research options are discussed.

Keywords: Prisoners, families, support, systematic, review.

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# 1. Introduction

## 1.1 Family Visits in the Context of Imprisonment

Maintaining a sense of family connectedness has frequently been shown to be an important factor for prisoners' wellbeing (Woodall, 2010). Mills and Codd (2008) explored existing literature which highlighted the positive impact that this connectedness can have upon desistance from crime and resettlement in prisoner populations. This echoes the findings of Mills (2005), who reflected upon the that role familial relations play in reducing reoffending, and also suggested that maintained familial support can help to reduce the "pains of imprisonment" (p2). This sense of connectedness can be cultivated through acts such as telephone calls, letters, and more intimately through family visits in the prison setting (Woodall & Kinsella, 2017). Although visitation between prisoners and families has been shown to be an important factor in both the maintenance of familial connectedness and indeed to resettlement following imprisonment (Brunton-Smith & McCarthy, 2016), there has been less research on the experiences of families in relation to having a family member in prison.

## 1.2 Families as Silent Victims

Families of prisoners are a unique population. In contrast to the majority of individuals who spend time within and outside the prison, their connection to the prison is not tied up with professional roles and/or legal obligations, but in connection with the incarceration of their relative (Granja, 2016).

Families of prisoners have been shown to experience a lack of sympathy and support from people when faced with the incarceration of a loved one, unlike other contexts of loss (i.e. death or illness) (Schoenbauer, 1986; Arditti, 2003). Furthermore, it has been shown that families can also be blamed, shamed and stigmatised due to their perceived proximity to the offence (Condry, 2007). Certain populations, such as the families of sex offenders, may experience heightened levels of what Goffman (1963) termed "courtesy stigma", akin to guilt by association (Edwards & Hensley, 2001; Farkas & Miller, 2007) due to the continued support they provide to their family member (Bailey & Klein, 2018) in the face of crimes which are deemed to be particularly shaming or stigmatising (Schultz, 2014). Such stigma holds the

possibility of not only alienating the family from societal links, but also further alienating the prisoner, due to the potential cutting of family ties (Bailey & Sample, 2017; Reichle & Montada, 1994) as a result of the stress families experience from “contagious stigma” (Austin, 2004). This so called “web of shame” (Condry, 2007, p129) may therefore impact upon relationships in different ways; for example, the nature of the family’s relationship with the individual, due to perceptions of blame around why they have also been stigmatised, or indeed a withdrawal from interaction with the prisoner in order to protect and maintain external relationships in lieu of the family’s relationship with the prisoner. In addition, family members and partners can often be the victims of the crime which precipitates the respective imprisonment (Condry, 2007). This could therefore add further complexity to already strained familial relations following offences.

There exists a complex interplay between both the potential for familial support to be a key factor in prisoners’ wellbeing and rehabilitation (e.g. Dixey & Woodall, 2012; Mills, 2005), and the possibility that the provision of support has the potential to be challenging, if not restrictive, to family members (Condry, 2007). Furthermore, spending time in prison environments in order to visit family members can be unpleasant in itself. As highlighted by Light and Campbell (2006), intrusive searches and unfriendly or insensitive prison staff can deter visits and the associated support provision. Despite these challenges, many families continue to provide support to imprisoned children, partners, parents and more. In addition, family visits in prison can predict higher quality ratings of familial relationships following imprisonment (La Vigne, Naser, Brooks & Castro, 2005), and maintained familial relations have also been linked to reduced reoffence rates (Mills, 2005). Due to the potential for positive outcomes associated with maintained family contact, and in order to better understand the complex dynamic between prisoner and family, the review will examine the landscape of research which explores the experiences of these family members. Research into study participants’ accounts of phenomena often utilises qualitative methodologies due to the subjective nature of experience and the associated role for qualitative approaches in these contexts (Curry, Nembhard & Bradley, 2009). Therefore, the present review will focus on qualitative studies exploring this area of study.

### 1.3 Qualitative Research and Synthesis

Through exploration of subjective lived experiences in context, qualitative research affords researchers a deeper understanding of phenomena (Barker, Pistrang & Elliott, 2002); appropriate when a descriptive and in-depth understanding is sought (Audet & Everall, 2010). Qualitative synthesis allows researchers to utilise a broader approach to evaluating qualitative data. Through the process of identification of studies, integration and contextual interpretation of the respective results, (Dixon-Woods et al., 2006; Harden & Thomas, 2010), it is possible to elucidate themes which arise across the literature being explored. As qualitative data are typically specific to the context of the original study and do not offer generalisability (Malterud, 2001), systematic searching and analysis affords an opportunity to identify themes spanning multiple studies which may have wider applicability (Stuart, Tansey & Quayle, 2017). Whilst generalisation is not the aim of qualitative research, synthesis allows for the illumination of a broader picture, and a critical interpretation of data generated through existing literature (Paterson, Thorne, Canam & Jillings, 2001).

### 1.4 Framework Synthesis

Framework synthesis is based on framework analysis (Pope, Ziebland & Mays, 2000), which suggested five stages to qualitative data analysis: Familiarisation; Identifying a thematic framework; Indexing; Charting; and Mapping and Interpretation. Whilst there are many means of synthesising qualitative data (grounded theory, meta-ethnography, meta-study, realist synthesis), framework synthesis offers a method which is transparent, flexible, and draws upon an a priori framework deemed appropriate for the data being synthesised (Carroll, Booth & Cooper, 2011; Dixon-Woods, 2011). The a priori framework need not represent a complete match of the data being reviewed, but instead must offer a useful starting point, as designated by the label “best fit” (Booth & Carroll, 2015). This framework can then be tested, reinforced, and/or built on, to allow for a context-specific way of synthesising and describing phenomena being explored (Carroll, Booth, Leaviss & Rick, 2013). It is therefore an augmentative and deductive approach which builds on existing frameworks, as opposed to being grounded or inductive (Carroll et al., 2011).

### 1.5 Aim

The present study aimed to synthesise findings of qualitative studies that have sought to explore families' experiences of supporting a relative in prison. Given the absence of a review of its kind, the authors aimed to provide a comprehensive synthesis of the available data whilst addressing the respective literature gap. Through the process of systematic searching and analysing, this study aimed to bring to light the findings of qualitative studies that have identified the narratives of families of prisoners. By drawing upon framework synthesis methodology (Carrol et al., 2013), the authors explored the potential utility of a framework to synthesise qualitative data looking at the experiences of families of prisoners.

## 2. Method

The process of the review involved identifying suitable studies for inclusion, critically appraising the respective studies, and synthesising research findings. This is in keeping with guidelines for qualitative systematic reviews developed by Popay et al. (2006), who developed a guidance document focused on improving quality in approaches to evidence synthesis.

Prior to initiation of the study, a search was conducted on Google Scholar as well as PsycINFO, EMBASE, Medline electronic databases and the Cochrane database for systematic reviews to ensure that such a review had not yet been published. No previous systematic reviews were identified.

### 2.1 Search Strategy

The search was conducted over four databases: PsycINFO, EMBASE, Medline and ProQuest. These databases were decided upon in consultation with a librarian with extensive experience of systematic reviews in this study area.

The SPIDER (Sample, Phenomenon of Interest, Design, Evaluation, Research Type) tool was used to assist in the development of search terms (Cooke, Smith & Booth, 2012). This tool was developed to provide an effective alternative to search tools which are more focused on quantitative research. A modified version of the SPIDER tool was used, focusing on ensuring

sensitivity to allow the identification of a range of studies as opposed to focusing on specificity (Stickley & Wright, 2011).

The final search terms used across databases were:

1. Terms relating to sample: “Famil\*” OR “spous\*” OR “partner\*” OR “parent\*”
2. Terms relating to the evaluation: “experienc\*” OR “visit\*” OR “perspective\*” OR “support\*”
3. Terms relating to the phenomenon of interest: “prison\* OR imprison\* OR criminal\* OR offend\* OR forensic\* OR secure unit\* OR incarcerat\* OR high secur\*"

Databases were searched from their inception until November 2018, and full article texts were searched. The search yielded 2,581 results prior to deduplication.

## 2.2 Eligibility Criteria

Studies were only included if they met inclusion and exclusion criteria (see Table 2). It was decided that only adult family members of prisoners would be included, as children of prisoners’ experiences could be qualitatively different, for example due to the potential developmental impact that the imprisonment of parents can have (Martin, 2017). Grey literature was also excluded due to potential issues with study quality in absence of peer review.

Table 2. Inclusion and Exclusion Criteria for Systematic Review

	<b>Inclusion Criteria</b>	<b>Exclusion Criteria</b>
Study Design	Published primary research. Qualitative research.	Reviews of studies. Grey literature. Quantitative research.
Sample	Adult family members of prisoners.	Friends or others who are not identified as family of prisoners. Non-adult children of prisoners.

		Studies reviewing a prison programme for families.
Study focus	Families' experiences of having, supporting and visiting a family member in prison.	Families who have not maintained contact with imprisoned family member.
Date	1970-2018.	Pre-1970.
Language	Studies written in English.	Studies not written in English.

### 2.3 Study Selection

The study selection process took several steps to complete. Drawing upon the Preferred Reporting Items for Systematic Reviews (PRISMA) protocol (Moher, Liberati, Tetzlaff & Altman, 2009), the process is detailed in Figure 1.

As a result of database searches, 2,581 potential studies were identified. Once duplicates had been removed (N = 284), records were imported into Covidence reference management software (a Cochrane technology platform available from <https://www.covidence.org/home>). Study titles and abstracts were screened against inclusion/exclusion criteria (Table 2). Of these, fifteen were deemed suitable for full text review. Following full text review, eleven articles were excluded on grounds of exclusion criteria not evident at abstract review.

It has been highlighted that indexing quality of qualitative research in databases such as Embase and MEDLINE may be lacking and can leave researchers experiencing uncertainty as to whether all relevant articles have been uncovered (Shaw et al., 2004). Furthermore, effective retrieval is dependent upon the quality and clarity of title and abstract. However, individuals tasked with indexing articles may have varying interpretations of studies (Cooke et al., 2012). Therefore, searches for qualitative data may run the risk of omitting certain terms due to a disparity between authors' and searchers' definition of concepts (Evans, 2002).

With this in mind, the authors are sensitive to the notion of the potential for inadvertent omission of relevant studies. To account for this, an external search was undertaken, which involved a hand search of key journals, manual searching of reference lists of included studies, and contacting authors of published studies in the topic area. Following these processes, eight additional articles were identified: seven by examining reference lists of included studies; and one through existing knowledge of authors working in the research area.

The four eligible studies resulting from the database search plus the eight additional studies found elsewhere were put forward for quality assessment.

#### [2.4 Data Extraction](#)

An overview of the twelve studies identified from the search process can be found in Table 3. All studies used qualitative methodology, though there was variance within the specific data collection methods. Eleven studies used interviews as their main data collection method, whilst Christian (2005) used observation techniques as a primary data collection method, however, these observations informed the construction of open-ended interview questions which were used with family members of prisoners. Six of the studies specified using semi-structured and one study used an unstructured interview approach. The other studies referred to generic “interviews” (n=3), closed and open-ended interview questions (n=1), or a blend of observation and open-ended interview questions, as described above (n=1). In total, four studies described using additional approaches to data collection, such as observations and focus groups with staff, however only direct quotations from interviews with family members were used for the purpose of this review study.

Dixey and Woodall (2012)’s study was the only article which did not explicitly label the themes identified in their research. However, the results focusing on families’ experiences were clearly arranged into three sections, and the author of the present review created theme labels for these sections accordingly to allow for framework synthesis processes (*Visits as traumatic; Travel and transport logistics; and Financial implications*).

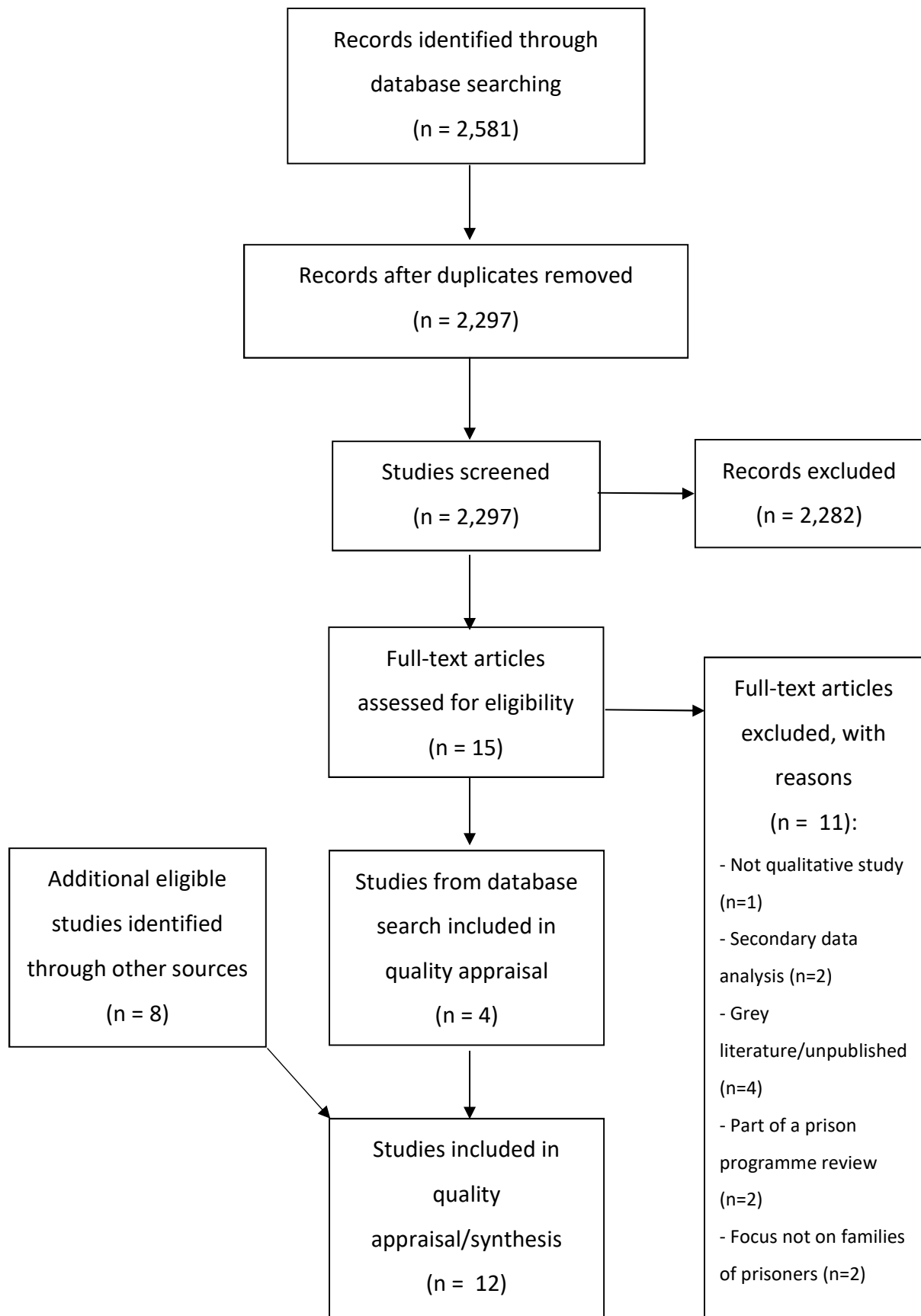


Figure 1: Flowchart showing selection and appraisal of study process based on Moher et al. The PRISMA Group (2009)

## 2.5 Critical Appraisal

### *Quality Assessment*

Certain bodies deem qualitative research as “second class” to quantitative approaches (Tong, Sainsbury & Craig, 2007). As such, one could argue that it is the role of the qualitative researcher to take steps to ensure methodological rigour within respective research. Furthermore, quality in systematic reviews depend, at least in part, on the quality of the literature included within the review, as poor-quality data may distort the overall synthesis, thus creating difficulties in interpretation (Dixon-Woods et al., 2004). For this reason, it is imperative that the overall quality of included data is assessed and reported to ensure transparency.

Existing research has highlighted the utility of and guided researchers towards assessment tools which are multidimensional in nature and adopt a checklist approach (Centre for Reviews and Dissemination, 2009; Hannes, 2011). For this reason, the present study utilised the Critical Appraisal Skills Programme (CASP) qualitative tool (2018), which has been widely used in similar reviews. It is a ten-item tool developed to help with the appraisal of qualitative research. The tool helps the reviewer to critique research across three broad areas: the validity of the study, the results themselves, and the local utility of the results.

### *Secondary rating*

The quality of each study was assessed by the first author. Five out of twelve studies (41.66%) were also selected at random and independently rated using the same quality criteria by an independent reviewer. A dual reviewer strategy is desirable in order to enhance rigour, objectivity, and to avoid potential for error in quality appraisal processes (Braga, Pemberton, DeMaria & Lorenzo, 2011).

## 2.6 Epistemological Stance and Subjectivity

The present study acknowledges and adopts a constructivist approach to research; both that of the papers included in the current review, and that of the overall review itself. In this sense, the author acknowledges that research is time and context bound, and that these are factors

by which the papers included in the present review will be influenced, and that of the present study.

Furthermore, the context of the present author; as a white, Scottish female who has never been in prison nor had a loved one in prison; situates the author in a starkly different situations to those studied in the included studies. It is also important to acknowledge this when considering the process of the review itself, in that the author was tasked with the role of labelling theme names, and indeed relabelling themes identified by the authors of the included studies where appropriate. Whilst this was appropriate to ensure a coherent overall framework resulting from included study data, this adds another layer of subjectivity and has the potential to further remove the data from its origin. An awareness of one's own subjectivity was key in order to critically consider and ensure that this process was done in a transparent and appropriate way.

### 3. Results

#### 3.1 Included Studies

Twelve full studies met inclusion criteria. A summary of included studies' characteristics and findings can be found in Table 5. The majority of studies (n=10) recruited family members via prison services, however two studies recruited through observation of a self-help organisation (Condry, 2006) or through social media, voluntary organizations that worked with prisoners' families, through word-of-mouth or by advertising in a national prison newspaper (Kotova, 2018). The studies were predominantly based in the UK (n=7) with two studies further specifying their location as Scotland and two specifying England. Other studies were based in the USA (n=3), Portugal (n=1) or Australia (n=1). The total sample size across included studies was 339 (M=28.25, range=11-61), which included parents, partners, siblings, children, grandparents, nieces, aunts, and great aunts. Whilst the majority of studies included both male and female participants (n=8), the significant majority of participants across the dataset were women. Ages of participants or prisoners were not typically provided.

### 3.2 Quality Assessment

Inter-reviewer ratings on the CASP tool showed an agreement of 82%, a value deemed acceptable (Stemler, 2004). Cohens Kappa was calculated to account for the probability of agreement based on chance alone. The Kappa value calculated ( $K = .589$ , 95% CI [0.354 - 0.825]) suggested moderate levels of agreement. However, this calculation only considered exact matches between raters. As the qualitative rating tool gave the opportunity for raters to select out of three ordered categories (“Yes”, “Unsure”, “No”), the author chose to calculate a weighted kappa in recognition of the fact that certain rating pairs, i.e. “Yes” and “Unsure” or “No” and “Unsure”, are more closely matched than “Yes” and “No”. The weighted kappa therefore accounted for the distance between two deviating ratings ( $k = 0.667$ ) and suggested substantial levels of agreement overall (McHugh, 2012). All successive disagreements in ratings were resolved through discussion.

The CASP tools were designed for use as educational pedagogic tools and therefore the use of a scoring system is not suggested (CASP, 2018). However, Butler, Hall and Copnell (2016) developed a scoring system for use with the CASP based on previous experience of quality ratings. It was decided that a scoring system would enhance rigour and aid comparison of ratings between the primary and secondary rater. Therefore, the author drew from the scoring system proposed by Butler et al. (2016) for the purposes of the current study and articles were given a global rating of “High”, “Moderate” or “Low”, based on performance against the ten CASP checklist items (see Table 4). Whilst a numerical scoring system was used to inform the quality assessment and increase rigour, global quality ratings were descriptive in nature in accordance with best practice guidelines (Higgins & Green, 2011).

Two of the studies received “High” global quality ratings, whilst nine received “Moderate” and one received “Low” ratings. Butler et al. (2016) recommend excluding articles that score less than six points, however no studies scored six or less (see Table 4). Overall, studies were rated more highly when ethical issues were taken into consideration and a sufficiently rigorous data analysis took place (e.g. Dixey, 2013; Holligan, 2016), and received a lower rating when these items were not present, and the recruitment strategy was not clearly stated

(e.g. Codd, 2000; Halsey & Deegan, 2015). Table 4 depicts the final quality ratings and the range of scores given to each article with regard to the quality criteria being assessed.

Table 3: Summary of included studies

Author Year	Location	Study Aim	Setting Participants Sample size	Methods & analysis	Qualitative Findings	Themes identified in original papers. <small>Key: Normal font thickness denotes a theme. Bold font denotes a superordinate theme.</small>
Arditti, J. A. (2003)	USA	To explore family visits in correctional facilities in an explorative and descriptive way, using an ecologically grounded loss framework that acknowledges the ambiguity associated with having a family member incarcerated.	Setting: Mid-Atlantic state prison.  Participants: parents or caregivers visiting incarcerated family member.  Sample size: 56.	Semi structured interviews.  Qualitative content analysis.	The majority of parent/caregivers found visiting their family member at the jail difficult. Over half (52.7%) reported that visits went “very badly”.  The lack of physical contact between the inmates and their children was seen as the most serious problem (visiting booths).	1) Lack of physical contact and/or privacy. 2) Long waits. 3) Short/infrequent visits. 4) Emotionally painful visits. 5) Poor conditions for the visit. 6) Harsh/disrespectful treatment.
Christian, J. (2005)	USA	To explore the way in which families manage prison visiting, with a particular focus on barriers for families visiting prisons and the ways that families manage these barriers.	Setting: Two upstate New York prisons.  Participants: Families and partners of imprisoned family members.  Sample size: 19.	Observation and open-ended interview questions.  Grounded theory.	The findings highlighted that prisoners’ familial relationships are complex, fluid and dynamic, partly due to the demands associated with prison visitation processes and the associated maintenance of family contact.	1) Describing the journey. 2) Cost and timeline. 3) Waiting for the visit. 4) Barriers to visiting and maintenance of connections. 5) Watching the system. 6) Moral support. 7) Hope/Parole. 8) Visiting cycles and the fluid nature of

Author Year	Location	Study Aim	Setting Participants Sample size	Methods & analysis	Qualitative Findings	Themes identified in original papers. Key: Normal font thickness denotes a theme. Bold font denotes a superordinate theme.
						connections to prisoners.
Christian, J. & Kennedy, L.W. (2011)	USA	To explore the impact and consequences of imprisonment for the prisoner, family member, and their relationship.	Setting: Two New Jersey prisons, USA.  Participants: family dyad/triads.  Sample size: 13 inmate family dyads and one inmate family triad	Closed and open-ended interview questions.  Thematic analysis and comparative analysis (within dyad/triad).	There was variation in the impact of imprisonment on relationships, and the different categories of relationships were labelled (see adjacent column). The nature of the relationship prior to imprisonment- including degree of involvement in each other's lives, degree of conflict, and level of mutuality between them- impacted upon which category participants fitted into, as did the type of relationship (i.e. partner or parent).	1) Until he comes home: Disrupted relationships. 2) I'd have sent him to jail sooner: Transforming relationships. 3) I don't know if I can trust him: Precarious relationships.
Codd, H. (2000)	UK	To explore the experiences of women who are older than most women that are in relationships with imprisoned men.	Setting: Participants were either recruited from support groups or had responded to notices in prison visiting areas. No interview location specified.	Semi-structured interviews.  Unspecified analysis of the interviews, though completed with reference to	Analysis revealed that gender roles and power were constant factors in participants' explanations of experiences. Once their partners were imprisoned, the participants were required to adopt new roles or extend existing ones.	<b>Roles, power and decision-making</b> 1) The "mother" role. 2) The "breadwinner, handyman and organizer" role. 3) The role of "wife". <b>Role strain, moderators and escalating factors</b> 1) Life experience as a moderator.

Author Year	Location	Study Aim	Setting Participants Sample size	Methods & analysis	Qualitative Findings	Themes identified in original papers. <small>Key: Normal font thickness denotes a theme. Bold font denotes a superordinate theme.</small>
			Participants: Female partners of male prisoners.  Sample size: 11.	the “Model of Role Transitions” (Moerings, 1992).		2) Support groups as moderators. 3) Stigmatization as an escalating Factor. <b>Personal development and the return of the male partner</b>
Condry, R. (2006)	UK	To explore how relatives made sense of their experiences, individually and collectively: how they described the difficulties they faced; whether they were blamed and shamed and in what manner; how they ‘understood’ the offence and the circumstances which had brought it about; and how they dealt with the contradiction inherent in doing this and yet not condoning his or her actions.	Setting: Local jail, or at participant’s own home.  Participants: Partners or relatives of offenders.  Sample size: 32.	Semi Structured interviews.  Observation of a self-help organisation and in prison visitor centre.  Ethnographic fieldwork.	Overall, the study highlighted the important and different roles that female relations of male offenders tended to adopt, in comparison to literature exploring male relations of female offenders.	1) Finding out. 2) Increased responsibilities. 3) Stigmatisation and familial blame. 4) Self-help and gender.

Author Year	Location	Study Aim	Setting Participants Sample size	Methods & analysis	Qualitative Findings	Themes identified in original papers. <small>Key: Normal font thickness denotes a theme. Bold font denotes a superordinate theme.</small>
Dixey, R. & Woodall, J. (2012)	England	To explore perceptions of the same event – the visit – from the families’, prisoners’ and prison staff’s viewpoints in a category-B local prison in England.  For the purposes of this review, attention is paid to the visit from the families’ perspective.	Setting: Prison visit centre.  Participants: Family visitors.  [Prisoners and staff]  Sample size: 30 Family visitors [16 prisoners, 14 staff]	Semi-structured interviews.  [Focus groups for prisoners and staff]  Thematic analysis.	The findings suggest that the three parties frame their perspective of visiting very differently, however prisoners’ families often see visits as an emotional minefield fraught with practical difficulties.	1) Visits as traumatic. 2) Travel and transport logistics. 3) Financial implications.
Granja, R. (2016)	Portugal	To analyse how relatives of prisoners experience and attribute meanings to the imprisonment of one or more family members.	Setting: Two Portuguese prisons; one male, one female.  Participants: Prisoners’ relatives (spouses, mothers, fathers in law, aunts, daughters, siblings and grandparents.)  Sample size: 30.	Interviews.  Thematic synthesis.	Interviewees’ described the impact of a family member’s imprisonment resulting in them experiencing a version of a prison sentence beyond the prison walls. The imprisonment of a family member became a period of time that changed the way they experienced both the present and the future, impacted on the way they acted out their familial roles, and impacted on their own identity. Whilst imprisonment of a relative could create additional pressure and financial burden for families who were already at the	<b>Experiencing a “parallel sentence” beyond prison walls.</b> 1) Suspended time. 2) Creative negotiation of family involvement. 3) “Spoiled identity” negotiations. 4) Childcare settings and economic costs. <b>Complex effects.</b>

Author Year	Location	Study Aim	Setting Participants Sample size	Methods & analysis	Qualitative Findings	Themes identified in original papers. Key: Normal font thickness denotes a theme. Bold font denotes a superordinate theme.
					lower end of the social scale, it could also provide the opportunity for a more stable family dynamic.	
Halsey, M. & Deegan, S. (2015)	Australia	To explore how female significant others conceive of their roles during and following the incarceration of their intimate and addresses in detail some of the personal, situational and structural factors that characterize their lives.	Setting: Interviews were conducted in community settings – predominantly women’s place of residence or at another mutually agreed location.  Participants: Female significant others of offenders.  Sample size: 27.	Interviews.  Grounded Analysis.	Prisoners’ female significant others are an important but highly marginalized and often traumatized group within the correctional and post-release landscape. Visiting a family member in prison brought around both positive and negative outcomes for the visitor, as did the wider experience of a family member being in prison. The study also highlights the apparent gendered nature of prisoner supporters.	1) Logics of blame. 2) Desire for proper punishment. 3) Facing the ‘monster child’. 4) Becoming stranded. 5) Confronting the criminal justice system. 6) Incarceration as brief reprieve. 7) Suspicion of maternal insights. 8) Sublimation of self. 9) Dealing with own trauma.
Holligan, C. (2016)	Scotland	To give voice to prison visitors via semi-structured interviews about their experiences of journeys to prison and support given to prisoners during imprisonment.	Setting: Three prisons in Scotland, interviews recorded over telephone call.  Participants: 2 male, 35 female	Semi structured interview.  Thematic coding.	The themes described capture differences in the ways that visitors not only communicate with loved ones, but also experience how their relationship with the prison service alters aspects of their own lives.	1) Maintaining morale. 2) Travel and transport logistics. 3) Not being in control.

Author Year	Location	Study Aim	Setting Participants Sample size	Methods & analysis	Qualitative Findings	Themes identified in original papers. Key: Normal font thickness denotes a theme. Bold font denotes a superordinate theme.
			visitors. All white Scottish.  Sample size: 37.			
Jardine, C. (2018)	Scotland	To develop a more nuanced account of the lived experiences of these families by examining what it means to be a family in the context of imprisonment, how these relationships are constructed and maintained, and how those affected by the imprisonment of a family member are perceived by, and interact with, the criminal justice system.	Setting: Visitors' Centre at Prisons in Edinburgh and Greenock.  Participants: 7 partners, 7 mothers, 1 daughter, 1 son, 1 niece, 1 great aunt, 1 stepfather. 17 Female, 2 Male.  Sample: 19	Unstructured interviews.  Analysis method not specified.	The study revealed a range of strategies for displaying family and maintaining relationships in the context of imprisonment. The author stated that family relationships affected by imprisonment are not only highly individual, but also actively constructed through embodied displays of care and commitment.	1) Visits. 2) Objects, mementos and memories. 4) Unconventional displays.
Kotova, A. (2018)	UK	To identify and examine the temporal pains of imprisonment as experienced by female partners of male long-term prisoners in the UK, and how long sentences shaped their	Setting: Quiet, neutral locations such as private rooms in public houses, cafes or community centres.	Semi-structured interviews.  Thematic analysis.	The article discusses how sentences interrupt partners' life courses, shape daily life, and result in an attempt to balance living in reference to both prison time and "outside" time. It also highlights the need to consider the extent to which prisoners and their families	1) Interruption of the normative life course. 2) The deprivation of couple and family time. 3) Waiting and re-adjusting life time and everyday time.

Author Year	Location	Study Aim	Setting Participants Sample size	Methods & analysis	Qualitative Findings	Themes identified in original papers. <small>Key: Normal font thickness denotes a theme. Bold font denotes a superordinate theme.</small>
		relationships with the imprisoned partners.	Participants: married and unmarried female partners of male prisoners.  Sample: 33.		are deprived of mundane but meaningful family moments. It is argued that time is not just a critical aspect of a long-term prisoner's sentence, but also of his partner's experiences	
McCarthy, D. & Adams, M. (2018)	England	Focusing on primary caregivers maintaining relations with young men in prison, authors examine how and why relationships between prisoner and family may improve during the sentence, and considers what role incarceration may play in helping some families to rebuild relationships with prisoners.	Setting: Two large young (male) offender prisons in England.  Participants: Primary caregivers of young men in prison.  Sample: 61.	Interviews.  Thematic analysis.	Distance from imprisoned young men provided caregivers an escape from challenging situations that caused strain prior to incarceration, and an opportunity to rebuild ties. Traumatic events experienced by prisoners acted as a turning point and encouraged families and prisoners to open up to one another. Re-marking ties and building trust followed incarceration, in an incremental fashion.	1) Respite, recovery and change. 2) Prisoner trauma as facilitator of family support. 3) Re-marking family ties and building trust.

Table 4: Quality ratings table

Articles (First author/year)	Quality Criteria										Total Score	Global Rating
	(1) Aim	(2) Methods	(3) Design	(4) Recruitment	(5) Data Collection	(6) Researcher role	(7) Ethics	(8) Analysis	(9) Findings	(10) Value		
Arditti (2003)	1	1	1	0.5	1	0.5	0	1	1	1	8	Mod
Christian (2005)	1	1	1	0.5	1	0.5	0	1	1	1	8	Mod
Christian (2011)	1	1	1	1	1	0	0.5	1	1	1	8.5	Mod
Codd (2000)	1	1	1	0	1	0.5	0.5	0.5	1	1	7.5	Mod
Condry (2006)	1	1	1	1	1	0.5	0.5	0	1	0.5	7.5	Mod
Dixey (2012)	1	1	1	1	1	1	1	1	1	1	10	High
Granja (2016)	1	1	1	1	1	0.5	0.5	0.5	1	1	8.5	Mod
Halsey (2015)	1	1	0.5	0.5	0.5	0	0.5	0.5	1	1	6.5	Low
Holligan (2016)	1	1	1	1	1	0.5	1	1	1	1	9.5	High
Jardine (2018)	1	1	1	1	1	0.5	0.5	0	1	1	8	Mod
Kotova (2018)	1	1	0	1	1	0	0.5	1	1	1	7.5	Mod
McCarthy (2018)	1	1	0.5	1	1	0	1	1	1	1	8.5	Mod

Scoring system: Yes: 1 point

Unsure: 0.5 points

No: 0 points

High-quality paper: Scores 9–10

Moderate-quality paper: Scores 7.5-9

Low-quality paper: Less than 7.5

Exclude: Less than 6

### 3.3 Framework Synthesis

Upon examination of the Granja (2016) results, the authors recognised that the themes identified corresponded to much of the data identified in the other studies included in the review (See Table 5). The Granja paper therefore provided a coherent theoretical overview from which to conceptualise the role of prison visits, using data from the remaining studies describing families' experiences of supporting prisoners. Consequently, the themes identified by Granja were therefore chosen as the a priori framework from which to organise the wider dataset using a best fit framework synthesis approach. Framework synthesis allows researchers to undertake high-quality work within a context of time and resource constraints (Dixon-Woods, 2011) by offering "a highly structured approach to organising and analysing data" (Barnett-Page & Thomas, 2009, p5).

Table 5. Granja (2016) theme table

<b>Superordinate themes</b>	<b>Subthemes</b>
<b>Experiencing a parallel sentence beyond prison walls</b>	Suspended time
	Creative negotiation of family involvement
	"Spoiled identity" negotiations
	Childcare settings and economic costs
<b>Complex effects</b>	(No subthemes proposed)

A process of coding took place which was informed by the principles suggested by Carroll et al. (2011). Data in the form of verbatim extracts and author summaries supported by the text was extracted from Results sections of studies, as it was felt unlikely that respective Discussion or Conclusion sections would yield additional data beyond interpretation and reflection. Through a process of line by line analysis, results sections of each article were compared against themes identified in the a priori framework (Granja, 2016). This allowed the author to identify whether themes in the framework were well supported by papers identified during the systematic search, whether the framework was adequate in explaining the results from the additional papers, or whether data from the papers were not fully accounted for by the a priori framework. When data did not match the a priori framework, a secondary thematic analysis took place (Braun & Clarke, 2006) to identify suitable additional themes. This enabled the construction of the final framework, synthesised as a result of

combining the a priori theme table data with the data extracted from the additional studies included within the review.

As Granja had organised data into both superordinate themes and subthemes, this was an appropriate manner in which to continue the organisation of data. Whilst Granja (2016)'s study identified two superordinate themes (*Experiencing a "parallel sentence" beyond prison walls*, which had four subthemes, and *Complex effects*, which unusually had no subthemes), the process of secondary thematic analysis highlighted additional themes and subthemes which required amendments to be made to the a priori theme table (see Table 6 for updated theme table). The most significant amendment was the inclusion of a new superordinate theme, *Shifting roles and relationships*. Many of the studies commented on relationships, roles, and indeed the changes that took place within these as a result of imprisonment (e.g. Christian, 2005; Codd, 2000; Condry, 2006). As Granja did not explicitly identify relationships to be a theme, yet many other studies identified relationships to be a potent factor across the dataset, it felt appropriate to develop a new superordinate theme to accommodate this. In line with the data extracted from the studies, and by adopting the language used in theme labels from Christian & Kennedy (2011) and Codd (2000), subthemes were labelled *Gendered role*, *Increased role*, *Disrupted relationships*, *Transformed relationships*, and *Precarious relationships*.

Granja (2016)'s subtheme of *Suspended time* was renamed *Submitting to the system*. Although *Suspended time* suggested a sense of time being postponed due to imprisonment, data from the synthesis highlighted that this idea of suspended time related to the relationship between prisoner and visitor. For this reason, this aspect was best described under the new subtheme of *Disrupted relationships*. However, data did exist which highlighted the ways that families were required to submit to prison processes in ways that went beyond the impact imprisonment had on relationships, i.e. long waits (Arditti, 2003) and not being in control (Holligan, 2016). Therefore, *Submitting to the system* felt an appropriate theme label from which to explain these experiences.

The subtheme titled *Childcare settings and economic costs* was abbreviated to *Economic costs*, as the data which explored childcare issues related to women whose caregiving

responsibilities appeared to increase during the family member's imprisonment (i.e. Codd, 2000). Therefore, the *Childcare settings* element of this theme appeared to fall under the *Gendered role* subtheme following amendment. Whilst *Economic costs* remained important throughout the studies and respective data (i.e. Christian, 2005; Dixey & Woodall, 2012), this remained in the final theme table.

Some studies described the lack of opportunity to be physically close to the imprisoned family member, or indeed the lack of privacy overall (e.g. Arditti, 2003). The prevalence of this highlighted the need for a new subtheme, which was entitled *(Lack of) physical contact and/or privacy*. This theme was placed underneath the superordinate theme of *Experiencing a "parallel sentence" beyond prison walls*, due to the ways in which both prisoner and family were affected by this barrier.

In addition, an existing superordinate theme, *Complex effects*, was renamed to *Ambivalence* and delineated by explaining this with two subthemes: *Pros and cons of imprisonment* and *Mixed emotions*. In Granja's study, *Complex effects* appeared to correspond primarily to the notion that imprisonment could create both difficult and positive outcomes for family members. It was therefore renamed to *Ambivalence* to provide further clarity on the focus of the theme. To give additional detail and to account for the data identified from the wider dataset, the subthemes of *Pros and cons of imprisonment* and *Mixed emotions* spoke to both the ambivalence of the broader imprisonment context and the more direct experience of visiting an imprisoned relative.

The fourth column in Table 6 highlights occasions in which authors have discussed topics which corresponded to the themes included in the updated framework, however the topics were not labelled as themes in the original study results. For example, Holligan (2016) talked about the financial aspect of prison visits. Whilst this was not explicitly stated as a theme by Holligan, it did map on to the subtheme of *Economic costs* included in the final framework.

Table 6: Updated framework

<b>Superordinate theme</b>	<b>Subtheme</b>	<b>Subsumed original themes (first author)</b>	<b>Discussed though not present as a theme in:</b>
<b>Experiencing a “parallel sentence” beyond prison walls</b>	<i>*Submitting to the system</i>	<i>Long waits (Arditti); Short, infrequent visits (Arditti); Waiting for the visit (Christian); Finding out (Condry); Sublimation of self (Halsey); Not being in control (Holligan).</i>	Jardine
	<i>Creative negotiation of family involvement</i>	<i>Moral Support (Christian); Maintaining morale (Holligan); Visits (Jardine); Objects, mementos and memories (Jardine); Unconventional displays (Jardine)</i>	Condry, Dixey, Holligan, Kotova, McCarthy
	<i>“Spoiled identity” negotiations</i>	<i>Harsh/disrespectful treatment (Arditti); Stigmatisation and Familial Blame (Condry); Facing the “monster child” (Halsey); Suspicion of maternal insights (Halsey)</i>	Holligan, McCarthy
	<i>*Economic costs</i>	<i>Cost and Timeline (Christian); Financial implications (Dixey)</i>	Arditti, Condry, Dixey, Holligan, Jardine
	<i>*(Lack of) physical contact and/or privacy</i>	<i>Lack of physical contact and/or privacy (Arditti)</i>	Holligan, Jardine, Kotova

<b>*Shifting roles and relationships</b>	<i>*Gendered role</i>	<i>Watching the system (Christian); Moral support (Christian); The “Mother” Role (Codd); Life experience as a moderator (Codd); Support groups as moderators (Codd).</i>	Condry
	<i>*Increased role</i>	<i>The “Breadwinner, Handyman and Organiser” Role (Codd); Increased Responsibilities (Condry).</i>	Condry Granja
	<i>*Disrupted relationships</i>	<i>Disrupted relationships (Christian &amp; Kennedy); Suspicion of maternal insights (Halsey); Interruption of the normative life course (Kotova); The deprivation of couple and family time (Kotova); Waiting and re-adjusting life time and everyday time (Kotova).</i>	Halsey
	<i>*Transformed relationships</i>	<i>Transformed relationships (Christian &amp; Kennedy); Remarking family ties and building trust (McCarthy); Prisoner trauma as facilitator of family support (McCarthy).</i>	
	<i>*Precarious relationships</i>	<i>Precarious relationships (Christian &amp; Kennedy); Facing the “monster child” (Halsey), Sublimation of the self (Halsey)</i>	Condry
<b>*Ambivalence</b>	<i>*Pros and cons of imprisonment</i>	<i>Barriers to Visiting and Maintenance of Connections (Christian); Visiting Cycles and the Fluid Nature of Connections to Prisoner (Christian); Becoming stranded (Halsey); Incarceration as a brief reprieve (Halsey); Respite, recovery and change (McCarthy); Remarking family ties and building trust (McCarthy)</i>	Arditti, Condry, Dixey, Jardine, Kotova

	<i>*Mixed emotions</i>	<i>Emotionally painful visits (Arditti); Visits as traumatic (Dixey), Confronting the criminal justice system (Halsey); Dealing with own trauma (Halsey), Not being in control (Holligan)</i>	Condry, Jardine, Kotova, McCarthy
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\*Indicates a newly created or reworded theme from Granja's themes

Table 3 provides an overview of all studies included in the analysis and displays all themes which were considered for inclusion in the synthesised framework.

### 3.4 Themes Derived Through Framework Synthesis

As mentioned, three superordinate themes and twelve subthemes were included following framework synthesis. Subthemes grouped under the superordinate theme of *Experiencing a “parallel sentence” beyond prison walls* were: *Submitting to the system*; *Creative negotiation of family involvement*; *“Spoiled identity” negotiations*; *Economic costs*; and *(Lack of) physical contact and/of privacy*. Subthemes grouped under the superordinate theme of *Shifting roles and relationships* were: *Gendered role*; *Increased role*; *Disrupted relationships*; *Transformed relationships*; and *Precarious relationships*. Subthemes grouped under the superordinate theme of *Ambivalence* were: *Pros and cons of imprisonment*; and *Mixed emotions*.

By paying attention to each theme identified, we can explore in greater detail the contribution respective themes make to this framework.

#### 3.4.1 Experiencing a “Parallel Sentence” Beyond Prison Walls

Granja’s first theme speaks to the fact that the lives of prisoners’ families are often shaped by the context within which they find themselves once a relative has been sentenced (Granja, 2016). These collateral consequences of imprisonment, such as the catalysation and/or exacerbation of social exclusion and financial hardship, have been noted in previous research (e.g. Braman, 2004; Christian & Kennedy, 2011; Mills & Codd, 2008). However, few studies have explored the phenomenological experience of family members, that is, what it is like to be a family member of a prisoner, as opposed to more quantifiable outcomes associated with imprisonment such as how much it costs to visit an imprisoned relative. In the subthemes that follow, it is possible to identify the ways in which the imprisonment of a family member creates ripple effects impacting upon the lives of relatives and significant others.

##### 3.4.1.1 *Submitting to the System*

This renamed subtheme highlights that for some, the provision of family support in the form of visits meant accepting unpleasant or troublesome prison processes. Examples of these included changeable visiting times which had the potential to make it more challenging to visit prisoners (Holligan, 2016), and being made to wait for long periods of time, sometimes with children, until visits took place (Arditti, 2003).

*You wait a long time and sometimes you don't even get in to see your family member.*  
(Arditti, 2003, p125).

In this example, it was uncertain as to whether families would successfully see their family member despite making themselves physically present in the prison. This appeared to be an aspect of visiting that necessitated a compliant response from families; either they would or would not be successful in securing a physical visit with their family member, and they were required to be accepting of the outcome either way.

Another way in which families were required to submit to the system centered around security processes, such as physical searches. Whilst some families found the security processes degrading (Arditti, 2003), or physical searches aggravating due to the perception of being individuals who may bring banned substances to the prison (Holligan, 2016), they were required to adhere to such processes in order to visit their family member, in spite of such challenges.

#### *3.4.1.2 Creative Negotiation of Family Involvement*

As highlighted by Jardine (2018), it is imperative that unconventional displays of what it is to be a family are attended to. Individual understanding of family is informed by subjective experiences of family life; informed by one's own history. In this sense, it is important that we recognise that familial displays may vary between individuals.

In much of the data, family members described taking food into the prisons for their family member, and often eating together.

*Or going out for a meal or eating together, that was something that my family did a lot so things like the Italian night\* that meant the world to us. And it is not even just for the family, it could make my dad feel better too; like my dad always says I'd love it if they had a garden for tea and a fag with your mum, and these are just little things but they mean the world to us.* (Jardine, 2018, p126).

\*A recent Italian themed night had taken place where families shared a meal together.

As highlighted above, it was not only the more obvious displays of family practices, such as sharing a meal that felt important, but also more subtle activities such as a cup of “tea and a fag”. These types of activities could serve as reminders of the traditions and routines undertaken in life on the outside. Furthermore, as prisoners were restricted in terms of the resources available to them, some prisoners showed creativity in the ways in which they provided familial displays:

*My son has made a vases a couple of vases, it is like a paper vase and it has flowers on it, I can't really explain it but I have photographs I could show you but he made one for me the first Christmas he was in.... the most important Christmas present that I have ever had. (Jardine, 2018, p123).*

In this extract a mother had been given a handmade gift by her son in his thirties. Perhaps not a stereotypical gift for an adult male to gift his mother, however this creative gifting strategy appeared to represent a manifestation of love that was deeply meaningful to her.

#### *3.4.1.3 “Spoiled Identity” Negotiations*

Due to association, marital or otherwise, families of prisoners can face societal ostracism (Granja, 2016), and can even be accused of being implicated in the actual offence (Condry, 2006).

*“Officers treat you badly like you are in jail” “Some treat you like the gum on their shoe” (Arditti, 2003, p125)*

The above extract highlights the fact that a sense of secondary stigma could extend to families’ experiences within the prison, by experiencing a sense of maltreatment from the prison officers.

Other data pointing to a diffusion of stigma was displayed through an example of a participant being asked about knowledge of her husband’s offence prior to him being charged.

*...and his [participant's Community Psychiatric Nurse] first words to me were, 'Did you know it was going on and did you condone it?' And I thought if somebody of a professional nature has said that, how many other people were saying that? And whether some people thought that I knew it was going on I don't know, but I have lost a hell of a lot of friends. (Condry, 2006, p110)*

Secondary stigma was experienced and displayed in a number of ways across studies: family members chose not to tell friends anything at all (Halsey & Deegan, 2015), friendships ended, and peers would cross the road to avoid conversation (Condry, 2006).

#### *3.4.1.4 Economic Costs*

Across publications, visitors described a financial aspect to the visits. For example, getting to and from the visits on public transport (Dixey & Woodall, 2012; Holligan, 2016), bringing in items for the prisoner they are visiting (Condry, 2006) and sending in money (Condry, 2006; Dixey & Woodall, 2012). Not only could visiting be expensive, but the imprisonment of a family member could precipitate additional financial challenges due to heteronormative roles that many male prisoners had previously held, such as the family breadwinner (e.g. Codd, 2000; Condry, 2006). In response, many female partners attempted to continue to provide financially in the face of financial challenges, and this renamed subtheme explores the financial costs of supporting an imprisoned family member:

*I'm still going crazy paying the phone and the rent and the lawyer so he gets better time. I'm paying the fines and I'm trying, like I told him I wouldn't do anything to make it more uncomfortable cause he did it for us [referring to his crime] too. (Christian & Kennedy, 2011, p394)*

In order to sustain the relationship with the prisoner, this woman was required to invest potentially limited financial resources. Others also described visiting their partners as an economic challenge:

*I need to prioritize if I feed the electric or see my husband. (Holligan, 2016, p103)*

In parallel to the previous example, a wife to an imprisoned male displayed the competing financial demands placed upon her. In order to continue seeing her husband, she had to forego the arguably basic domestic need of electricity. This highlights the fact that families of visitors may be required to make challenging decisions regarding available resources which could have negative effects either way; in this example either the loss of contact with a spouse or the inability to pay bills. This indicates that family absence during prison visit periods may reflect the fact that available financial resources have been allocated to the requirement of satisfying basic human needs, as opposed to making a deliberate choice not to visit the imprisoned family member.

#### *3.4.1.5 (Lack of) Physical Contact and/or Privacy*

Prison rules which prevented intimate contact or displays of affection were seen as challenging for parents, children and partners of prisoners. This new subtheme explored the impact of a lack of physical contact during visits for families and prisoners.

*No kiss or hug... this is harmful to the child. It is coldness... touch is so important... if cannot touch, how is child supposed to bond with parent? (Arditti, 2003, p125).*

Here the suggestion was made that the lack of physical contact allowed in the prison creates a harmful effect for the child visiting his or her parent. This implies that parents must decide whether to risk causing their child harm either by bringing them into the prison context whilst denying them the opportunity to kiss or cuddle the imprisoned parent, or by deciding the child should remain at home, thus electing for the child to go without contact with a potentially important attachment figure.

This harm can also be seen in partners' descriptions of intimate relationships:

*And the other thing is physically, you can't touch one another. And that creates quite a lot of distance in your relationship. And that's happened to us. (Kotova, 2018, p14-15)*

The lack of physical contact emphasised the distance in romantic relationships; an emotional separation was mirrored by the physical separation. Given the rationale for the majority of prison visits; an opportunity to reconnect and maintain a sense of closeness; the implications of the restrictions concerning physical separation undermine the very reason for the visit taking place in the first place.

### 3.4.2 Shifting Roles and Relationships

Studies highlighted the ways in which roles, responsibilities, and indeed relationships were required to change and adapt in the context of a relative's imprisonment. Furthermore, such changes not only affected the prisoner and family member's immediate relationship, but also the way the family member had to adjust him or herself in wider life to accommodate these changes. This novel superordinate theme, and the five associated subthemes, explore the ways roles and relationships shift and adapt to such situations.

#### 3.4.2.1 Gendered Role

Whilst the present study did not seek to explore solely women's experiences of supporting an imprisoned family member, the higher ratio of women compared with men who adopted the role of visitor or supporter was apparent. This role of gender appeared to influence the experience of the women interviewed across the dataset.

Some women described an enhancement to the stereotypically protective mother role; becoming the emotional lynchpin which held the family together following a family member's imprisonment:

*... everybody looks to Mum ... "We'll be alright because me mum's alright" (Condry, 2006, p103)*

In this example, a woman described supporting her family in the face of her husband's charge of sex offences. She felt as though her own emotional response to the situation should be hidden, and instead a portrayal of strength in the face of adversity was constructed in order to support those around her.

*I'm on my own with three kids. If you go on an evening visit you don't get home until ten and it's too late for the wee one – she's four (Holligan, 2016, p102)*

In the above example, a mother described how she has become the sole caregiver to her younger children following the imprisonment of her adult son who lived with her prior to sentencing, and more subtly highlighted her attempts to continue to provide motherly support to her son in the face of childcare needs for her younger offspring. This motherly role had become increasingly stretched following her son's imprisonment, and similar effects were seen across various studies. In addition, studies failed to describe instances where fathers had been left alone with young families following the imprisonment of the respective mother, further indicating the fact that childcare role in these contexts often fell to women.

#### *3.4.2.2 Increased Role*

In line with the previous subtheme, it was also highlighted that many family members were required to adopt increased responsibilities in the face of the imprisonment of a relative (e.g. Codd, 2000; Condry, 2006). As mentioned, women were disproportionately represented in the dataset, however, this also represented a change in pre-existing power balances inherent in many heteronormative relationships. Furthermore, this shift in power, wherein women de facto became the decision makers regarding many financial or practical issues in the face of a male partner's imprisonment, may not always be welcomed due to powerful assumptions regarding gender roles in relationships (Codd, 2000).

*I painted a whole lounge, ceiling and hallway all in four days, and put the furniture back myself. I didn't have to ask anyone to do anything, and I laid the tiles on the kitchen floor. I can do it, because I had to. (Codd, 2000, p73)*

In this example, a woman was required to take on the role of handyman, which was previously occupied by her partner. The language of "*I had to*" highlights her relationship with this new role as something that has been imposed upon her.

Others relied on their children at home to take on the roles previously adopted by partners:

*I used to depend on him a lot to do things, and then when he went, I had to depend on the children to do them, which wasn't fair on the children. It sounds sort of silly, but he used to do a lot of the shopping for me, changing plugs, repairing things [...] There was lots of things, loads of things, numerous things that he used to do. (Codd, 2000, p72)*

Some women reflected on the stereotypically “male” tasks which husbands or partners would have previously undertaken. Imprisonment therefore represented either a “stepping up” of women’s roles: gaining more responsibilities in tasks that were previously designated to partners or accessing support from their offspring for support with the same.

Some family members recognised that their role had now become focused solely on the imprisoned family member.

*My own life had to be shelved, we had to a) try and make [my son] realise there was a reason for living and b) just try and see him through this nasty mess and everything else had to just go by the board. (Condry, 2006, p105)*

For this individual, their life had become inextricably linked with the wellbeing of the prisoner, and their own personal successes and roles fell by the wayside. In this sense, they saw their role as not only the prisoner’s parent, but also their supporter, life coach and therapist.

#### *3.4.2.3 Disrupted Relationships*

The subtheme spoke of the barrier of imposed time for relationships between prisoners and families. For example, many family members, particularly partners, spoke of the difficulties inherent in coming to terms with the fact that their lives were on hold.

*[We don't] really discuss the future, because we don't know what the future brings with our boy, so we don't even go there. We don't even, you know, sort of try and plan anything. It's all living in the moment.” (Halsey & Deegan, 2015, p142).*

This highlights the fact that relatives felt that not only was the current sentence taking away from their relationship with the respective prisoner, but also that it meant they were having

to lower or abandon expectations about what the time spent together would be like following release.

Of note, many described the fact that “normal” relational practices, such as getting married or having children, had to be either suspended or rejected. Kotova (2018)’s themes of *Interruption of the normative life course* and *Deprivation of couple or family time* spoke to this temporal pain directly.

*Interviewer: Do you have any children?*

*Susan: No, I don't. Um... You know, that's a bit of a sore subject, really, because we were thinking about it, about trying, and then this [imprisonment] comes along and it's effectively ruled out our chances (Kotova, 2018, p9).*

Stereotypical relational processes, in this example having a family, were therefore halted due to the current physical absence of the prisoner, but more subtly the woman’s biological clock. Even following release, the potential age-related fertility changes could mean pregnancy was no longer possible.

#### *3.4.2.4 Transformed Relationships*

For some, prison offered a more stable scenario in which there was an opportunity for relationships between families and prisoners to improve. Prison sentences could promote reflection, allowing both family and prisoner to consider where their values lay.

*I think he loves me more. I think he appreciates everything now. He can see that all his friends were useless (laughs), you know, they all promised him false hope, but he can see now where the money comes from, where the love comes from, and when he needs something his mum and dad are always there for him. (McCarthy & Adams, 2018, p12)*

In the above example, a father described the bond between him and his son improving in the absence of influence from unhelpful third parties, such as antisocial friends on the outside.

In a similar vein, a mother highlighted the improved relationship with her son since his imprisonment:

*Yes, it has, we've become really close. I think he trusts me a lot more because I've done more for him, maybe badly or not, but I've supported him 100% since he's been inside. Whereas a lot of his family haven't, and I think he's trying, I think he's now learning, he gives them lip service and he actually means what they say. (McCarthy & Adams, 2018, p13)*

This highlights the role that visitation could play in the re-establishment of trust between prisoner and family. In addition, this mother highlighted the difference that unconditional support had upon their relationship in comparison to the prisoner's relationship with other family members who had not shown support to the same extent. It appeared a sense of complete trust was significant in allowing these relationships to grow in a positive way.

Intimate partner relationships could also become transformed in the context of imprisonment:

*We had our ups and downs, like I said, but it was, we would always help each other out, and I was there for him more than him for me since he was getting in trouble. The up was he was always there for his kids and house. He would do whatever it took. The downs was he cheated, and I never gave him any reason to do that...And now he's in there and he's realizing he didn't have to make me go through these things, and he said that love has nothing to do with money and it's being there through thick and thin. And I said you didn't have to get locked up to realize I was there for you. (Christian & Kennedy, 2011, p394)*

This woman's experience highlighted the realisation processes that imprisoned partners may face, offering an opportunity for partners to re-connect following relationship difficulties that appeared to be more salient prior to prison. In this sense, imprisonment acted as a relationship aid; fostering perspective, mentalisation, and re-connection with values and loved ones.

#### 3.4.2.5 Precarious Relationships

Participants across the dataset often spoke of a sense of uncertainty around their relationships. This could be due to an unknown sense of future; be it the inability to know just how long a family member would be away for, or what the relationship would be like following imprisonment.

*I don't plan anything because you just never know. You always start off with the hopes and dreams and all that stuff, but it gets thrown out the window (Halsey & Deegan, 2015, p142).*

The above example displayed how partners had to repeatedly lower or abandon expectations of how relationships with prisoners could be due to historical experiences of being let down. This sense of unknowing left partners in a state of limbo, devoid of the opportunity to make real future plans.

Uncertainty or instability could also be reflected in the state of the current relationship:

*I'm not as attached to him as much; I used to talk to him every day, to his mother every day. I used to write him every day, now if I don't finish, I don't finish. And now if I don't visit, I don't visit. It's hard for me to trust someone. I don't know; he says that he's honest but I wish he was really honest and not just saying he's honest. (Christian & Kennedy, 2011, p395)*

In this example, a partner highlighted that the ways in which she had previously put effort into the maintenance of her relationship had diminished. The lack of desire to maintain a relationship with a prisoner who had historically been untrustworthy meant that the future of their relationship was precarious. For this individual, the dating experience was no longer enjoyable, and in the face of adversity and a lack of positivity, there were few motivating factors to continue pursuing such a relationship.

### 3.4.3 Ambivalence

As highlighted, there are many challenging aspects of the context within which families of imprisoned individuals find themselves. However, the data also revealed that on multiple occasions, ambivalence and dual perspectives of the situation at hand could arise. This superordinate theme speaks to these ideas: initially by highlighting the fact that imprisonment could bring about more stability in the life of both family member and prisoner; and by discussing the challenge of managing the emotional pain inherent in having a family member imprisoned, whilst balancing this pain with the positive opportunities that prison visitation offers. Although Granja (2016) identified the superordinate theme of *Complex effects* in the original study, it was renamed to *Ambivalence* for clarity. In addition, the review process illuminated the fact that it could be further explained by delineating it into two novel subthemes: *Pros and cons of imprisonment*; and *Mixed emotions*.

#### 3.4.3.1 Pros and Cons of Imprisonment

As mentioned, incarceration can bring about mixed feelings for family members, who may have previously been subject to emotional strain or even abuse prior to sentencing.

In the following extract, a mother described imprisonment as a mixed blessing, recognising that whilst she would miss her son, her world would no longer be fraught with fear:

*He's locked up now so of all of the things, psychologically, it's good for me because I don't have to worry, where we used to, I remember me and my partner used to say every time we heard police sirens we'd be worried is it him? You know, we couldn't sleep at night until he got in so there was always dramas, there was always virtually every single week. (McCarthy & Adams, 2018, p8).*

The safety and legal wellbeing of this women's son was no longer her primary concern, as prison afforded her the knowledge that he was no longer at direct risk of the harm he was exposed to in the outside world.

*[When he's incarcerated], I know where he is ... I used to not want to answer the phone for the pure and simple fact [that] I didn't want to hear my boy was on a cement slab somewhere. (Halsey & Deegan, 2015, p140).*

Some family members described imprisonment as a “necessary evil” (Halsey & Deegan, 2015, p140) which, whilst a challenging process to navigate, provided families with some respite and comfort.

*We'd like to have been able to keep him at home but, like I said, I'm the mother of six, not one ... We don't want this ... car wreck of a person to be coming back into our lives. We love him dearly but, you know, we don't want that back. (Halsey & Deegan, 2015, p143)*

In the above excerpt, a mother displayed her ambivalence at the idea of her son remaining in the family home versus being sentenced. She reflected on the fact that whilst on one hand she would have liked him to remain at home, he was, on the other hand, a “car wreck of a person” who prevented her from appropriately parenting her other children.

#### *3.4.3.2 Mixed Emotions*

For obvious reasons, imprisonment of a family member was emotionally challenging for many participants includes across studies. However, accounts showed that visits could be both positive and negative events. This spoke to a lot of the contrasting individual experiences of family members, who felt both hurt by, yet obliged to support the imprisoned person.

*I really had a lot of faith in him, that he wasn't going to go to gaol, and I'm very disappointed in him because a lot of promises were made. But I feel, like, obliged to stick by him (Halsey & Deegan, 2015, p138).*

This sense of emotional pain experienced by a girlfriend of a prisoner gets side-lined to put his needs first and remain an active support in the face of her own hurt. Condry (2006) stated that “The women [in prisoners' lives] ...[are]... “women in the middle” caught between competing demands” (p104).

Other experiences of putting the imprisoned individual first existed across studies:

*I think he [son] thought I was going to, you know, go off the rails and I did at one stage and I pulled myself back. And you know I was like ... got to get my shit together for him* (McCarthy & Adams, 2018, p12).

In this example, a father highlighted his choice to suspend his own feelings of anger toward his son in order to prioritise his ability to support him during his sentencing.

## 4. Discussion

### 4.1 Framework Themes

The current study explores and highlights the dynamic and often challenging nature of families' experiences of supporting an imprisoned family member. Using best-fit framework analysis, the study drew upon the themes identified by Granja (2016) in his analysis of how prisoners' relatives experience and attribute meanings to a family member's imprisonment. The study sought to explore the utility of these themes as a framework from which to understand the experience of families across the studies. Overall, the results suggest that whilst Granja's framework encapsulated a number of the themes identified across studies, the framework had to be expanded to provide a broader understanding of the family experience in this context (see Table 6 for edited theme table). However, the expanded framework appears to provide a comprehensive means from which we can begin to articulate the experience of families of prisoners.

One of the new themes identified was *(Lack of) physical contact and/or privacy*. Of note was the fact that the effects of a lack of physical connectedness inherent in imprisonment had an impact of parent-child relationships as well as intimate partner relationships. Participants described this inability to engage in physical contact as upsetting as well as damaging to relationships, as this obstruction served to create barriers to families attempting to foster meaningful bonds (Arditti, 2003). It has been shown that significant attachment bonds *can* continue to take place in the context of imprisonment when families outside of prison make

efforts to sustain the support given to imprisoned family members (Christian, Mellow & Thomas, 2006). However, when considering attachment processes, human touch is a key facilitator of bonding and the maintenance of positive relationships (e.g. Schubert, Duininck & Shlafer, 2016). Multiple studies in this review described this lack of physical contact and/or privacy to be a negative part of visiting (Arditti, 2003; Holligan, 2016; Jardine, 2018; Kotova, 2018). Furthermore, Holligan (2016) argued that artificial relational contexts stemming from security needs which prohibit the interpersonal connectedness implicit in many relationships may indirectly undermine prisoners' potential for desistance, due to frustration at the processes which prevent meaningful contact with family members. Whilst there are obvious reasons for certain security protocols which prohibit or restrict physical contact, it appears that this has the potential for negative effects, at interpersonal and emotional levels for both prisoner and family, as well potentially influencing prisoners' desistance, during and following imprisonment. Visher and O'Connell (2012) suggested that family support during an experience such as imprisonment may be imperative in supporting the cognitive effort involved in believing in the possibility of a non-offending lifestyle following release from prison. In light of this, one could argue that decisions taken regarding physical contact should be informed and considered, and potentially taken in context of the individual risk/benefit posed; both for an immediate positive family encounter, but also for the potential of a more positive trajectory following release.

An additional theme identified was *Mixed emotions*, which spoke to the emotional experience involved in pursuit of visiting and supporting a family member in prison. Whilst visits could provide opportunities for families to spend positive, quality time together, visits could also be emotionally challenging. This came about in a number of ways, such as the anxiety and emotional strain concerning the visit itself (Arditti, 2003; Halsey & Deegan, 2015), the overarching emotional toll that the imprisonment of a family member had had upon families (Halsey & Deegan, 2015), and indeed concerns for the imprisoned individual's mental health, stretching to concerns that they may attempt suicide (Condry, 2006). Furthermore, some visitors would frequently put the needs of the prisoner before their own needs, which could be challenging in multiple ways (McCarthy & Adams, 2018). It is worth drawing attention to the fact that visiting could be difficult as well as positive, as the visitation process may be correlated with the reliving of trauma and loss, and we cannot therefore assume that visits

facilitate adjustment for families or prisoners (Arditti, 2003). Perhaps this information is important for policy makers or those involved in the facilitation of prison visits, to ensure that an ethical and comfortable experience is promoted, for both families and prisoners.

Codd (2008) described prison visits as *“the lynchpin of contact between prisoners and their families, [as they] provoke joy and unhappiness in almost equal measure”* (p152-153). This highlights the powerful and conflicting experience of the visit, and also links with the superordinate theme of *Ambivalence* which was identified across the majority of the studies. Ambivalence was present in many ways, for example the happy yet distressing nature of visits (Halsey & Deegan, 2015), and the fact that imprisonment of a family member was a loss, and yet a welcome respite for many (McCarthy & Adams, 2018), defined as a *“necessary evil”* (Halsey & Deegan, 2015, p140).

Studies included in this review highlighted the ways in which *“Spoiled identity” negotiations* were navigated, which was similar to Goffman’s portrayal of the *“courtesy stigma”* (1963) family members of prisoners often receive (Mills and Codd, 2008). Families were ostracised from friendships and reported a societal shift in attitude towards them as a direct result of the family member’s imprisonment (Condy, 2006; Halsey & Deegan, 2015). Murray-Parkes, (1975) described this as a loss of the *“assumptive world”*; of what the individual thought they knew, and what they believed in. We can therefore see a variety of difficulties connected to families’ experiences of visiting and supporting a family member in prison, and this is highlighted by the larger presence of superordinate themes and subthemes pertaining to difficulties associated with the family’s role in the context of imprisonment. However, this contrasts with literature that has explored prisoners’ experiences of familial support, with studies showing visit to be the highlight of their time in prison, and that family visits are predominantly positive (Dixey & Woodall, 2012). This could perhaps be explained partially by context, and consideration to both the prisoner and the family’s norm. That is, the visit may be the prisoner’s opportunity for meaningful interaction and a reminder of their external world, whilst the visit may serve to remind families of the traumatic experience which precipitated imprisonment of the other, and acts as a source of unease.

When considering the positive aspects of visiting, the visit can be seen as a “domestic satellite” (Comfort, 2002), where home life can be enacted through sharing food, stories and gifts (Holligan, 2016). The act of exchanging objects and gifts is understood to be a common family practice across many cultures, as it provides a tangible display of love (Comfort, 2008). However, Jardine (2018) highlights the importance of attending to unconventional displays of family life, particularly in the knowledge that white, middle class models of family life are often over represented in literature (Gabb 2011; Heaphy 2011), in addition to the fact that appraisals and understanding of family is unique to each individual and is informed by experience. This is important across all literature, though perhaps significantly important in contexts of power imbalance, where researchers have the role of assigning meaning to acts displayed by prisoners and family.

As highlighted by the subtheme *Gendered role*, it was clear throughout many transcripts that prison visitation and prisoner support was largely dominated by women. Whilst prison populations are shown to have a significantly higher percentage of male prisoners than female (Howard League 2006), we would expect to see a higher number of female visitors when the visitor is the partner of the prisoner in the context of heteronormative relationships. However, one cannot assume that all prisoners are visited by partners. In fact, research in men and women’s prisons identified that for male prisoners, 51% were visited by parents, 42% by siblings, 36% by children and 46% by partners (Murray, 2003a), whilst 56% of female prisoners were visited by parents, 39% by siblings, 43% by children and only 28% by partners (Murray, 2003b). Overall, women across these studies received fewer visits than men, and one could argue that this is because women are more likely to visit men in prisons than vice versa when considering hetero-normative trends and the fact that women received 18% fewer visits from partners. Similarly, the literature in the current study did suggest a dominance of women taking on both a practically and emotionally supportive role; both for prisoners and wider families. As highlighted by Condry (2006, p103), women often described themselves akin to an “emotional lynchpin” for the family, whose role is to be leant on by both prisoner and other family members in the period following discovery of a relative’s offence. In previous studies exploring the experiences of female partners of prisoners engaged in self-help groups, it was identified that women established and maintained a positive sense of identity by supporting others (Codd 2002). This may be partly helpful in

understanding the why so many women support prisoners. However, it does not explain why there is an apparent gendered difference between male and female visits.

Another topic which gained some attention across a couple of the studies was the cost of visiting prisons for family members. Holligan (2016) highlighted the fact that Scotland does not have a national policy to address the problem of associated high costs despite official policy stating the importance of family visits upon outcomes for prisoners. If financial burden associated with visiting family in prison is a relatively common experience for families of prisoners, it is likely that many families unable to attend visits as frequently as liked, and beyond this, some families will be financially unable to visit at all. Given the potential positive impact of visits upon prisoners' wellbeing (Mills, 2005) and desistance (Vaughan, 2007), it is arguable that prisons, or indeed governmental policies, should consider ways to financially support this aspect of rehabilitation in a proactive manner.

#### 4.2. Methodological Considerations and Limitations

We echo the concerns discussed by Stuart et al. (2017) and Cooke et al. (2012) regarding issues around searching for qualitative literature in electronic databases. Of particular concern is the fact that 66.6% of the studies included in this review were not identified during the inclusive database search, and the first author found these via external searching methods.

Although the SPIDER method (Cooke et al., 2012) provided a useful tool from which to begin the search process, the manual screening of titles and abstracts proved time consuming. In addition, this screening process is not infallible, for example, accidental omission of potentially appropriate studies by human error.

Synthesising data from the results of multiple studies can be a challenge to do accurately and meaningfully given the potential range of methodologies used, in addition to a multitude of potential themes and/or presentation of themes (Thoman & Harden, 2008). This was particularly salient in the case of one study (Dixey & Woodall, 2012) where themes had not been explicitly stated. Instead, it was necessary to assign theme labels for each of the three results sections used within the study. Whilst this worked on a pragmatic level, this does pose

questions relating to the accuracy of the theme labelling given the distance between the present researcher and the original data, and therefore the rigour of combining qualitative methodologies within a synthesis.

In addition, it is worth drawing attention to the notion that synthesis of qualitative data does not scrutinise the theoretical, methodological or societal factors which may have impacted upon the results of reviews. Therefore, syntheses may neglect layers of context which primary research has more opportunity to describe and discuss. Of note is the fact that the papers included in the present study do not address their respective epistemological stances. This may provide a greater understanding of context, and the absence of these is therefore a limitation to both the included studies and the present study consequentially.

Finally, whilst exclusion of grey literature (described by Grayson & Gomersall, 2003) feels like a useful method of ensuring rigour and a level of shared quality, it is possible that relevant studies may have been omitted. This is perhaps more salient in a research context whereby it is an individual's subjective experience being explored, and therefore, there may be a significant amount of data in non-scientific journals or published online (Stuart et al., 2017).

## 5. Conclusion

By drawing upon framework synthesis as a tool to synthesise an array of qualitative research, it has been possible to gain a nuanced glimpse of the experiences of families of prisoners. Families describe a variety of responses to supporting and visiting a relative in prison, though most of these experiences are related to difficulties or challenges associated with their role as a support provider to someone in prison. Whilst perhaps unsurprising that families face many challenges in this context, it is notable that this does appear to contrast with research on prisoners' experiences of being visited and supported by family (e.g. Dixey & Woodall, 2012), which shows prisoners' experiences to be profoundly significant and positive. Given the significance of the visit for prisoners' immediate sense of wellbeing and indeed post-release success (Mills, 2005; Vaughan, 2007), and the difficulties that many families experience whilst supporting a relative in prison (e.g. Arditti, 2003; McCarthy & Adams, 2018), it would be useful for future studies to explore and/or reconcile the difficulties of families

with the positives for prisoners to promote both the wellbeing of prisoners and families and the associated potential for desistance post release.

Whilst not an explicit part of the article, some participants in Condry's (2006) study were members of *Aftermath*, a self-help group for families of offenders. Participants who had used this organisation reflected on the sense of empathy and understanding gained by attending *Aftermath* groups. It seemed as though participants accessed a means of understanding their difficulties, and repairing broken identities, recognising themselves to be "the other victims of crime" (see Howarth and Rock 2000). Considering this information, and the findings of the current study, further exploration into the availability and format of family support groups for relatives of prisoners might be an important step in promoting and maintaining positive family involvement in prisoners' lives.

Given the fact that the topic in hand explores subjective experience, and this review explores only literature from scientific journals; future studies may wish to explore non-scientific resources, such as online forums and non-scientific journals, to access a broader wealth of data. One might argue that it is difficult to access the unique characteristics of individual experience through pre-determined search strategies and by defining strict inclusion criteria. In this sense, perhaps it makes sense to explore a broader repertoire of data in order to elucidate a wider understanding of the topic.

To the best of the authors' knowledge, this is the first systematic review investigating families' experiences in the context of imprisonment of a family member. This research is important largely for several reasons: firstly, if familial support can have positive influence on prisoners' outcomes in terms of both wellbeing and desistance post-release, then it is important to understand the experience from the family's perspective so that prisons and policy makers can attune their approaches sensitively to the needs of families in this context; furthermore, due to costs associated with imprisonment (Jardine & Whyte, 2013), this understanding of families' experiences could hold potentially positive financial implications if used to promote family-prisoner contact; and finally, as we have seen, families are often the "forgotten victims" (Matthews, 1983) within the penal system. In recognition of the trauma and

challenges associated with having a family member imprisoned, it is important to illuminate the experiences of those who are often voiceless within the criminal justice system.

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**Exploring high secure forensic patients' experiences of  
familial support: An Interpretative Phenomenological  
Analysis**

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## Abstract

Research has identified relationships between familial support and outcomes for forensic mental health patients. Such support has been linked to reduced recidivism, improved mental health and increased prosocial behaviour. Whilst some studies have explored families' experiences of providing such support, there is a paucity of research exploring patients' narratives. Using Interpretative Phenomenological Analysis, the current study interviewed patients at a high secure forensic hospital and asked questions about their experiences of familial support. Results indicated four superordinate themes; Connection, Growth, Power, and Ambivalence. These results are discussed in relation to existing findings and clinical implications. Areas for future research are suggested.

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# 1. Introduction

## 1.1 Support in Forensic Settings

Research has long recognised the importance of social support in varying aspects of rehabilitation. Mills and Codd (2008) reviewed existing literature which highlighted the positive impact that family connectedness has upon desistance from crime and resettlement in prison populations. They suggested that interest in prisoners' families had grown from research findings in the mid-nineties which highlighted that prisoners who do not receive family support during imprisonment are between two and six times more likely to reoffend upon return to the community than those who maintain familial support in prison (Ditchfield, 1994).

The presence of maintained family visits during imprisonment predicts higher ratings of familial relationship quality following release from prison (La Vigne, Naser, Brooks & Castro, 2005), as measured by the Family Relationship Quality (FRQ) scale (adapted from a study by Sherbourne and Stewart, 1991). These findings echo those of Mills (2005), who reflected upon the role that familial relations may play in reducing reoffending, perhaps as families provide prisoners with incentive to change offending behaviours (Woolf 1991) or "something to say no for" when opportunities to become involved in criminal activity arise (Garland, Pettigrew & Saunders, 2001; p38). Mills also highlighted that maintained familial support can help to reduce the "pains of imprisonment" (Sykes 1958) by providing prisoners with both goods and emotional support. This work emphasises the importance of recognising not only the pro-social aspects of familial support, but also the benefit this may have on a person-centred level in forensic settings.

Familial relationships and associated support have been shown to have a significant and lasting effect on individuals' wellbeing within the general population (Thomas, Liu & Umberson, 2017). Such relationships are a key source of social influence for individuals across the lifespan (Umberson, Crosnoe, & Reczek, 2010). Therefore, one may be inclined to hypothesise that maintained familial relationships within custodial forensic populations could hold an even stronger importance to these individuals, due to the often-distressing nature of their imprisonment (Brunton-Smith & McCarthy, 2016) and separation from pre-existing

support networks (Listwan, Sullivan, Agnew, Cullen & Colvin, 2013). For some, visits from family members are experienced as the highlight during time in forensic settings (Dixey & Woodall, 2012). When attempting to foster a context of recovery and rehabilitation, it is important to consider individualistic aspects such as the perceived importance of supportive relationships in care planning.

Timko and Moos (2004) explored relationships between aspects of treatment programmes in psychiatric inpatient settings, including the social climate and organisational factors which shape them, and associated patient outcomes. Broadly, positive therapeutic outcomes such as increased self-esteem, increased psychosocial function, decreased aggression, and improved integration in the community were achieved when programmes emphasised supportiveness, good-organisation, and patient autonomy. However, as highlighted by Needs (2016), in one setting studied, prisoners described the social climate with features such as low perceived support, autonomy and order; almost precisely opposite to those described by Timko and Moos as required for therapeutic change. Needs (2016) suggested a parallel between Timko and Moos' proposal of the factors required to evoke personal change and the conditions required for a "secure base" for development as proposed in attachment theory (Ainsworth & Bowlby, 1991). Bowlby (1988) theorised that infants form one key attachment with a primary caregiver, and this attachment figure becomes a secure base from which to explore the world. This attachment, and the associated secure base, is seen as the blueprint for all future social relationships, and attachment disruptions can therefore have longstanding consequences.

When considering attachment in forensic settings, admission processes enact a separation or removal from familiar settings within which patients reside prior to admission. Being moved into a new setting which is locked and may be characterised by an imbalance of power and control could act as a frank reminder of historical attachment disruptions (Adshead, 2002). With this in mind, in addition to descriptions of the social climate in such settings (Needs, 2016), one could argue that the locations within which detained forensic patients live do little to foster a secure base that offers a remedy to attachment disruptions. Furthermore, individuals from forensic populations are drawn disproportionately from some of the most marginalised groups in society (Wilkinson & Pickett, 2009). Since there is a strong prevalence

of attachment disruptions within these groups (Adshead, 2002), more could be done to work with this knowledge, perhaps by considering the change in relationships during a detention (Comfort, 2008), the impact that offences may have upon relationships (Bailey & Sample, 2017), and the impact that maintained relationships have upon the individual during detention (Woodall, 2010).

Most of the forensic research which looks at support in forensic settings is set in prisons as opposed to secure hospital settings. However, a recent unpublished thesis explored the nature of shame in forensic patient populations (Macey, Newman, Quayle & Kreis, 2017), highlighting that secure, compassionate and available relationships appeared to have a positive effect on the cycle of shame and violence following hospital detention, and participants reflected on the ways in which the experience of receiving compassion and support from others helped them to engage in more prosocial behaviours as opposed to violence or offending.

### [1.2 Absence of Support](#)

Social exclusion has been connected to difficulties with antisocial behaviour and poor self-regulation (Baumeister, DeWall, Ciarocco, & Twenge, 2005). This is important to bear in mind when considering the experience of patients in an inpatient forensic hospital; separated physically from community and familial ties, and with security processes which inhibit the availability of family connectedness. In this sense, not only may social exclusion be an undesirable outcome related to admission to a forensic hospital, but negative effects such as antisocial behaviour and poor self-regulatory skills may also be implicit. This is mirrored in research that has identified that social climate and sense of community predict disruptive behaviours in a high security forensic environment (Puzzo, Aldridge-Waddon, Bush & Farr, 2018). This also mimics our understanding of the effects of childhood trauma, as trauma can impair the development of emotion regulation processes which may impact intra and interpersonal behaviour in a multitude of ways (Barnes & Brown, 2016).

There have been well-established links between psychological trauma and offending behaviour (Macinnes, Macpherson, Austin & Schwannauer, 2016), and between offending behaviour and family relationship breakdowns (Loopoo & Western, 2005). Offending

behaviour can also be a further form of traumatisation for both perpetrators and victims of crime (Mohamed, 2015), however, it is argued that recovery from trauma can only take place in the context of relationships (Herman, 1992). This therefore means that in a hospital environment where trauma is an intrinsic characteristic of individuals' life histories (Sweeney, Clement, Filson & Kennedy, 2016), it is important to consider relational aspects of their life in order to promote recovery. Furthermore, familial connectedness has been identified as having a positive impact on desistance from crime (Mills and Codd, 2008) and wellbeing (Woodall, 2010) in forensic populations. In this light, one might question whether a lack of such support could curtail individuals' prospects for optimal outcomes with respect to recovery from trauma, desistance, and wellbeing.

### 1.3 Understanding of Family Support in Forensic Literature

Research to date has focused mainly on experiences of the families on the outside within the context of imprisonment, as opposed to the individual who is serving a sentence (e.g. Jardine, 2018; Holligan, 2016). However, this growing body of information has informed our understanding of the perceived barriers to supporting an individual in such a setting. Furthermore, families can experience direct negative effects from supporting a family member in this context. Families have been shown to experience a lack of sympathy and support from others unlike other contexts of loss (i.e. death or illness) when faced with the imprisonment of a loved one (Schoenbauer, 1986; Arditti, 2003). This holds with it the possibility of alienating the family, and indirectly further alienating the prisoner, due to the potential cutting of surrounding ties. Furthermore, it has been shown that families can also be blamed, shamed and stigmatised due to their perceived proximity to the offence (Condry, 2007). This metaphorical contamination, or so called "web of shame", may impact upon relationships in different ways: for example, the nature of the family's relationship with the offender, due to perceptions of blame around why they have also been stigmatised; or indeed a withdrawal from interaction with the offender, with a view to protecting external relationships in lieu of the family's relationship with the offender.

Boss (1999) suggests the term "Ambiguous Loss" comes in two forms: the first is physical absence with psychological presence; the second is psychological absence with physical presence. To illustrate, the first may be what is commonly experienced by families of those

detained in forensic settings such as hospitals or prisons: a family member is not present physically in the family home, though present in mind. At the same time, it is plausible that families could experience aspects of the second type of loss during visits- that whilst their family member is with them for a short period of time, they may be psychologically absent due to trauma associated with their offence, the potentially challenging nature of the visit, or indeed the adverse cognitive side effects of medications. If this is the case, families of offenders may alternate between different states of loss during their family member's detention, which could lead to profound difficulty (Arditti, 2003) when attempting to negotiate these two challenging realities.

In light of the role that the maintenance of familial connections can play, it is important to consider and explore the significance of family visits in custodial settings (Dixey & Woodall, 2012).

When considering forensic populations within a recovery focused framework, it is surprising more is not done to explore supportive relationships as experienced by individuals in forensic settings, particularly given the presence of problematic attachment histories and associated relational difficulties (Adshead, 2002). Even when considering forensic mental health populations where person centred care and treatment is key (Livingston, Nijdam-Jones & Brink, 2012), we still see little research into the experience of support by forensic inpatients.

#### [1.4 Family Support from Patients' Perspectives](#)

Although existing literature promulgates the notion that familial support is a key factor in rehabilitation in forensic mental health (e.g. Mills, 2005; Mills & Codd, 2008), and despite the fact that literature exists which explores the experiences of family members who have loved ones in prison (e.g. Jardine, 2018; Kotova, 2018), the experiences of individuals in prison or other forensic settings remains relatively unacknowledged. In their study exploring prisoners', families' and prison officers' experiences of the prison visit, Dixey and Woodall (2012) highlighted the importance of adopting the perspective of prisoners when considering the prison visit itself due to the fact that prisoners' views and narratives are relatively unheard or even withheld during research processes (Ammar & Weaver, 2005; Hek, 2006). The study

showed the visit to be predominantly a positive and therapeutic experience for prisoners, which acted as “a chance to keep check of reality” (p16). However, the visit was fraught with difficulties, such as transport logistics for family members, the physical environment in which the visit took place, and the continual reminder of the world outside that they were missing out on.

One may hypothesise that there may be similarities found when exploring patients’ experiences of family visits in a secure hospital setting to those in prison. However, the nature of a prison is qualitatively different to that of a hospital environment, perhaps due to associations of care and support that are more overtly linked to healthcare contexts than prisons. Therefore, it is possible that the nature of family visits may differ too. Furthermore, research studying the experience of familial support by individuals in secure hospitals is almost entirely absent. With this in mind, alongside the fact that familial support has been shown to be linked with positive outcomes for individuals in forensic settings, both during and following detention, an argument to explore this topic is constructed.

### [1.5 The Current Study](#)

This study set out to explore the ways that patients within a high secure forensic hospital experience familial support. By drawing on qualitative methodology, it focused on the perceived importance of familial support, how familial support changes in a high secure hospital, the values that are placed on familial support, and the experience of receiving familial support within a sample of patients who have maintained such support.

The present study operationalised the concept of family as a relationship defined by blood or marriage. The concept of family support was evidenced through family visits, whereby participants in the present study were patients in a high secure forensic hospital that were in receipt of ongoing family visits.

Qualitative methods are befitting in studies seeking to examine and elucidate relatively unexplored phenomena (Audet & Everall, 2010). Within a forensic context, qualitative research has been accepted as useful way of accessing these phenomena in a sensitive and respectful way. For example, Holligan (2016) used semi structured interviews with Scottish

prison visitors to better understand the benefits of visits and perceptions of support for prisoners. Similarly, qualitative studies have been used fruitfully to explore the experience of recovery from the perspectives of individuals in forensic settings (e.g. Stuart, Tansey & Quayle, 2017). Interpretative Phenomenological Analysis (IPA) is a research methodology which seeks to explore and capture commonalities in data using phenomenological and hermeneutic principles (Smith, Flowers & Larkin, 2009). Thus, it is an attractive methodology when investigating the lived experience of individuals who share a common experience. IPA therefore presents a meritable hermeneutic antithesis to conventional methods of study, such as questionnaires or straightforward interviews, allowing the attention to land on new knowledge, instead of the preconceptions of the interviewer (Smith, 2007). Consequently, IPA is an appropriate methodology for the proposed study, as the topic itself is novel and requires elucidation.

The primary aim of this study was to answer the question “what does familial support mean to patients in high secure forensic settings?” Due to the inductive nature of IPA (Reid, Flowers & Larkin, 2005), hypotheses were suspended, and an exploratory approach was used. In this study, data was interpreted using a bottom-up approach, and therefore beyond the principal research question, no further questions or aims were posited. This was to ensure the findings of the study were not coloured by pre-conceived curiosities or beliefs of the researcher.

## 2. Methods

### 2.1 Design

This study drew upon the phenomenological principles of Interpretative Phenomenological Analysis (IPA), due to its exploratory nature and utility within unresearched areas. Participants were interviewed using semi structured interview questions, focusing on their individual experiences of maintained familial support during admission to The State Hospital (TSH). The State Hospital is Scotland's high secure forensic mental health hospital, which provides care and treatment to all-male patients in order to support rehabilitation and ensure transfer to lower levels of security. Interviews were recorded, transcribed and analysed using IPA methods. Analyses were grounded in the data, with an attempt to suspend predisposing beliefs about the subject area whilst recognising the subjectivity inherent in all research.

## 2.2 Sample and Sample Identification

Recruitment took place amongst patients (all male) at TSH; a national facility for patients who require high security care across Scotland and Northern Ireland. The hospital is located in a semi-rural town which is approximately one hour by car from Scotland's major cities (Edinburgh and Glasgow), with relatively limited public transport options. Therefore, attending a visit is often difficult due to distance, travel cost, and travel availability. Once at the hospital, visitors must go through a series of security processes, initially a physical search as well as a search of any items the visitor has taken. They are then escorted to the relevant building by staff on a hospital minibus before being taken into the ward, in which they are asked to sit in a dining room area with glass walls which connect to the patient living area. Therefore, visitors are observed by both patients and staff, and staff may also be present in the dining room itself whilst the visit is happening for reasons of security.

Participants were patients who had maintained familial support in the form of ongoing family visits. Other forms of contact may be an aspect of certain patients' experience of familial support, for example, via video link for families that live further away from the hospital. However, this method may change the nature of familial support, perhaps by removing factors associated with physical closeness that research exploring families' experiences has referred to (e.g. Arditti, 2003; Jardine, 2018), and therefore the sample only included patients who received face to face visits.

Identification of eligible participants was carried out by a member of security staff at TSH who examined existing visit data and selected patients who received at least one visit per month from one or more family members. This individual sent the relevant case file numbers along to the hub that each case belonged to, requesting the respective Responsible Medical Officer and Lead Psychologist to consider whether these patients would be appropriate to participate (after considering their current mental state, risk, and capacity), to promote the safety and wellbeing of both patient and researcher. These clinicians were also provided with a Clinician Information Sheet (Appendix 5) to share information and give context for the study. From these remaining patients, staff offered patients the opportunity to participate in the research. Those that chose to take part were offered an initial meeting with the researcher, who was

until this point blind to potential participants, to learn more about the study and were provided with a participant information sheet (see Appendix 3). If the individual wished to participate, he met the researcher for a second time at least one week later to sign a consent form and take part in an interview lasting up to one hour. Patients were informed that participation was entirely voluntary and that they could withdraw from the study at any time.

Smith, developer of IPA, and his colleagues (2009) advise 4-10 participants for professional doctorate research projects. The rationale is to enable researchers to promote the true idiographic nature of IPA, through deep exploration of a smaller amount of data, as opposed to more surface level analysis of a larger dataset. However, Smith and Osborn (2003) argue that there is no correct or incorrect answer in terms of sample size in IPA studies. Instead, they reflect on the interplay between factors such as the commitment to the case study level of analysis, the richness of participants' accounts, and the constraints under which the researcher is working. From the potential participants identified, eleven patients agreed to participate and completed the interview process. As the participants were part of a unique population within Scotland, demographic details are kept to a minimum to preserve anonymity.

### [2.3 Data Collection](#)

Each participant engaged in a semi structured interview lasting up to sixty minutes with the lead author. The interviews covered questions around the nature of the patients' familial support, the importance of this support, how this support had changed since admission and the perceived consequence of this support. A semi structured interview schedule can be found in Appendix 6. Questions were open ended in nature, to allow for rich data to be gathered and to prevent researcher bias which may be seen in closed questions, in accordance with IPA principles (Smith et al., 2009). Interviews were digitally recorded on an encrypted dictation device provided by the local health board to allow for transcription and then analysis.

## 2.4 Analysis

The analysis was completed using IPA methodology. Due to the relatively unexplored territory within which this study lies, a qualitative approach was deemed appropriate due to its ability to capture rich data from which one can draw themes and understandings from those experiencing the phenomena.

Themes were derived through a process of coding, organising and interpreting interview data with a focus on transparency and reflexivity, in line with good practice guidelines (Elliot, Fischer & Rennie, 1999). Interpretations of participants accounts were made cautiously, so as not to impose significance that has been coloured by the researcher's "natural attitude" (Husserl, [1931] 1967). Husserl popularised the term "epoché" or phenomenological "bracketing", which refers to the suspension of an individual's own subjectivity during attempts to understand the meaning of experience. However, criticisms of Husserl's ideas have been well documented for many years by philosophers who have argued that experience must be understood in context (i.e. Heidegger, [1927] 1962; Sartre, [1943] 2003; Merleau-Ponty, [1945] 1962). Therefore, as subjects of experience, we cannot separate ourselves from our own "natural attitude". Instead of arguing that it is possible to suspend one's own subjectivity, the researcher acknowledged natural biases or presuppositions which develop as a result of one's own situated experience (see 2.6 *Epistemological Stance and Subjectivity*); whilst making attempts to examine the descriptions of phenomena as they naturally arose (Langdrige, 2007). This was to ensure that themes drawn from interviews were well grounded in the data, with an awareness of reflexivity and the situated experience of the researcher.

Despite no prescribed way to conduct analysis in IPA research, the study followed the steps proposed by Smith et al. (2009): (1) reading and re-reading; (2) initial noting; (3) developing emergent themes; (4) searching for connections across emergent themes; (5) moving to the next case; and (6) looking for patterns across cases.

## [2.5 Ethical Considerations](#)

The researcher recognises the complex and dynamic nature of familial support. Therefore, within the context of a high secure hospital where contact with family members is somewhat restricted, this has the potential to become even more complicated. For this reason, steps were taken to ensure the wellbeing of participants, given the possibility that relationships may be strained or complex, particularly in recognition of the fact that family members could be previous victims of the patient. The researcher liaised with clinical staff working with potential participants to ensure participation was appropriate with regard to the relational dynamic between the patient and relevant family member(s).

The study was approved by the NHS South East Scotland Research Ethics Committee 02 and by the hospital's research committee (Appendix 7). The hospital-issued dictation device uploaded the recorded interviews to a secure cloud system specific to the health board, which only the lead author had access to via encrypted and password protected entry. Recordings were deleted following transcription, and no patient-identifiable data were included in transcripts. Handovers were received from and provided to staff involved with participants' care prior to and following both the initial meeting and the interview session. Contingencies were put in place in case patients became distressed or disclosed information relating to risk during the interview. No contingency plans had to be acted upon.

## [2.6 Epistemological Stance and Subjectivity](#)

The present research adopts a constructivist approach; not seeking to identify a single truth but identifying and seeking to elucidate the variety and complexity of conceptualisations of phenomena. Given the method of IPA and the relative focus of phenomenology; the study of individual experience (Smith et al., 2009); this was appropriate.

The present study was completed in part fulfilment of the author's doctoral training in clinical psychology. In this sense, it is important to acknowledge the pragmatic underpinning of this research, as something that was required. However, the author constructed the research idea due to an interest in the role of familial relationships in forensic settings. The formulation of research questions involves an implicit assumption about what such data may tell us (Smith,

Flowers & Larkin, 2009), and this may be related to the researcher's own experience of familial support, in that the researcher may bring an underlying assumption that family support is in some way meaningful, or indeed positive, for individuals; including for participants in the current study. It is possible that this may have impacted upon the interview schedule or the interview itself, however, the researcher made active efforts to be reflexive nature. Furthermore, the researcher was a white, female, middle class member of staff interviewing white males who were patients within the hospital and were predominantly from low socioeconomic status backgrounds. The researcher therefore held relative power over the participants, which may have impacted upon the research process. Furthermore, IPA methodology involves making sense of research participants making sense of their experiences. However, it is the making sense of the researcher that has overall primacy, due to the nature of the research process. Ongoing use of reflection in supervision and gaining advice from supervisors to maintain openness and remain curious in nature as opposed to being closed or driven by a priori beliefs was therefore key.

### 3. Results

Four superordinate themes were identified from the analysis: *Connection; Growth; Power; and Ambivalence*, with each containing four subthemes. Evidence of superordinate themes were seen across all transcripts, and subthemes appeared in the majority of the transcripts. Smith (2011) recommends that for IPA studies with a sample of eight or more, there should be extracts from at least three participants for each theme, and a display of theme prevalence across the dataset. This was adhered to in the current study. Table 6 displays the superordinate and subordinate themes and highlights the transcripts in which the themes were present.

Table 6. Superordinate and subordinate themes across participant interviews

	Philip	George	Christopher	Paul	Gregor	Danny	Cameron	Jamie	Grant	Jim	Johnny
<b>Connection</b>											
Connection to world outside	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Connection to true self	✓	✓	✓	✓	✓	✓		✓	✓		✓
Protective of family and protected by family	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓
Opportunity for ordinary familial displays		✓	✓	✓	✓	✓	✓		✓	✓	✓
<b>Growth</b>											
Desire to do well for the family	✓	✓	✓	✓		✓	✓			✓	✓
Planning for the future	✓			✓	✓	✓	✓	✓	✓		✓
Therapeutic nature of visit	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Improved family relationship	✓			✓	✓				✓		✓
<b>Power</b>											
Impact of staff presence and authority		✓	✓	✓	✓		✓	✓	✓	✓	✓
The visitor holds the power			✓		✓	✓	✓	✓	✓	✓	✓
Lack of freedom	✓	✓		✓	✓		✓	✓	✓		✓
Fragility associated with visit	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
<b>Ambivalence</b>											
Visits as a reminder of wider impact of offence/guilt	✓	✓	✓	✓	✓	✓		✓		✓	✓
Comparison between my life and theirs	✓			✓			✓	✓	✓	✓	✓
What do I talk about?	✓	✓	✓	✓	✓		✓		✓	✓	
Not the person I want to be/unable to help	✓		✓	✓	✓	✓	✓	✓		✓	✓

### 3.1 Connection

The superordinate theme of *Connection* was seen across all transcripts and accounted for the highest number of entries during initial coding. All participants spoke of the impact of feeling connected to someone or something as a result of the visit.

#### 3.1.1 Connection to the World Outside

In the context of being detained at TSH, visits provided participants with a sense of connectedness to the world beyond the hospital gates. Christopher felt that the visit alone served to maintain his familial relationships by staying aware of how his wider family was doing:

*Christopher: Eh, you're positive, you know, you can keep up the family connection and eh, hear how the family are doing.*

Christopher experienced the visit as a clear and practical way of maintaining family connectedness. Others found this connection through being informed on daily matters that would have concerned them in their lives prior to hospital admission:

*Paul: I mean eh, you touch ground with your family visits, em, you get a wee bit of touch of reality with what's happening at home, what's going on in the street, em, how your kids are, em, what they're up tae. It just extends your life somehow.*

The visit acted as a means of enhancing the participant's life, by providing a fuller narrative in which the individual could orientate themselves. Furthermore, the act of being informed of external news and activities allowed participants to feel connected to individuals with whom they no longer had direct contact:

*Johnny: They make me feel happy because [...] each member of ma family tells me different things about what's happening outside and that and it makes me feel like I'm catching up wi' people outside as well who ask for me and things like that, other members of ma family or street pals and just other folk and that, you know? [...] Aye, I'm still part of it. Even though I'm no' there in person[...].*

This sense of connectedness therefore extended beyond those that were physically part of the visit. Johnny's experience of the visit included finding out that external friends and acquaintances were asking for him, which appeared to promote the dual aspect of the connection, in that both parties are thinking of one another, despite not sharing the physical environment with others.

### 3.1.2 Connection to True Self

Participants described visits as a method of accessing their true selves, and this access came about in different ways. A sense of letting one's guard down during the visit appeared evident across a number of participant accounts.

*Paul: Aw, you just can relax, you don't put up a front, be yourself. Then after it I feel a wee bit regenerated. So, it's nice.*

Some participants spoke of an implicit need to "put up a front" (Paul), however the visit provided an opportunity in which individuals were able to relax, be their "normal self" (Jamie). In the context of a mental health hospital where patients are continuously observed and assessed, the visit became an opportunity for respite. In line with this, George reflected on the visit as an opportunity to speak without a filter and without inhibition:

*George: The one to one visit? It makes it mair, mair freedom to speak, you know, instead of going like that, looking about ye to say, say things, you know what I mean? <laughs>.*

The visit seemed to promote a sense of freedom and natural conversation, and the participant reflected on a tendency to otherwise become hyperaware of his surroundings or to consider what he should or should not say for fear of being appraised in a certain way if his conversation was overheard.

Participants also highlighted the potential for visitors to remind them of their own positive attributes.

*Gregor: Well, like, my Gran, she was quite unsteady on her feet. I used to go in and pick her up <laughs> and take her out to the car and take her out to a nice wee pub for her meal. I used to take her friend and that wi' her. So it's quite good to hear. 'Cos my Gran passed away.*

*R: I'm sorry to hear that.*

*Gregor: It's alright. It's good to hear that I was, I made her life a wee bit better, you know? That makes me feel great. That's why I like the visits, you know, 'cos it picks your mood up and things like that, you know?*

For Gregor, the visit served as a reminder of his positive characteristics and behaviours which were internalised and experienced in a mood enhancing way. This was echoed by Jamie, who described the visits as a reminder that he was more than his offence:

*Jamie: Make you feel like your normal self. Make you feel as if, I'm no' just a number, I'm no' a patient, I'm no' a prisoner, I'm no' a bad person, I'm no' a guy who's committed a crime, I'm no' just that.*

The reminder that patients were more than their current context and/or charge was important and allowed participants to get in touch with a more positive appraisal of themselves. In similar ways, other participants experienced visits as ways to connect with the roles they held outside of TSH. Danny and Cameron described their role as being a father as vital to their sense of self, and the visits with their children as being highly significant events:

*Danny: Well, when I have a visit wi' him, when I have a visit wi' him, it's a totally different, it's a totally different environment wi' him. I'm wi' ma child, you know? And am no' wi' somebody that I don't know, or, you know? I'm wi' ma child, and I could sit there and talk to him all day.*

The language and repetition in this excerpt spoke to the importance of the visit for Danny and suggests that this reminder of his fatherhood status had a strong impact on his sense of self.

### 3.1.3 Protective of Family and Protected by Family

Many participants described a sense of protectiveness towards their family, and the visits provided an opportunity to demonstrate this protective nature.

*Cameron: The most important thing about family visits is, is eh, just making sure they're alright, you know what I mean? That they're alright.*

In this excerpt, Cameron stated that finding out his family were doing okay was the most important part about a visit. This is an interesting dichotomy, considering the participant is the person who is being visited, and is an inpatient in a secure mental health hospital, yet felt the visit experience served to reassure him of his family's wellbeing. Others described this sense of protectiveness in a more bidirectional manner:

*Jamie: But she feels better when she comes to see me, it puts her mind at rest and when I see my ma it puts my mind at rest, you know? It's basically, brushing off each other makes ourselves feel better, that's what it's like, know what I mean?*

*Grant: It reassures them to see you're doing alright [...], it puts your mind at rest as well.*

The shared experience of familial protectiveness and associated reassurance following a successful visit is experienced in a positive way. The barrier of distance associated with hospital admission prevented patients from readily accessing or checking up on family members and vice versa, and therefore visits acted as a portal through which wellbeing enquiries to one another were made and satisfied.

Protective urges and responses towards families were also described in the recommendations or restrictions participants made upon their families. For example, by encouraging families not to visit too frequently:

*George: But she did come up twice a week, she did, she did used to come up twice a week. That was an effort and I was like, "Ma, just make it once a week", cos it's, it's fuckin', far too far for travelling, know what I mean? She wis going aboot, six hours, there and back, know what I mean?*

Throughout his transcript, George reflected on the visit in a positive manner, though in this excerpt described a conversation with his mother in which he encouraged her to visit less frequently due to the associated travel time required. In this sense, participants were enabled to make selfless, protective statements with an underlying concern for the visitor. In a context where participants are patients under constant receipt of monitoring and care, this begs the question of whether there is a sense of empowerment associated with being able to provide protection and care to another individual.

#### 3.1.4 Opportunity for Familial Displays

Many participants reflected on typical family interactions which the visits afforded an opportunity to be played out.

*George: It's like outside basically. You'd be sitting there and we're just, eating wir dinner together. That's what it was like up at the Skye Centre when we had our Christmas meal, know what I mean? Sit and eat, eat, eat your dinner and all that together. I paid my Mum's. £12 it wis. So, no' bad. Enjoyed it. I paid for mine an' a'.*

Being able to share a meal with his mother allowed the participant to be reconnected with his experience of life on the outside. The hospital allowed certain patients to share a Christmas meal with their families, and George drew attention to the added act of paying for his mother's meal.

Games and activities were also opportunities through which families could connect during visits. For Christopher, this was a sense of familiarity, as he and his parents would regularly invest time in playing games at home. For Jim, however, playing card games was a new shared activity, and provided a chance for him to teach his mother a card game.

*Christopher: Eh, sometimes we do the crossword, but we didn't do the crossword because it was my mum and dad together, so we played that Boggle game instead which was good. My Mum usually plays that with me, but eh, played it with my Mum and Dad which was different. [...] Aye, it's good aye. Used to do that outside with my family.*

*Jim: Em, my Mum came over and we played some cards [...] Switch [a card game]. [...] I've been teaching my Mum the rules.*

These ordinary familial displays centred around a game-based activity, however offered different outcomes for participants: either a sense of familiarity and a connection with previous shared interests; or a new opportunity where the participant was able to share a new experience with his mother.

Familial displays were also seen as participants were enabled to portray their familial role. For example, Paul, Danny and Cameron referred to their role as parents, and described situations in which they were still able to actively parent their children.

*Paul: Ooh...No, it wasn't so positive when Euan and Sheila were upset at each other and they were going through quite a rough patch and I had to try and support the two of them even though the two of them were at loggerheads. Sheila wanted him out, she was gonnae put him out the house. [...] So it's tough love. And I didn'y believe in it. So I said I'd pay his dig money 'cos that was one of the arguments- he was paying no dig money. [...] So em, eh, I said, "right okay, I'll pay his dig money". So I paid his dig money for between six months and a year. Eh, that was quite hard.*

Paul referred to the challenge of attempting to mediate his partner and son's relationship during visits, as well as providing financially for his son's monetary housing contribution. The quality of the visit appeared to be impacted by the difficulty in the mother and son's external relationship, which led Paul to trying to support his son in his capacity as a father, and indeed his partner in the context of their own relationship.

The provision of financial support was described as a factor of parental support across all three cases of parenthood within the sample. Danny described feeling obliged to provide his son with money so that he could purchase a Christmas present for his girlfriend.

*Danny: The reason, the only reason I'm giein' him money is so he can get hisself something and aw'. But if he's still with this young bird he's goin' wi, he'll need tae buy the bird a Christmas present and aw', [...] because he's no' got the fucking money, he's no' got the money of his ain tae go and go "right, there you go, I've got ye a bottle of perfume" or something.*

This somewhat typical display of father and teenage boy highlights the participant acting selflessly to provide his son with the materials required to act in accordance with social norms around relationships and gift giving; an example of a father providing his son with both money and relationship guidance, in spite of the obvious barriers surrounding this exchange.

## 3.2 Growth

Participants described a sense of change and forward movement when reflecting upon the visits. The visits offered a starting point from which change, or indeed the thought of change, could come about.

### 3.2.1 Desire to Do Well for The Family

Participants' motivation to do well in terms of their recovery and journey through the healthcare system generally came from their families:

*Jim: Yeah, yeah. I want to do well anyway, that's important. But, em, you know, I do want to do well for my mother's sake.*

This individual showed that whilst his focus was on doing well, the driver to do so was his mother. This was extremified in the following quotation from Paul, who placed the reason to progress entirely on his partner:

*Paul: She makes me want to get out of here. She makes me want to do my best. She makes me want to make sure I don't get upset with anybody, don't do anything wrong. Just be my best all the time. Em, then I'll finally get outside to her.*

Paul made no reference to his personal drive to do well, and simply placed the rationale behind his forward thinking solely on his partner. For some, their own sense of accomplishment was secondary to the desire for a family member to see and believe that they were doing well.

*Philip: Eh, I want my Mum to see me that, you know, that I'm doing something, eh, productive. You know as opposed to stealing, doing drugs, things like that.*

In this excerpt, the individual wanted his mother to see him in a different light to that of his past. His hope was for his mother to recognise the efforts he was going to in order to turn his life around and hoped for his mother's approval in the context of a criminal history to be disapproved of.

In another example of a desire to impress or display himself positively, George described his pre-visit self-care and grooming routine prior to a visit from his mother.

*George: I get happy rush, you know, my Mam's coming up. Get all, get washed, showered, deodorant, aftershave, get my good clothes on. Then, see how it goes, aye.*

George's pre-visit preparations mirrored those of a date, a job interview, or a situation in which the individual wishes to be received positively by another person. The visit therefore became a situation in which he could put forward his best self, in the hope that this pleased his mother.

### 3.2.2 Planning for The Future

Eight of the participants described ways in which the visit provided them with a window to the future by offering an opportunity to think about or discuss what the future will look like. For some, this involved thinking about what their relationships would be like on the outside:

*Gregor: Just I think they reassure me and things like that, you know? Tell me things are gonna be okay, we're gonna still talk, I'm gonna get oot, they're needing this done and that done (laughs).*

*Grant: Eh, just fae ma Mum and her man saying that they'll be there for me on the outside. That cheers me up. Somebody showing you they care about you.*

In the above examples, both participants were made aware that they will continue to be supported by family members upon return to the community. They described reassurance and being cheered up, therefore suggesting that whilst this topic could bring about anxiety or distress, they were instead comforted by the thought of what their familial relationships will look like in the world outside.

As opposed to more relational qualities, the visits for some allowed for consideration of what family life will look like in terms of practical displays of support. In the following example, Cameron described his plans for being a good father to his son:

*Cameron: Eh, amazing. See for Christmas? If I got there for Christmas beside him, man? Oh, it would be fantastic, Martha. He's my goal, he's my number one. My child. I'm gonnae get him somewhere. In a good way, like give him a social worker, multi community care team, and I'm gonnae go and get my wee man and see if they'll let me take him to the bowling or the swimming pool or the football. Or some place tae eat. Or trampoline things, or, eh, bowling.*

For others, the dynamic between themselves and a family member who lived in the community allowed for conversations which focused on outside opportunities, such as going on holiday and similar activities.

*Johnny: But eh, he used tae visit me and he used tae say, "You've only got a couple of years left and you'll be oot wi' us and we'll go ower tae Spain and we'll get a wee holiday" and things like that, and it cheered me up a bit. And he says, "I'll pay for it*

*man, I'm working, I've got a great wee job and aw' that and we'll get ye a start." So things like that just cheer you up.*

Johnny and his visitor discussed activities that awaited in the community. This allowed the respective participant to consider such activities and feel excited about what the future might hold. Being able to imagine experiences that may be in their future appeared meaningful to participants, as it kept the reality of life beyond the confines of the hospital alive.

### 3.2.3 Therapeutic Nature of Visit

All eleven participants talked of the visit as being therapeutic, in that it provided them with an immediate sense of wellbeing or therapeutic benefit. Some talked about the way in which they were able to disclose information to their families or complain about topics that they would not generally share with staff or peers at the hospital.

*Paul: Em, just I feel relaxed, I feel as though I've got a lot off my shoulders if I've had to moan about something, I get the chance to moan. Em, I feel good.*

Whilst moaning is an understandable if not expected part of life, patients described a hesitation to moan or even share certain thoughts or experiences with staff for fear of being seen as unwell. However, the visits with families provided an environment in which moaning was acceptable, and the anxiety around having to inhibit natural conversation was absent. Similarly, some participants noticed a tendency to put on a mask or a front when in the hospital environment, which often served to either keep others at arms' distance or to hide any difficulties they may be experiencing.

*Jamie: Aye. Feel like, feel like you become vulnerable.*

Instead of putting up a front, participants were able to relax into their natural modes of being by becoming able to bring down their defences during a visit. This had the impact of a feeling of therapeutic vulnerability.

The visit also allowed participants to notice a decrease in symptoms associated with distress:

*Jamie: Aye, just makes me feel like, less, like, nervous, less angry, less irritable. It takes away the frustration of being stuck inside, you know what I mean? Makes me a lot happier and just, it's as if you're like, you've got somebody there to support you, you know what I mean? That's what it feels like.*

*Grant: Make me feel well and washes your worries away and stuff like that as well. They're very helpful.*

Jamie and Grant talked about feeling less worried and less irritable, and instead an increase in positive experiences were brought to the fore. These positive outcomes were directly associated with the visit and allowed for a sense of wellness that was qualitatively different to those brought about by exchanges with staff and peers in the hospital.

#### 3.2.4 Improved Family Relationship

Some participants reflected on the fact that since admission to TSH, their familial relationships had improved:

*Philip: I get on with my family more now than I ever have done in my whole life, you know what I mean?*

For Philip, his relationship with his family had never been better than it was at time of interview. This shift was highlighted by Gregor, who described what his relationship with his mother had been like on the outside:

*R: And do you feel like that relationship has changed at all since you've come here?*

*Gregor: It's probably gotten stronger now, I think. A stronger relationship, aye. [...] Me and my Mum talk more noo', we didn'y really talk much outside, so that's kinda new for me.*

Gregor and his mother's relationship had changed quite dramatically, from having not spoken in years, to receiving a weekly visit which was experienced very positively. Paul, Grant and

Johnny also talked about the positive changes that had come about in their familial relationships and highlighted this in the absence of drug taking behaviours and improved mental health.

*Johnny: ma drug taking and things like that, I used tae hide it all away from ma Mum [...] so like, I'm open tae ma Mum noo'.*

Whilst parents and family members were inevitably aware of individuals' drug use, a desire to hide this away was portrayed. However, being in an environment which promotes physical and mental health allowed participants' family contact without the stress of drug taking, poor mental health, and associated issues such as financial worries and lying to family members. Therefore, a context of openness and honesty was fostered.

Conversely, Jamie described how the visits served as a reminder that there was distance within his familial relationships:

*Jamie: I'm kinda used tae it noo, but you're just like, feeling a bit... awkward because you're like, it's like, just the same as like, if you've no' seen somebody in a while. If you've no' seen them in fucking yonks you're like, it feels as if it's no' the same anymair, you know what I mean? Sometimes it can make you feel a bit low as well, you know what I mean?*

As highlighted above, visits could be awkward as the relationships had changed. Even in a caring relationship, the visit itself could be challenging, as it highlighted the changes brought about due to the individual's index offence and/or detention.

### 3.3 Power

Inherent in being a patient in a high secure hospital is the issue of power, or indeed, disempowerment. Participants described how power operated in their visits and their lives in multiple ways.

### 3.3.1 Impact of Staff and Patient Observation

This subtheme was described by all but one participant, and this seemed to recur throughout participants' transcripts. Due to the nature of the hospital, visits generally took place in ward dining rooms which had glass walls. This meant that staff and/or patients sitting in the day room area at the time of the visit were able to observe the visit as it took place. For many, this created a feeling of awkwardness:

*R: Okay. And what's awkward about the visits?*

*Christopher: Eh, just there's people watching. It's no' as if you're feeling the same as when you're home with your family.*

*Cameron: It's everybody looking at ye, wi' yer Mum and yer Dad or something. They're looking through the window at ye, and like, aw' the patients are just keeking through the window just looking at ye*

Both Christopher and Cameron described the discomfort associated with being watched whilst trying to enjoy their time with their family. There was a disparity between family time at TSH and family time at home; namely the fact that despite attempts to recreate a comfortable space to nurture family connectedness, the nature of being observed by others removed some of the authenticity. The visit became something to be observed as opposed to simply being something to be experienced.

An extension to being observed by patients in the dayroom was the experience of being directly observed by staff during the visit. Some patients were required to have their visits observed by staff members due to either mental state or perceived risk. However, the experience of staff observation impacted the visit in different ways.

*Jamie: Never really had a difficult visit. Only if, like, a staff member was there, and they're pure listening tae everything you're saying and ye canny get talkin' about things, know what I mean?*

In this example, Jamie highlighted the fact that when observed by staff members, he tended to inhibit his natural conversational style. This appeared to be due to the fact that staff members had insight into what patients were talking about, be it staff, medication, or fellow patients, and a sense of scrutiny characterised the observed visit. This was echoed by Jim:

*Jim: It's a bit eh, imposing having someone standing over your visit and stuff like, for the whole time and stuff [...] It's a bit awkward, you know, a member of staff are there sitting, watching, knowing everyone you're saying stuff about. You know what I mean?*

This sense of scrutiny is described in both the lexical aspect of the interview, in how Jim describes the “imposing” nature of the visit, and indeed in the semantic aspect, by describing someone as “standing over” the visit. A feeling of inspection by a powerful other is portrayed. This links with the sense of disempowerment which is explored in the following subtheme; *The visitor holds the power.*

The unobserved visits were experienced more positively, as patients are freed up to talk at ease about naturally arising topics:

*Paul: Well, eh, just you can speak more freely, you know what I mean? There's nobody there listening so you can say what you like. [...] It makes things a lot easier.*

Unobserved visits therefore afforded patients an increased sense of ease and freedom.

### 3.3.2 The Visitor Holds the Power

The visit was often experienced as something that was done to the participants, not as something that they were an active participant in with respect to the planning and decision-making process prior the visit itself.

*Christopher: Eh, suppose when they're dropping in, you know, it can make you feel a bit powerless.*

Christopher highlights the disempowerment that being visited can bring about. The visit was a reminder that his family could decide to drop in and out at their leisure, however his movement options were much more limited. This chimed with Grant's experience of wishing his father and brother would attend for a visit, in the face of being powerless to their decision:

*Grant: I just wish ma Dad and ma brother would come and see me. Try and let them know I'm doing well.*

The visit would allow Grant to show his family members that he was doing well following a multitude of historical difficulties, however through their non-attendance, he was be unable to prove this to them.

For Danny, the power imbalance in the visit was complicated with questions as to why he was being visited:

*Danny: he's only coming up here, and I'm like that, it's like he's watching the clock for money [...] and he'll go. It hurt – it doesn'y hurt me or anything like that, but it annoys me to see, "you are using me, and I know it. The only reason I'm daeing this to you, letting you dae this tae me is because I love you."*

For Danny, the visit was an important way of connecting with and nurturing his relationship with his son. However, he described his son's rationale for making the visit every two weeks to ensure receiving £50 from his father, as this was the routine they had fallen into. This highlights the powerlessness inherent in being visited, as the visitor holds the power of when, why, and if they choose to visit, leaving the visited to passively accept these aspects of the visit. This was mirrored in Cameron's experience of being a father:

*Cameron: As I say, she's no' bringing him noo'.*

*R: Mmhmm.*

*Cameron: She's no', she's no' playing ball (laughs). The ball's no' in my court.*

*R: It sounds like it's not right now, is it?*

*Cameron: No, she's no' bringing him. So, if she disn'y bring him, she disn'y bring him. It's up to her. But as I say, it's, it's, it's no' fair.*

Cameron's account shows his reluctant submission to the fact that his ex-partner was no longer taking their son to visit him in hospital. By stating "the ball's no' in my court", he brought the focus back to the power imbalance, in that his ex-partner had the final say of whether or not he would see his son, and his only option was to accept the outcome.

### 3.3.3 Lack of Freedom

In extension to the experiences described in the previous subtheme, participants also described the constraints placed on them in the visits and beyond, and how a lack of freedom underpinned their familial interactions. For Paul and Gregor, restrictions around telephone calls had impacted upon his ways of maintaining familial contact out with the visit itself:

*Gregor: But we're kinda restricted noo' 'cos they've put a stupid lock on the phone so you can only get one phonecall a day. And I used tae phone ma sister nearly four, five times a day. And now I need tae pick between her and my Mum and Dad, who I phone. So that's no' very good.*

A change in procedure meant that a further restriction had been put on Gregor methods of communicating and staying in contact with his family. Where he had previously been at liberty to make multiple phone calls to family members, he was now limited to one per day, resulting in a situation where he had to "pick between" his sister, mother and father. His language of "stupid lock" highlights the frustration associated with a further barrier to his desired actions of having easy access to familial contact.

A number of participants described wishing for visits to be different, be that unobserved visits, more frequent visits, or in the case of Jamie, to be able to walk around the grounds with his visitor:

*Jamie: See if you could, if they could let you walk aboot the ground wi' yer Mum or one of your visitors, just tae get a wee walk wi' them. I think that would be quite nice, you*

*know what I mean? [...] Instead of just being closed in a kitchen wi' the other people in there who's looking at ye. [...] Aye, I'd feel as if I'm, you'd feel as if you're half free because you're walkin' about and you're outside and that, you know what I mean? So, you widn'y be feeling as if you're confined, so it would be a lot better that way. Mair relaxed and that.*

Jamie suggested that being able to go for a walk with his visitor would be a positive experience in that it would promote the feeling of freedom. His use of words “closed” and “confined” highlights his relationship to the visits as they are, whereas his word choices of “free” and “outside” suggest a sense of liberty when imagining how visits could be.

For some, the visit highlighted the physical constraints places upon them due to their own inability to go with their visitors back to their home environment

*Philip: Well they're going back to my home area, you know what I mean? Eh, obviously I just wanna go home to my Mum's and get some soup, stuff like that, do you know what I mean Martha?*

*Jim: And I can't go over to her to try and make her feel better, you know? So.*

*R: What does that make you feel like?*

*Jim: Helpless.*

This helplessness and a desire for things to be different spoke of disempowerment; wishing things were not as they were but recognising an imposed inability to do anything about it.

### 3.3.4 Fragility Associated with Visit

This subtheme was pervasive across all participants accounts and spoke to participants' fragile sense of self which appeared to be dependent, for better or worse, on the visit.

*Philip: I hate the idea of being a patient. I'm always out and about doing stuff. I hate being trapped, do you know what I mean? [...] I was always out on my bike all the time. Eh, and this is killing me.*

Philip described the conflict between his historical identity as an independent, active person in the community and his current identity as a patient, someone who receives treatment and is dependent on healthcare professionals. The visit served to remind him of these opposing dynamics and challenged him to try to negotiate his own sense of self in his current context.

For others, the visit was the quintessential element of their time at TSH; the thing that life revolved around. Grant highlights this to the extreme:

*Grant: [inaudible]. I'd probably end up killing myself if she wasn'y coming up tae me.*

This participant's sense of self was so fragile that he believed he would not cope in absence of his mother's visit and instead would try to end his life. This potent example displays how the visit, for some, was the thing that their own personal narrative was based upon, or rather, was dependent upon. Whilst not all participants felt the strength of the visit to the same extent, others spoke of the impact of being let down by an intended visitor:

*Johnny: Ma cousin wis comin' up tae see me [...] and then he let me doon for the visit and it wis really upsettin.' [...] And I phoned him and he says, "Aww, I had this on and that on", making excuses. And I just felt a wee bit upset, like, a wee bit hurt. [...] I felt a bit hurt fae it, aye, that he wis bamming me up a wee bit about a visit. Tellin' lies tae me, you know? [...] ye don't, ye don't lead somebody on about a visit. You look forward tae your visits 'cos it's a comforting thing, you know what I mean? Something you look forward tae.*

In the context of visits being key for individuals' sense of self, a planned visit not going through was significant for the patient waiting to be visited. Johnny used words and phrases such as "upset", "hurt", being led on or lied to about the visit, and his visitor "bamming" him up (in this context, "bamming" someone up is a Scottish phrase for winding someone up). The participant felt as though the loss of a visit was intentional, cruel and withholding, as opposed to simply something that had to be cancelled or rearranged. Therefore, due to the perceived

power the visitor has over the patient being visited, the act of being let down was experienced as being bigger than the sum of its parts.

### 3.4 Ambivalence

The final superordinate theme speaks to the ambivalent nature inherent in receiving family visits in a high security hospital. The overarching idea present in the following subthemes is that whilst it is good to receive family visits, there are a multitude of difficulties associated with being visited too, as if to say “I am glad to receive family visits, *but...*”

#### 3.4.1 Visits as a Reminder of Wider Impact of Offence/Guilt

This subtheme suggests that whilst participants were glad to be in receipt of family visits, the visits prompted individuals to feel guilty about what they had done in order to be receiving visits in such an environment; their respective index offences.

*Philip: It's a very difficult thing when you consider what I've been charged with. Do you know what I mean? It's like I've brought shame on the whole family. And myself obviously [...] I've still got... they still visit me. Still respect me. Not that I deserve it, you know what I mean?*

Philip articulated the conflicting interplay between still being in receipt of support and respect from his family yet questioning whether he was deserving of this due to the nature of his offence and the associated shame put onto his family. George's experience resonated with this:

*George: Aye it's... thanks for coming in, sorry for... \*laughs\*.*

In George's transcript, he reflected on the fact that whilst he was thankful to receive a visit, he felt it was necessary to use the visit as an opportunity to apologise for his previous offending behaviour. The participants were therefore grateful to have continued familial support, yet guilt and/or awkwardness around the nature of these visits could linger. In another example the visit itself was upsetting as it reminded the participant of the distress he caused his family:

*Gregor: Eh, sometimes it's a bit upsetting, knowing that I've upset them.*

Danny suggested the distress he placed on his son mirrored his own sentence:

*Danny: But it's just unfortunate that I'm here and, like, I feel that he's done a sentence along wi' me, you know what I mean?*

The word "sentence" suggests an oppressive reality placed upon someone against their will. For Danny, it felt as though his son has been inflicted with the residual effects of his own offence. Similarly, Jamie described the ambivalence associated with his mother visiting him:

*Jamie: My Mum's travelling all the way, my Mum's travelling tae see me and, and she's away... it's good, obviously her coming up and that, you're like... but you feel like, quite sad for her. Like, she has to see her son inside a place like this, you know what I mean?*

Whilst he maintained he was pleased to see her; he regretted the fact that she had to see him in the context of the secure hospital. The environment itself was a reminder of what he had done, both for his mother and for himself. This in turns evoked feelings of guilt towards his mother regarding what he had, and continued to, put her through.

#### 3.4.2 Comparison Between my Life and Theirs

Many participants reflected on the disparity between their lives and that of their visitors. Whilst the visit gave them a window to the outside world, it also showed them a better existence, one they would prefer to be in.

*Cameron: Eh, just "hiya, how are you? How're you keeping?" They're living on the outside world, you're living in the inside world.*

*Jim: You see Mum going away and I wanna go with her like. That's how it is.*

The participants in the above examples highlighted the key fact of this matter; they were committed to a hospital whilst their visitor was free in the community. This divergence between the two worlds was clear, both in the participants' minds and in their physical environment. Not only did the comparison exist, but it also created a source of distress:

*Jamie: Aye, it's just, the visits can be alright but it's just when they go away and that you just feel very low. Know what I mean? As if, aye, it's like, you're stuck in here, but they can go away at the end of the day, you know what I mean?*

The visit acted as a constant reminder of the participants inability to leave, and a cause of pain following each visit.

Even beyond the visiting hours, participants found themselves comparing their lives with those of their visitors. As the visits acted as a source of information, with what their families were doing on a day to day basis, they could compare the activities of both lifestyles:

*Johnny: Eh, well it's just a bit, a wee bit emotional. Sometimes, eh, a tear comes tae yer eye when you're in yer room at night. And you're lying maybe in your bed and you're goin', "It's eight o'clock at night, how could I be in ma bed at this time?" when ma young brother's maybe having a night oot or something like that and I could be wi' him. And I just miss oot on things like that. Just... makes me feel a bit emotional, you know, sometimes.*

Johnny reflected on the difference between his life and that of his brother; not only highlighting the qualitative gap between the two, but also recognising the pain associated with missing out on opportunities to create memories with his family that are external to the hospital environment.

### 3.4.3 What Do I Talk About?

Another source of ambivalence surrounding the visit stemmed from the fact that whilst participants found the visits important, they frequently reported feeling unsure as to what to talk about.

*George: But it gets.... You're on the phone to her, and then she comes up, and you're like that, "I don't know what to talk about". \*laughs\* You know, don't know what to talk about. And then we find something to talk about. Eh, sisters, and sisters' wee kids. So talk about them eh. They're crawling eh. My niece, she's bonkers, she loves dugs... dogs.*

Despite looking forward to the visit, George reflected on the fact that it can be difficult to find conversational topics. However, this was generally remedied by discussing familiar topics such as the wider family and their news. Paul also recognised the challenge of keeping conversation going:

*Paul: Em, I get on quite well – I always worried about whether we're gonna run out of things to say. But Cairn's quite good, he keeps the conversation going and he asks about things and he asks questions. I try and tell him in depth as possible so's we're no' just, "Aye, yeah, no..."*

Paul described being "always" worried about running out of conversation, however he was able to rely on his son to maintain a dialogue in the visit. He also highlighted his strategy of employing a technique whereby he answered questions in detail so to elongate the interaction. For Cameron, the difficulty of keeping conversation going was due to the fact he was always surrounded by the same people, both staff and peers.

*Cameron: Just try tae, sometimes you try, you don't know what tae talk about. 'Cos you're talking about seeing the same faces, you're like that, "Oh, don't really know what to talk about."*

*Jim: You don't really have anything to say, there's not much new for me to say to her, like there's not much new for me to tell her, you know, apart from it's the same here as every week, and stuff like, so.*

The lack of variety in their social lives, and indeed lives in general, acted as a barrier to authentic and natural conversation, and instead conversation had to be structured or manufactured in a way that promoted length and detail, as opposed to spontaneous sharing of information. For some, this could increase anxieties regarding the visit:

*Grant: Aye, somedays you're a bit nervous aboot them. You don't know what tae say, you don't know what you're gonnae talk about*

The visit therefore could act as a source of anxiety and awkwardness when a lack of conversational topics was available due to the limited repertoire of activities and socialising available to the participants, which then impacted upon the repertoire of stories to be shared during the family visit.

#### 3.4.4 Not the Person I Want to Be

Almost all participants reflected on the challenging dynamic that the visit evoked; a reminder that, whilst they were happy to continue having relationships with various family members, they were unable to be the person they wished to be in the context of the respective relationships. Often, this was in relation to being unable to support their family members due to practical aspects involved in hospital detention or being unable to carry out their perceived roles within their relationships.

*Paul: Oh, it was a bit, it was really tough, you know what I mean? Because you're really limited to what you can do when you're here. So eh, I just, I didnae know what to do. So I just eh, tried to make sure I had a good ear for both of them.*

Paul spoke of the challenges involved in having his partner and son in conflict with one another, despite continuing the visits to see him in hospital. He was at a loss as to what he could practically do in the context, and so tried to ensure the provision of helpful listening skills for both individuals. This challenge of a desire to help was also discussed by Philip, Gregor and Cameron:

*Gregor: Just that, you know, he's brought me up all of my life, and eh, it's ma turn tae help him and I'm no' there tae help him. So it kinda makes me feel a wee bit guilty, you know? There's nothing I can do about it, so.*

*Cameron: My Mum and Dad are getting old noo', they're 59 each. So I just want to out there and basically be with my family and dae things that's good.*

These participants talked about the shifting sense of responsibility within families; that as parents age, their children become involved in caregiving or supportive roles. However, they reflected on a sense of discord between the way they wished to support their parents, and what they were at liberty to do. This discrepancy brought about feelings of guilt and sadness, as participants were unable to enact the identities they felt they should have at this point.

A threat to Danny's identity was also seen within the data, due to the barriers to being able to parent his son in a positive way:

*Danny: And him coming intae see me, sometimes he comes in he's rough which you can get, know what I mean? He's an old boy. I'm like that \*sniffs\* "I reckon ye need a shave." "Aw no I don't, I like it" he likes aw' this manly stuff. But I like clean shaves, clean fingernails, good stuff oan, and, ach, you know? As I says, it's an influence he's got, he needs a better influence. He needs a, he needs a better character, he needs somebody he can look up tae, somebody that can guide him the right ways. And that probably won't be this wee man.*

Danny's desire to be a good parent to his son and to protect him were keenly felt, and he described his attempts to encourage his son to look after himself. The final two sentences, however, highlight the reluctant recognition that Danny was unlikely to be the "better character" for his son to look up to or be guided by. The recognition that this positively influential role no longer belonged to him therefore emphasised the fact that he was unable to be the father he wished to be, or the person he wished to be.

## 4. Discussion

This study explored subjective experiences of familial support as described by patients in a high secure forensic hospital who had maintained familial support through family visits. By drawing upon the methodological principles of IPA, four superordinate themes were identified in the data: *Connection*; *Growth*; *Power*; and *Ambivalence*.

Many participants described ways in which family visits provided opportunities for them to connect with their true selves. Due to participants' lack of immediate connection with people, places, and the social context within which they had orientated themselves prior to hospital admission, they were stripped of the social anchor points which had previously allowed them to maintain their "true" sense of self. In a recent systematic review and narrative synthesis of qualitative studies which explored what recovery meant to forensic mental health patients (Clarke, Lumbard, Sambrook & Kerr, 2016), two of the key themes identified were *Connectedness* and *A sense of self*. These themes clearly map onto data identified in the current study; adding weight to the current findings. Not only did participants in the current study state that family visits made them feel more connected to the world and themselves, but Clarke et al. highlighted that such connectedness was found to be associated with recovery across qualitative literature. Therefore, one could argue that family visits create a sense of connectedness, which in turn could contribute to recovery processes in forensic patients. Clarke et al. also highlighted hope to be a cornerstone of recovery in mental health literature, and whilst psychiatric populations speak of hoping not to be defined by diagnoses, forensic populations hope not to be defined by their offence. Therefore, whilst the present study does not look explicitly at the role of familial support in recovery, the two become inextricably linked, given the fact that the opportunity to connect with a more hopeful narrative is established through a sense of connection.

This extended sense of self could be furthered in situations where participants were able to act out subjective displays of what it meant to be a family, for example; eating together, playing games, or indeed showing protectiveness over a visiting family member. Having the ability to provide protection and care to family members could feel significant to participants as it enabled a relational shift; patients become carers as opposed to being cared for, which

could increase feelings of self-worth. Research has highlighted the role of self-esteem as a buffer in the prevention of further criminal behaviour (Ward, 2002). If these opportunities that are accessed through visits do indeed promote self-esteem, it is worth considering the different roles patients may adopt during visits, as supporting patients to access self-esteem promoting experiences could precipitate both long- and short-term outcomes. For example, self-esteem has been negatively correlated with violent criminality (Morley, Terranova, Cunningham & Kraft, 2016) and aggression (Murphy, Stosny, & Morrel, 2005). In addition, occupying a socially valued role may increase self-esteem among forensic patients, and as suggested by Wilkinson (2008), an increase in patients' sense control over their situation. This may be supported by being able to display familial roles such as protection and care to a relative, which could also reduce feelings of hopelessness and increase a sense of empowerment. However, the relationship between self-esteem or wellbeing and recidivism is contestable, as a study conducted by Bouman, Schene & de Rooter (2009) failed to identify a negative relationship between subjective wellbeing and criminal behaviour. Therefore, further exploration would be required prior to making assumptions about the long-term impact of self-esteem and recidivism in a forensic mental health population. Furthermore, opportunities for allowing control and autonomy for patients in forensic settings may be limited given the fact that clinicians need to consider issues of risk for patients as well as visitors and broader society given the potential history of serious offences (Niveau & Welle, 2018), which may have victimised family members (Ferriter & Huband, 2003).

Another theme identified from the data gathered in the study, *Growth*, spoke to the way that family visits offered a space from which growth could happen in various ways. For some, visits provided an opportunity to consider what life could be like once back in the community. When this future focus was present, participants' ideas of what the future would be like was unanimously positive which made them feel "cheered up" (e.g. participants Grant and Johnny). Given the aforementioned presence of research findings which highlight the fact that positive subjective wellbeing can reduce both short- and long-term recidivism in forensic populations (e.g. Morley et al., 2016), it is worth considering that thinking about the future in a positive way can cultivate a sense of security in these individuals, which can in turn promote positive outcomes in a reduction in recidivism. However, thinking about the future has also been described as anxiety provoking for forensic patients due to imagined challenges of the

transition into the community (Kinney, 2018). These include practical aspects of relocating, dealing with public perception of offenders, managing domestic skills independently, and coping with societal or technological changes during an (often lengthy) admission. The future may therefore not always seem appealing, particularly when exploring the experiences of those without maintained social support.

For some participants, relationships with their relatives had improved during their time at TSH. This was often related to the fact that participants' mental health had improved, and they were no longer using illegal substances. Generally speaking, hospitalisation had enabled a context of honesty and sharing between patients and family members. Learning how to be honest and, in essence, vulnerable with family members has the potential to have positive outcomes for patients' resettlement in the community, in that individuals could continue using honesty with family members and others beyond the hospital setting. One could argue that this learning could encourage individuals to effectively lean on family members and potentially services in the face of difficulties in the community. This could include financial, substance-related, or mental health difficulties; setting the scene for more effective relationships in the community. A number of studies have shown that therapeutic relationships are integral to treatment processes for forensic patients in secure facilities (Ford, Sweeney, & Farrington, 1999; Mason & Adler, 2012; Mezey, Kavuma, Turton, Demetriou, & Wright, 2010; Schafer & Peternelj-Taylor, 2003; Vaughan & Stevenson, 2002). This reinforces the importance of maintaining therapeutic relationships where possible, whether professional or familial.

Participants described the way that *Power* operated in the visits in many ways. Of prominence was the frequency of excerpts describing the fact that many visits between patient and family member were observed by staff. Some participants found these observational processes an imposition and suggested this inhibited the natural flow of their conversations with family members. In a study by Dixey and Woodall (2012) who explored family visits in the context of prisons, they reflected on the ways in which staff presence affected the dynamics of family visits. They suggested that the staff role should be carefully balanced between managing security responsibilities and allowing valuable reconnection opportunities without a sense of scrutiny or constant surveillance. This is important, particularly when considering the

aforementioned value of allowing openness, vulnerability and honesty during visits. In this sense, staff observation could inhibit such therapeutic “opening up” that was described across the dataset. However, given the issue of risk in this population, it may be more of a challenge to amalgamate therapeutic approaches with security needs during visits.

Another way in which power operated during the visits was the fact that visitors were at liberty to choose when, why and if they chose to visit. Patients, on the other hand, were subjugated to become passive recipients to such decisions. However, autonomy (Timko & Moos, 2004) and control (Wilkinson, 2008) have been identified as important factors in forensic settings when considering rehabilitation and therapeutic change. The loss of power and control can lead to psychological distress such as anger, frustration, agitation, hopelessness or depression (Cooke, Baldwin & Howison, 1990), and a lack of interest in the future (Barton, 1966). These potential outcomes go against the intended aims of a recovery-oriented environment, and therefore highlights a potentially unforeseen consequence of family visits: a resulting sense of disempowerment which could contribute to adverse effects.

Results also described the dual nature of receiving familial support: it was often welcomed, meaningful and celebrated; yet could be emotional, difficult and, at times, embarrassing, in that the family presence served to remind them of the wider impact of their offending. Whilst reminders of such events are likely to be difficult and accepting both personal and social consequences of such offences are likely to be challenging (Adshead, 2015), it may be an important aspect of recovery. Drennan and Alred (2012) suggested that recovery in forensic mental health settings involves the acceptance of one’s own offence and indeed the personal and social consequences of such, as well as recognising the necessity to alter attitudes or beliefs that may have impacted past offending behaviours or may impact future risk of reoffence. In order to accept social consequences of one’s offence history, offenders may require a social context within which to do this. Therefore, social visits from family or peers could be necessary to support this process of acceptance and change.

In addition, many participants described being unsure of what to talk about, in recognition of the fact that conversation did not flow with family members during visits, sometimes due to a small repertoire of stories to share with them given the reported lack of variety in their lives

in hospital. This caused worry or nervousness about the visit itself, which could in turn affect the visit itself. In light of this, coupled with the fact that forensic mental health patients often have relational difficulties (Witt, Van Dorn & Fazel, 2013), one might argue it is staff members' duty to consider ways to foster and bolster communication during family visits. If, as professionals, staff are aware of the relational challenges inherent in patients' presentations, as well as the potential benefit of maintaining familial relationships, clinicians could utilise problem solving techniques and adopt a holistic approach to patient care in order to support these processes in order to encourage positive outcomes.

#### 4.1 Limitations

As IPA methodology allows for critical, in depth analyses of data from a population, participant accounts from the current study speak only to the subjects included in this piece of research instead of seeking generalisability. Therefore, broader claims about the applicability of the study findings are tentative. However, through in-depth analysis, original information has been accessed, which may be relevant in informing practice and policy pertaining to a relatively under-researched population.

A secondary reflection on the methodology of IPA concerns the researcher and interviewer role. It is important to recognise the subjective stance all individuals occupy, and the ways that this may have impacted upon both the development of the research project itself, for example the construction of the interview protocol, as well as the facilitation of the interview itself. Smith et al. (2009) reflect on the fact that there may be multiple possible interpretations of the data, and that IPA studies are an invitation for readers to attempt to make sense of researcher's attempt to make sense of participants' experiences. Therefore, despite an awareness of one's own subjectivity, the positioning of this research can only be coloured by the researcher's own approach. Had a reflective diary been used, this may have provided a more informed measure of the influence of subjectivity on the research. This is a shortcoming of the research process.

The current study only includes participants who are visited by families embodying traditional, heteronormative family characteristics due to the scope of the study and the means in which visit data was provided. However, adopting solely this view of family is

problematic, and could prevent useful data being accessed which may give a more holistic overview of the current climate of family visits. As highlighted by Jardine (2018), family life has changed rapidly in recent years. In recognition of the varying models of family, Morgan (2011) argued that the defining criteria of contemporary family life should not be decided upon by researchers but should be determined by the research participants themselves. Whilst the study did include patients who received visits from extended family members, a more nuanced account of familial support may have been accessed had participants been invited to determine who they viewed as family members, beyond the predefined boundaries of the study.

Furthermore, patients from stereotypical family units (consisting of two parents and their offspring) may be drawn disproportionately from a population of higher socioeconomic status. For example, Lee & Bumpass (2008) identified that homeownership decreased the probability of divorce or separation, and subjective financial difficulty increased the probability of same. In this light, by adopting a more nuclear view of family, we may be inadvertently limiting the study data to participants whose familial experiences have included consistent parent or spousal relationships without family breakdown. One could hypothesise that this could skew the results by giving voice to patients drawn from more stable family experiences, as opposed to, for example, being brought up in foster care.

The nature of the environment in which the study took place determined that participants would be male only, and therefore the experiences of non-male counterparts are missing from the present study. In addition, clinicians screened potential participants to determine the appropriateness of participation. This may further introduce bias, as clinicians may hold individual biases regarding presentations that are deemed unsuitable for study involvement and may subsequently exclude patients who may have been deemed appropriate for participation should alternative clinicians have screened the respective patient, and vice versa.

Finally, it is important to consider the potential for volunteer bias (Thompson, 1999); that those who hold greater interest in the study topic may be more likely to participate.

## 4.2 Clinical Implications and Future Research

IPA studies do not seek to provide generalisable results, and instead seek to illuminate individual accounts of a phenomenon (Smith et al., 2009). Therefore, the current study makes no claims about the wider population of forensic patients; in TSH or in other settings. However, Polit and Beck (2010) acknowledged that there may be scope for those well acquainted with the field of study to assess the potential for results of such studies to be transferred to relevant settings. With this in mind, alongside existing literature findings, clinical implications are discussed, and suggestions for future research are given.

When considering the results of the current study and those of Clarke et al. (2016), one could argue that the maintenance of a sense of connectedness in forensic populations is so important to some that it could contribute to successful recovery and rehabilitation processes. With this knowledge, forensic settings could consider ways of sensitively encouraging opportunities for forensic patients to maintain relationships which could foster a sense of connectedness to promote the potential for positive recovery outcomes.

In light of the emergent theme of *Growth* and the associated impact for participants in areas such as thinking towards the future and improved familial relationships, it is important to recognise just how powerful family visits can be, both in the immediate sense and in terms of future outcomes. As discussed, a sense of wellbeing amongst participants could be evoked by talking about the future in a positive way with family members. Given the fact that research has linked subjective wellbeing to decreased rates of recidivism, clinicians should consider the ways in which the conversations had during visits, or indeed conversations in general, could potentially include content which encourages patients to focus on future goals. In addition, whilst visits could be challenging due to associated reminders of past offences, addressing and accepting the social effects of one's crime could be necessary for recovery (Drennan & Alred, 2012). In order to facilitate these processes, forensic settings should consider their role in the support and encouragement offered to families or friends who wish to visit such environments, as their potential to support recovery in forensic mental health patients should not be overlooked.

Familial relationships could improve during a family member's time at TSH as patients learned the value of honesty and vulnerability with family members. Given the benefit of learning these attributes for future relationships in the community, forensic settings could consider more overtly the value of directly supporting patients to access and maintain family visits, particularly given the incidence of relational difficulties in this population as a result of unhelpful or traumatic childhood relationships (Barnes & Brown, 2016). By learning successful relational skills, this could promote effective transition through services and rehabilitation in the community. Furthermore, given the importance of therapeutic relationships in enabling successful treatment processes for forensic patients (e.g. Mezey et al., 2010), providing relational support for patients who may struggle to maintain positive relationships could be effective in supporting treatment in a holistic way.

Staff should consider the ways in which they can promote a sense of privacy during familial interactions. In the current study, observation could feel awkward for patients and families, which could inhibit natural conversation and remove a sense of authenticity to familial interactions. Given the potential for positive short- and long-term outcomes associated with patients learning about honesty and vulnerability, it is important that patients in secure settings are given reasonable opportunity to do so. Understandably, there may be situations where patients must continue to be observed by staff due to security issues. However, providing clear reason or rationale for the same may allow for a sense of empowerment; fostering a shared understanding, which may promote patients' acceptance of the situation at hand. Otherwise, the staff role should carefully balance security management with the opportunity to promote connection between patients and visitors (Dixey and Woodall, 2012).

A balance in recognition of both the positive and negative potential outcomes of familial support should be acknowledged by staff and policy makers when considering and supporting family visits. Clinical staff involved in the facilitation of visits should consider carefully the individual's responses to family visits. Whilst standard practice does not tend to encourage clinical staff to formally debrief with patients following family visits, allocating time to explore individuals' responses, views and beliefs about family visits may be a worthy additional piece of assessment and formulation material. Therefore, allocating time to support patients before

or following such visits may support patients to get the most out of visits, or remedy the potential adverse effects of visits.

Future research should also explore beyond the nuclear boundaries of family when considering the role of familial support in forensic patient settings. Given the potential for a broader conceptualisation of such support by widening the lens of what family means, a more nuanced account of this phenomenon could be accessed.

## 5. Conclusion

In spite of the aforementioned limitations, there are strengths to the present study which merit acknowledgement. The study offers a useful account of an otherwise under-researched area, from which readers can access insightful reflections. Furthermore, suggestions are made which may inform clinical policy and practice given the results of the current study and that of previous research.

Overall, the four superordinate themes were characterised by two halves, with two themes describing significantly positive aspects of family support and two themes largely describing challenging aspects associated with visits. This provides the general summary of family support as described by participants throughout the study; positive yet difficult.

In a population whose voices are often left unheard (Mezey et al., 2010), a commitment to exploring and amplifying the perspectives of forensic patients themselves should be made. Beyond this, staff should prioritise establishing aspects of care in a collaborative way where possible, given the potential for improved outcomes for patients when they are involved in their own care design (Resnick & Rosenheck, 2008; Sidani, 2008; Warner, 2010). The authors hope that the current project has offered an account from which individuals and services alike can consider both the positive and challenging aspects of family visits and can draw upon this information to consider existing and indeed alternative approaches to practices.

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## Appendices

**Appendix 1:** International Journal of Forensic Mental Health Author Guidelines

**Appendix 2:** Critical Appraisal Skills Programme (CASP) Quality Tool

**Appendix 3:** Participant Information Sheet

**Appendix 4:** Participant Consent Form

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**Appendix 8:** Empirical Study Protocol

**Appendix 9:** The State Hospital Research Committee Proposal Form

## Appendix 1: International Journal of Forensic Mental Health Author Guidelines (Relevant sections)

### About the Journal

*International Journal of Forensic Mental Health* is an international, peer-reviewed journal publishing high-quality, original research. Please see the journal's [Aims & Scope](#) for information about its focus and peer-review policy.

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### *Checklist: What to Include*

1. **Author details.** All authors of a manuscript should include their full name and affiliation on the cover page of the manuscript. Where available, please also include ORCIDiDs and social media handles (Facebook, Twitter or LinkedIn). One author will need to be identified as the corresponding author, with their email address normally displayed in the article PDF (depending on the journal) and the online article. Authors' affiliations are the affiliations where the research was conducted. If any of the named co-authors moves affiliation during the peer-review process, the new affiliation can be given as a footnote. Please note that no changes to affiliation can be made after your paper is accepted. [Read more on authorship](#).
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## Appendix 2: Critical Appraisal Skills Programme (CASP) Quality Tool



**CASP Checklist:** 10 questions to help you make sense of a **Qualitative** research

**How to use this appraisal tool:** Three broad issues need to be considered when appraising a qualitative study:

- ▶ Are the results of the study valid? (Section A)
- ▶ What are the results? (Section B)
- ▶ Will the results help locally? (Section C)

The 10 questions on the following pages are designed to help you think about these issues systematically. The first two questions are screening questions and can be answered quickly. If the answer to both is “yes”, it is worth proceeding with the remaining questions. There is some degree of overlap between the questions, you are asked to record a “yes”, “no” or “can’t tell” to most of the questions. A number of italicised prompts are given after each question. These are designed to remind you why the question is important. Record your reasons for your answers in the spaces provided.

**About:** These checklists were designed to be used as educational pedagogic tools, as part of a workshop setting, therefore we do not suggest a scoring system. The core CASP checklists (randomised controlled trial & systematic review) were based on JAMA ‘Users’ guides to the medical literature 1994 (adapted from Guyatt GH, Sackett DL, and Cook DJ), and piloted with health care practitioners.

For each new checklist, a group of experts were assembled to develop and pilot the checklist and the workshop format with which it would be used. Over the years overall adjustments have been made to the format, but a recent survey of checklist users reiterated that the basic format continues to be useful and appropriate.

**Referencing:** we recommend using the Harvard style citation, i.e.: *Critical Appraisal Skills Programme (2018). CASP (insert name of checklist i.e. Qualitative) Checklist. [online] Available at: URL. Accessed: Date Accessed.*

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Paper for appraisal and reference: \_\_\_\_\_

Section A: Are the results valid?

1. Was there a clear statement of the aims of the research?

Yes	<input type="checkbox"/>
Can't Tell	<input type="checkbox"/>
No	<input type="checkbox"/>

- HINT: Consider
- what was the goal of the research
  - why it was thought important
  - its relevance

Comments:

2. Is a qualitative methodology appropriate?

Yes	<input type="checkbox"/>
Can't Tell	<input type="checkbox"/>
No	<input type="checkbox"/>

- HINT: Consider
- If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants
  - Is qualitative research the right methodology for addressing the research goal

Comments:

Is it worth continuing?

3. Was the research design appropriate to address the aims of the research?

Yes	<input type="checkbox"/>
Can't Tell	<input type="checkbox"/>
No	<input type="checkbox"/>

- HINT: Consider
- if the researcher has justified the research design (e.g. have they discussed how they decided which method to use)

Comments:

4. Was the recruitment strategy appropriate to the aims of the research?

Yes	<input type="checkbox"/>
Can't Tell	<input type="checkbox"/>
No	<input type="checkbox"/>

- HINT: Consider
- If the researcher has explained how the participants were selected
  - If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study
    - If there are any discussions around recruitment (e.g. why some people chose not to take part)

Comments:	
-----------	--

5. Was the data collected in a way that addressed the research issue?

Yes	<input type="checkbox"/>
Can't Tell	<input type="checkbox"/>
No	<input type="checkbox"/>

- HINT: Consider
- If the setting for the data collection was justified
  - If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)
  - If the researcher has justified the methods chosen
    - If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews are conducted, or did they use a topic guide)
      - If methods were modified during the study. If so, has the researcher explained how and why
    - If the form of data is clear (e.g. tape recordings, video material, notes etc.)
      - If the researcher has discussed saturation of data

Comments:	
-----------	--

6. Has the relationship between researcher and participants been adequately considered?

Yes	<input type="checkbox"/>
Can't Tell	<input type="checkbox"/>
No	<input type="checkbox"/>

HINT: Consider

- If the researcher critically examined their own role, potential bias and influence during (a) formulation of the research questions (b) data collection, including sample recruitment and choice of location
- How the researcher responded to events during the study and whether they considered the implications of any changes in the research design

Comments:

Section B: What are the results?

7. Have ethical issues been taken into consideration?

Yes	<input type="checkbox"/>
Can't Tell	<input type="checkbox"/>
No	<input type="checkbox"/>

HINT: Consider

- If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained
- If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)
- If approval has been sought from the ethics committee

Comments:

8. Was the data analysis sufficiently rigorous?

Yes	<input type="checkbox"/>
Can't Tell	<input type="checkbox"/>
No	<input type="checkbox"/>

HINT: Consider

- If there is an in-depth description of the analysis process
- If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data
- Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process
- If sufficient data are presented to support the findings
  - To what extent contradictory data are taken into account
- Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation

Comments:

9. Is there a clear statement of findings?

Yes	<input type="checkbox"/>
Can't Tell	<input type="checkbox"/>
No	<input type="checkbox"/>

HINT: Consider whether

- If the findings are explicit
- If there is adequate discussion of the evidence both for and against the researcher's arguments
- If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)
- If the findings are discussed in relation to the original research question

Comments:

Section C: Will the results help locally?

10. How valuable is the research?

HINT: Consider

- If the researcher discusses the contribution the study makes to existing knowledge or understanding (e.g. do they consider the findings in relation to current practice or policy, or relevant research-based literature
- If they identify new areas where research is necessary
- If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used

Comments:

## Appendix 3: Participant Information Sheet



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### **Participant Information Sheet**

**You are being invited to take part in a research study. Before you decide whether or not to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Talk to others about the study if you wish. Contact us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.**

#### **What is the study about?**

This study is about your experience of family support and family visits. You will be asked about how important support from your family is to you, and what it is like to get visited by your family.

#### **Why have I been asked to take part?**

You have been asked to take part because you get visits from your family, and the researcher would like to ask you about these visits.

#### **Do I have to take part?**

No. Taking part is completely up to you and you can leave the study at any time. Deciding not to take part or leaving the study will not affect the care that you receive.

#### **What will happen if I take part?**

After your RMO has discussed this study with you, the researcher (Martha Gillespie, Trainee Clinical Psychologist) will meet with you to tell you more about the study. If you would like to take part, you will be asked to sign a form.

You will then have an interview with the researcher for about one hour. The interview will be in an interview room on your ward. The researcher will ask you questions about your experience of family visits during your time at The State Hospital.

#### **What are the possible benefits of taking part?**

This study is about listening to people's experiences. By listening to you, the researcher hopes to improve the kind of care the NHS offers. Hopefully you will also find taking part an interesting thing to do.

#### **What are the possible disadvantages of taking part?**

It is possible that you might become upset in the interview, because talking about family can be emotional. If this happens, you can stop the interview, and/or the researcher will be there to talk to you and to support you. The researcher will also be able to tell your RMO about what happened in the interview, so that they can support you too.

**What if there is a problem?**

If you have a problem with this study, please speak to Dr Joe Judge who is a Clinical Psychologist at The State Hospital.

**What happens when the study is finished?**

At the end of the study, the results will be submitted to The University of Edinburgh as part of the researcher's Doctorate in Clinical Psychology. The results will then be published in a journal article and shared with staff at The State Hospital. The results will be completely anonymous.

**Will my taking part in the study be kept confidential?**

Your interview will be recorded and transcribed (typed out). The transcript of your interview will be made anonymous, so that you or your family cannot be identified from the results. The recording of your interview will be deleted as soon as it has been transcribed. With your permission the researcher will tell your RMO that you are taking part in the study, but they will not tell your RMO about what you talked about in the interview unless the researcher is worried about your safety or others, or if you tell the researcher about any previous criminal activity that was not known before.

**Who is organising the research and why?**

This study is being organised by The University of Edinburgh, as part of the researcher's Doctorate in Clinical Psychology.

**Who has reviewed the study?**

The study has been reviewed by The University of Edinburgh and The State Hospital. All research in the NHS is looked at by a group of people, called a Research Ethics Committee. *The Research Ethics Committee has also reviewed and approved this study (pending approval).*

**Who can I speak to about this study?**

If you would like to speak to someone independent of the study, please contact Dr Amelia Cooper, who is a Clinical Psychologist at The State Hospital.

If you would like to make a complaint about the study, you can go through the normal complaints process at The State Hospital. Staff will be able to help you with this.

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

## Appendix 4: Participant Consent Form



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### Participant Consent Form

#### What does family support mean to patients at The State Hospital?

**Participant ID:** \_\_\_\_\_

**Name of Researcher:** Martha Gillespie, Trainee Clinical Psychologist, The State Hospital

	Please initial	Yes	No
I confirm that I have read and understood the information sheet (V2. 16.04.2018) for the above study and have had the opportunity to consider the information and ask questions.			
I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason, without my medical care or legal rights being affected.			
I understand that relevant sections of my medical notes and data collected during the study may be looked at by individuals from the regulatory authorities and from the Sponsor (the University of Edinburgh) or from the NHS Board where it is relevant to my taking part in this research. I give permission for those individuals to have access to my records.			
I understand that my interview will be audio recorded.			
I understand that the anonymised findings of this study will be submitted for publication.			
I agree that my RMO will be notified of my participation.			
I agree to take part in the above study.			

\_\_\_\_\_  
Name of Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name of Person taking consent

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

## Appendix 5: Clinician Information Sheet



### **Clinician Information Sheet**

#### ***Exploring the value that high secure forensic patients place on familial support: an Interpretative Phenomenological Analysis.***

##### **What is the research about?**

This study sets out to explore the ways that patients within a high secure forensic hospital experience familial support. It will focus on areas such as the perceived importance of familial support, how familial support changes in a high secure hospital, and the values that are placed on familial support, within a sample of patients who have maintained familial support.

##### **Why is the research being carried out?**

The State Hospital (TSH)'s Clinical Governance Group produced a Clinical Outcomes Monitoring Report (2017), within which the authors state that non-professional visits at TSH have decreased, and the number of patients receiving no non-professional visits has increased. Due to existing literature's findings about the importance of familial support on recovery and rehabilitation, exploration into the nature of these visits and the experience of support is necessary.

There exists a paucity of research which includes the perspectives of forensic patients, alongside the lack of research exploring forensic patients' experiences of familial support. This is concerning due to the fact that there is some support for the link between familial contact and a reduction in recidivism, and the fact that there has been an abundance of literature exploring the experience of families who have loved ones in incarceration. In spite of this, researchers have failed to give voice to the individuals on the receiving end of punitive restrictions in this context.

Furthermore, research has largely focused on prison contexts, and therefore the experiences of individuals in forensic hospital settings are a novel yet imperative area to explore. Whilst one can assume some similarities between prison and hospital settings, the nature of familial support may vary due to the complex array of psychological difficulties that are more important of maintaining connectedness with family members whilst in forensic mental health contexts, this may be more salient than in prison populations. For example, if some of the blame of an individual's offense may be assigned to the mental state of that individual, then this perhaps increases the likelihood for the maintenance of supportive familial networks, as the attributions of blame are mildly external to the individual.

##### **Who is being asked to take part?**

Inclusion Criteria: Participants will be drawn from a sample of current all-male inpatients at TSH. Participants will be considered for participation if they receive at least one visit per month from one or more family members, and are fluent in the English language. Respective RMO's will also provide support for research to go ahead, having conducted a risk assessment of the

patient's mental state and ability to engage without risk of negative effects. Patients will be required to give informed consent to participate.

Exclusion Criteria: Excluded participants will receive less than one visit per month from family members, not be fluent in English and/or be deemed unsuitable to participate for reasons of risk by their RMO.

### **What are the possible benefits of taking part?**

There are no direct benefits but participants may derive some satisfaction from their inclusion in research intended to improve patient care. As the results of this study will be shared with staff at TSH, it is possible that the information gathered will help staff to understand the nature of family support, and encourage the staff to consider this more in care plans. This may have a longer term impact on the experience of participants whilst at TSH.

### **What are the possible disadvantages of taking part?**

Due to the emotional nature of families, it is possible that participants may experience distress if emotional content is raised during interviews. In order to safeguard participants against distress as far as possible, researchers will seek the professional judgement of RMOs and other staff involved in the individual's care to determine patients' suitability for participation. Participants will meet with the researcher prior to the study in order to receive information around the nature of the study, and to provide consent to engage. They will be reassured that participation is entirely voluntary and they may withdraw from the study at any time. If participants do become distressed during the interview, they may cease involvement immediately, and/or the researcher will be available for a follow-up conversation to offer support. The researcher will also be able to inform the participant's RMO about any distress experienced during the interview, so that they can continue to support the participant.

### **What am I being asked to do?**

The researcher will initially send a list of case file numbers to psychology staff across hubs. The respective patients have been identified as receiving at least one visit per month from family members by a member of security staff at TSH, and the researcher asks that hub psychology staff liaise with the relevant RMO to discuss current mental state and risk, and whether it would be appropriate to invite the patient to participate. This is done to ensure the safety and wellbeing of both patient and researcher. Out of the remaining cohort, clinical staff will offer patients the opportunity to engage in the research, if of the informed opinion that there are no potential risks to the patient/researcher through engagement.

### **Procedure**

The patients that are deemed suitable will be approached by a clinician who will inform them about the study, provide them with the information sheet, and ask whether they wish to consider participating. In the event that they are interested, the researcher will meet with the patient to discuss the study and give the patient an information sheet about the project. The researcher will meet with the patient after 7 days, and if they have decided they wish to participate, they will be asked to sign a consent form. Each participant will then engage in a semi structured interview lasting up to sixty minutes. The interviews will take place at TSH in hub treatment rooms. The interviews will cover questions around the nature of the patients' familial support, the importance of this support, how this support has changed since admission to TSH and the perceived consequence of this support. Questions will be open ended in nature, to allow for rich data to be gathered and to prevent researcher bias which may be seen in closed questions. Interviews will be digitally recorded to allow for transcription and then analysis.

**Who is doing this research?**

The main researcher (Martha Gillespie) is a Trainee Clinical Psychologist (TSH). This project will be submitted as part of the Clinical Psychology Doctorate Programme at the University of Edinburgh. The study will be supervised by Dr Ethel Quayle (Senior Lecturer, University of Edinburgh) and Dr Joe Judge (Clinical Psychologist, TSH).

You can contact the main researcher at [martha.gillespie@nhs.net](mailto:martha.gillespie@nhs.net) to obtain more information or to discuss whether a patient may be suitable for the study.

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

## Appendix 6: Semi Structured Interview Schedule



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### Semi Structured Interview Schedule

#### Introductory Questions

- First of all, could you tell me about family visits?
  - How do they make you feel?
- Tell me about a recent visit.
  - What do you feel like before/during/after a visit?

#### Meaning

- What do these visits mean to you?
  - How do they make you feel?
  - Does this change anything you do?
- (Why are they so important?) *if this is the sense portrayed*
  - Is it always positive? Can it be difficult?

#### Value

- How would you feel if the family did not visit?
  - Has that ever happened?
- What do the visits do for you?
- When you have problems is there anyone you talk to?
  - Can you give me an example? (Think mood, behaviour.)
  - Are there any difficulties in doing this?

#### Change

- Have things changed between you and your family since coming to The State Hospital?
  - Can you give me an example?
  - Have your relationships with your family changed?
- How do you keep in touch with your family?
- Would you like to change anything about these visits?

## Appendix 7: Ethical Approval

Lothian NHS Board

South East Scotland Research  
Ethics Committee 02



Waverley Gate  
2-4 Waterloo Place  
Edinburgh  
EH1 3EG  
Telephone 0131 536 9000

[www.nhsllothian.scot.nhs.uk](http://www.nhsllothian.scot.nhs.uk)

Date 17 April 2018  
Your Ref  
Our Ref

Enquiries to : Joyce Clearie  
Extension: 35474  
Direct Line: 0131 465 56734  
Email: [Joyce\\_Clearie@nhsllothian.scot.nhs.uk](mailto:Joyce_Clearie@nhsllothian.scot.nhs.uk)

17 April 2018

Miss Martha Gillespie  
Trainee Clinical Psychologist  
The State Hospital  
Carstairs  
Lanark  
ML11 8RP

Dear Miss Gillespie

**Study title:** Exploring the value that high secure forensic patients place on familial support: an Interpretative Phenomenological Analysis.  
**REC reference:** 18/SS/0027  
**IRAS project ID:** 235373

Thank you for your letter of 16<sup>th</sup> April 2018, 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.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to make a request to postpone publication, please contact [hra.studyregistration@nhs.net](mailto:hra.studyregistration@nhs.net) outlining the reasons for your request.

### Confirmation of ethical opinion



Headquarters  
Waverley Gate  
2-4 Waterloo Place  
Edinburgh EH1 3EG

Chair Brian G. Houston  
Chief Executive Tim Davison  
Lothian NHS Board is the common  
name of Lothian Health Board

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

#### **Conditions of the favourable opinion**

The REC favourable opinion is subject to the following conditions being met prior to the start of the study

Management permission must be obtained from each host organisation prior to the start of the study at the site concerned.

*Management permission should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).*

*Guidance on applying for NHS permission for research is available in the Integrated Research Application System, [www.hra.nhs.uk](http://www.hra.nhs.uk) or at <http://www.rdforum.nhs.uk>.*

*Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.*

*For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.*

*Sponsors are not required to notify the Committee of management permissions from host organisations*

#### **Registration of Clinical Trials**

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact [hra.studyregistration@nhs.net](mailto:hra.studyregistration@nhs.net). The expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from the HRA. Guidance on where to register is provided on the HRA website.

**It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).**

#### **Ethical review of research sites**

##### **NHS sites**

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS sites

### Approved documents

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

Document	Version	Date
Covering letter on headed paper [MG Cover letter to REC addressing provisional opinion points]	1	16 April 2018
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Evidence of sponsor ins and or indemnity docs ]		27 July 2017
GP/consultant information sheets or letters [MG RMO Letter]	1	06 February 2018
GP/consultant information sheets or letters [MG Clinician Information Sheet]	1	06 February 2018
Interview schedules or topic guides for participants [MG Semi Structured Interview Schedule]	1	06 February 2018
IRAS Application Form [IRAS_Form_15022018]		15 February 2018
IRAS Application Form XML file [IRAS_Form_15022018]		15 February 2018
Participant consent form [MG Consent Form]	2	16 April 2018
Participant information sheet (PIS) [MG Participant Information Sheet]	2	16 April 2018
Research protocol or project proposal [MG Study Protocol]	1	06 February 2018
Summary CV for Chief Investigator (CI) [MG CV]	1	06 February 2018
Summary CV for student [MG CV]	1	06 February 2018
Summary CV for supervisor (student research) [Ethel Quayle CV]	1	06 February 2018

### Statement of compliance

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

### After ethical review

#### Reporting requirements

The attached document "*After ethical review – guidance for researchers*" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

### User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If

you wish to make your views known please use the feedback form available on the HRA website:  
<http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/>

**HRA Training**

We are pleased to welcome researchers and R&D staff at our training days – see details at  
<http://www.hra.nhs.uk/hra-training/>

<b>18/SS/0027</b>	<b>Please quote this number on all correspondence</b>
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With the Committee's best wishes for the success of this project.

Yours sincerely



**Lindsay Murray**  
Chair

Email: [joyce.clearie@nhslothian.scot.nhs.uk](mailto:joyce.clearie@nhslothian.scot.nhs.uk)

Enclosures: "After ethical review – guidance for researchers"

Copy to: *Charlotte Smith*  
*Mr Jamie Pitcairn,*

Martha Gillespie  
Trainee Clinical Psychologist  
The State Hospital

Monday the 18<sup>th</sup> of December 2017

Dear Martha,

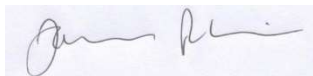
**Re: Exploring the value that high secure forensic patients place on familial support: an Interpretative Phenomenological Analysis**

Many thanks for your amended research proposal. The committee found the proposal to be an interesting and valuable piece of work, and I am happy to approve the study based on the amendments you have made to the proposal and documentation. This letter will be copied to the Associate Medical Director along with evidence of your ethical approval, and will subsequently provide final management approval for the study to take place within TSH.

One condition of the research committees' approval is that you provide the committee with regular 6-monthly progress reports and a study final report focused on implications for practice. This is an important mechanism by which the committee track progress, and is also a key component of our research governance processes.

If you require any further assistance, or have any feedback on the Research approval process then please do not hesitate to contact me.

Yours sincerely



**JAMIE PITCAIRN**  
**Research & Development Manager**  
**The State Hospital**

## The State Hospital

Carstairs  
Lanark ML11 8RP  
Telephone 01555 840293  
Fax 01555 840024  
E-mail [info@tsh.nhs.uk](mailto:info@tsh.nhs.uk)  
<http://www.tsh.scot.nhs.uk>



Martha Gillespie  
Trainee Clinical Psychologist  
The State Hospital

Date 20 April 2018  
Your Ref  
Our Ref DA/ag

Enquiries to Ann Gallacher  
Direct Line 01555 842221  
E-mail [ann.gallacher1@nhs.net](mailto:ann.gallacher1@nhs.net)

Dear Ms Gillespie

**Re: Exploring the value that high secure forensic patients place on familial support: an Interpretative Phenomenological Analysis**

Having considered the views of the Research Committee and noted that you have obtained Ethical Approval from South East Scotland Research Ethics Committee, I write to give you Managerial Approval to proceed with your project. This is subject to you fulfilling the requirements of the Ethics Committee and of the State Hospital Research Committee.

May I take this opportunity to wish you every success in your endeavour.

Yours sincerely

**Dr Duncan Alcock**  
Associate Medical Director

cc. Jamie Pitcairn, Research and Development Manager.  
Professor Lindsay Thomson, Medical Director.



The State Hospitals Board for Scotland  
Carstairs, Lanark, ML11 8RP.

Chair Terry Currie  
Chief Executive James Crichton



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**Exploring the value that high secure forensic  
patients place on familial support: an Interpretative  
Phenomenological Analysis.**

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**Study Protocol**

Version 1

**Protocol Author:** Martha Gillespie

## **Introduction**

### ***Importance of support***

Literature has long recognised the importance of social support in varying aspects of rehabilitation. Mills and Codd (2008) explored existing literature which highlights the positive impact that family connectedness has upon desistance from crime and resettlement in prison populations. This echoes the findings of Mills (2005), who reflected upon the role that familial relations play in reducing reoffending, and also suggested that maintained familial support can help to reduce the “pains of imprisonment”. This introduces the importance of recognising not only the pro-social aspects of familial support, but also the benefit this may have on an individual and person-centred level, in forensic settings.

The significance that familial support has upon an individual within the general population is easily assumed. Therefore, one may be inclined to hypothesise that maintained familial relationships within incarcerated forensic populations could hold an even stronger importance to these individuals, due to the often distressing nature of their incarceration and separation from support networks. Some studies have shown visits from family members are experienced as the highlight of prisoners time in prison (Dixley & Woodall, 2011). When attempting to foster a context of recovery and rehabilitation, it should be seen as important to consider individualistic aspects such as the perceived importance of supportive relationships in care planning.

Timko and Moos (2004) suggest conditions required for therapeutic change as being almost precisely opposite to those described by prisoners as being salient within the social context of prison (low perceived support, autonomy and order). Needs (2016) suggests a parallel between Timko and Moos' proposal of the factors required to evoke personal change and the conditions required for a “secure base” for development as proposed in attachment theory (Ainsworth & Bowlby, 1991). With this in mind, we can recognise that the locations within which forensically detained individuals live do little to foster a secure base that offers a remedy to attachment disruptions. Furthermore, individuals from forensic populations are drawn disproportionately from some of the most marginalised groups in society. Considering the fact that there is a strong prevalence of attachment disruptions within these groups, more could be done to work with this knowledge, perhaps by considering the change in relationships during a detention, the impact that different offences may have upon relationships, and the impact that maintained relationships have upon the individual during detention.

### ***Effects of absence of support***

Social exclusion can bring about effects in areas such as antisocial behaviour and poor self regulation (Baumeiser, DeWall, Ciarocco, & Twenge, 2005). When considering forensic populations within a recovery focused framework, it is surprising more is not done to explore supportive relationships as experienced by incarcerated individuals. More specifically in forensic mental health populations where the focus is removed from that of a punitive approach, and lands on a more compassionate outlook to inspire positive outcomes, we still see little research into the experience of support by forensic inpatients.

### ***Existing literature looking at familial support***

When reviewing existing literature, it is clear that research to date has focused mainly on experiences of the families on the outside within the context of imprisonment, as opposed to the individual who is serving a sentence. However, this growing body of information has informed our understanding of the perceived barriers to supporting an individual in such a setting. Furthermore, families can experience direct negative effects from supporting a family member in this context. Families have been shown to experience a lack of sympathy and support from others unlike other contexts of loss (i.e. death or illness) when faced with the incarceration of a loved one (Schoenbauer, 1986; Arditti, 2003). This holds with it the possibility of alienating the family, and indirectly further alienating the incarcerated individual, due to the potential cutting of surrounding ties. Furthermore, it has been shown that families can also be blamed, shamed and stigmatised due to their perceived proximity to the offence (Condry, 2007). This so called “web of shame” then disperses outwardly from the offending individual. This may impact upon relationships in different ways; for example, the nature of the families relationship with the offender, due to perceptions of blame around why they have also been stigmatised, or indeed a withdrawal from interaction with the offender, with a view to protecting external relationships in lieu of the families relationship with the offender.

### ***Familial support from patients' perspective***

Although existing literature promulgates the notion that familial support is a key factor in rehabilitation in forensic mental health, and despite the fact that literature exists which explores in great detail the experiences of family members who have loved ones in prison, the experiences of individuals in incarceration remains relatively unacknowledged. Furthermore, the experience of familial support by individuals in secure hospitals is almost entirely absent.

### ***Why Interpretative Phenomenological Analysis (IPA)?***

Qualitative methods are understood to be befitting in studies seeking to examine and elucidate relatively unexplored phenomena (Audet & Overall, 2010). Within a forensic context, qualitative research has been accepted as useful way of accessing these phenomena in a sensitive and respectful way. For example, Holligan (2016) used semi structured interviews with Scottish prison visitors to better understand visitation benefits and perceptions of support for prisoners. Similarly, qualitative studies have been used fruitfully to explore experiences from the perspectives of individuals living with a forensic label (e.g Stuart, Tansey & Quayle, 2017). As explained by Stuart et al., IPA seeks to explore and capture commonalities in data, as opposed to explain. As such, it is an attractive methodology when investigating experiences of participants that possess a common context. Interpretative Phenomenological Analysis therefore presents a meritable hermeneutic antithesis to conventional methods of study, allowing the attention to land on new knowledge, instead of the preconceptions of the interviewer (Smith, 2007). Interpretive Phenomenological Analysis is an appropriate methodology for the proposed study, as the topic itself is novel and requires elucidation.

### ***Why this project?***

The State Hospital Clinical Governance Group produced a Clinical Outcomes Monitoring Report (2017), within which the authors state that non-professional visits at TSH have decreased, and the number of patients receiving no non-professional visits has increased. Due to existing literature's findings about the importance of support on recovery and rehabilitation, exploration into the nature of these visits and the experience of support is necessary. Specifically, it was agreed that familial support in the traditional sense (individuals affiliated by birth, affinity, or historical co-residence) would be explored. This was determined due to the perceived lack of data on this from the perspectives of patients in high secure forensic hospitals, but also due to the scope of the study and to ensure a homogenous sample.

There exists a paucity of research which includes the perspectives of forensic patients (Coffey, 2006), alongside the lack of research exploring forensic patients' experiences of familial support. This is concerning due to the fact that there is some support for the link between familial contact and a reduction in recidivism (e.g. Mills & Codd, 2008), and the fact that there has been an abundance of literature exploring the experience of families who have loved ones in incarceration (e.g. Holligan, 2016). In spite of this, researchers have failed to give voice to the individuals on the receiving end of punitive restrictions in this context. Therefore, our understanding of this support is largely one sided.

Furthermore, research has largely focused on prison contexts (e.g. Hutton, 2016), and therefore the experiences of individuals in forensic hospital settings is a novel and imperative area to explore. Whilst one can assume some similarities between prison and hospital settings, the nature of familial support may vary due to the complex array of psychological difficulties that are more prevalent in forensic mental health settings. Additionally, whilst research has highlighted the importance of maintaining connectedness with family members whilst in forensic mental health contexts (Clarke, Lumbard, Sambrook and Kerr, 2016) this may be more salient than in prison populations. For example, if some of the blame of an individual's offense may be assigned to the mental state of that individual, then this perhaps increases the likelihood for the maintenance of supportive familial networks, as the attributions of blame are mildly external to the individual.

## **Aim**

### ***Primary research question***

The primary aim of this study is to answer the question "what does familial support mean to patients in high secure forensic settings?"

### ***Secondary research questions***

Due to the inductive nature of IPA (Reid, Flowers & Larkin, 2005), hypotheses are suspended and an exploratory approach is used. In this study, data will be interpreted using a bottom-up approach, and therefore beyond the principal research question, no further questions or aims are posited at this stage. This is to ensure the findings of the study are not coloured by pre-conceived curiosities or beliefs of the researcher.

## **Methodology**

### ***Design***

This study will draw upon the phenomenological principles of IPA, due to its exploratory nature and utility within under researched areas. Participants will be interviewed using semi structured interview questions, focusing on their individual experiences of maintained familial support during admission to TSH, Scotland's high secure hospital. These interviews will be recorded, transcribed and then analysed using IPA methods. Analyses will be grounded in the data, with an attempt to suspend subjectivity.

### ***Sample and sample identification***

Recruitment will take place amongst patients (all male) at TSH who have maintained familial support in the form of ongoing family visits. The researcher is aware that other forms of contact may be an aspect of certain patients' experience of familial support for example via Video link for families that live further away. However, as this method may change the nature of familial support, perhaps by removing factors associated with physical closeness that some patients may refer to, the sample will only include patients who receive face to face visitations.

Identification of eligible participants will be carried out by a member of security staff at TSH who will examine existing visit data and select patients who receive at least one visit per month from one or more family members (agreement has been obtained from this staff member). This individual will send the relevant case file numbers along to the Responsible Medical Officer (RMO) that each case belongs to, requesting the opinion of whether these participants would be appropriate to participate (following consideration of capacity, current mental state and risk), to ensure the safety and wellbeing of both patient and researcher. Out of the remaining cohort, clinical staff will offer patients the opportunity to engage in the research, if of the informed opinion that there are no potential risks to the patient/researcher through engagement. Due to the variance in length of stay of patients, the researcher will make active efforts to stratify the sample in a way which ensures a range of admission lengths are represented. Those that consent will be offered a meeting with the researcher to learn about the study and will be provided with a participant information sheet which will detail relevant aspects of the study. Patients will be given at least 7 days to consider to participation, before a decision is made. If the individual wishes to participate, formal consent will be obtained through a discussion and signing of the consent sheet. However, patients will be informed that participation is entirely voluntary and that they may withdraw from the study at any time.

Smith, Flowers and Larkin (2009) advise 4-10 participants for professional doctorate research projects. The rationale is to enable researchers to promote the true idiographic nature of IPA, through deep exploration of a smaller amount of data, as opposed to more surface level analysis of a larger dataset. However, Smith and Osborn (2003) argue that there is no correct or incorrect answer in terms of sample size in IPA studies. Instead, they reflect on the interplay between factors such as the commitment to the case study level of analysis, the richness of participants' accounts, and the constraints under which the researcher is working. With these factors in mind, and an awareness of some of the difficulties that participants in forensic settings may face (e.g. cognitive difficulties or secondary impacts of medication), the researcher will interview 10-14 participants. This will ensure sufficient depth can be uncovered from accounts, whilst not receiving more data than could be analysed to its fullest within the parameters of the study.

The researcher's Academic and Clinical supervisors have provided supervision on qualitative studies within The State Hospital, and have provided support indicating that a sample size of 10- 14 should be feasible in this environment, and for this project. With a current population of around 120 patients, and a majority of patients receiving non-professional visits, the sample size should be achievable. This is due to historical knowledge on patients' willingness to participate in research, as well as the nature of their stay.

### ***Data collection***

Each participant will engage in a semi structured interview lasting up to sixty minutes. The interviews will take place at TSH in interview rooms to ensure privacy and fewer distractions. The interviews will cover questions around the nature of the patients' familial support, the importance of this support, how this support has changed since admission to TSH and the perceived consequence of this support. Questions will be open ended in nature, to allow for rich data to be gathered and to prevent researcher bias which may be seen in closed questions. Interviews will be digitally recorded to allow for transcription and then analysis.

### ***Analysis***

The analysis will be completed using IPA methodology. Due to the relatively unexplored territory within which this study lies, qualitative methodology was deemed appropriate, due to its ability to gather rich data from which one can draw themes and understandings from those experiencing the phenomena.

Themes will be derived through a process of coding, organising and interpreting interview data with a focus on transparency and reflexivity, in line with good practice guidelines (Elliot, Fischer & Rennie, 1999). Interpretations of participants accounts will be made cautiously, so as not to impose significance that has been coloured by the researcher's "natural attitude" (Husserl, [1931] 1967). Husserl popularised the term "epoché" or phenomenological "bracketing", which refers to the suspension of an individual's own subjectivity during attempts to understand the meaning of experience. Therefore, by engaging this phenomenological concept, the researcher will make efforts to set aside natural biases, and examine the descriptions of phenomena as they naturally arise (Langdridge, 2007). This will ensure that themes drawn from interviews will be well grounded in the data.

Despite no prescribed way to conduct analysis in IPA research, the study will follow the steps proposed by Smith et al. (2009): (1) reading and re-reading; (2) initial noting; (3) developing emergent themes; (4) searching for connections across emergent themes; (5) moving to the next case; and (6) looking for patterns across cases.

### **Timetable of Work**

February 2018	- Complete Ethical Application process
January - March 2018	- Introduction and Methodology Write Up
March - June 2018	- Data Collection
May – July 2018	- Data Transcription
July – October 2018	- Data Analysis
October - December 2018	- Write results, discussion and abstract
February 2019	- Submit Draft
May 2019	- Submit Thesis

### **Academic Supervisor**

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## Appendix 9: The State Hospital Research Committee Proposal Form

### **TSH Research Committee Full Research Proposal**

#### **Applicant**

Martha Gillespie

Trainee Clinical Psychologist

The State Hospital

Arran Hub first floor offices

[martha.gillespie@nhs.net](mailto:martha.gillespie@nhs.net)

Tel: 07548165190

#### **Title of Project**

Exploring the value that high secure forensic patients place on familial support: an Interpretative Phenomenological Analysis.

#### **Summary of Project**

This study sets out to explore the ways that patients within a high secure forensic hospital experience familial support. It will focus on areas such as the perceived importance of familial support, how familial support changes in a high secure hospital, and the values that are placed on familial support, within a sample of patients who have maintained familial support.

#### **Proposed Starting Date**

08/01/2018

#### **Proposed Completion Date**

08/05/2019

#### **Details of Financial Support Requested (salaries, travel, equipment, miscellaneous)**

None

### **Ethical Approval Requirements / Status of Application Process**

A thesis proposal form has been submitted and accepted by The University of Edinburgh, who are supportive of the research proceeding in its current format.

NHS research ethics approval will be sought, and therefore an IRAS (Integrated Research Application System) form will be submitted once feedback from The State Hospital (TSH) Research Committee has been received. This is to ensure that the IRAS form reflects what has been agreed upon and approved by research committee members at TSH. A University of Edinburgh ethics form will also be submitted at this stage.

Due to the fact that the proposed study will not be drawing upon patient identifiable information, an application to the Caldicott Guardian will not be made.

### **Signatures**

Martha Gillespie

Supervised by Dr Joe Judge

### **Proposed Research Project**

#### **Title**

Exploring the value that high secure forensic patients place on familial support: an Interpretative Phenomenological Analysis.

#### **Introduction**

##### ***Importance of support***

Literature has long recognised the importance of social support in varying aspects of rehabilitation. Mills and Codd (2008) explored existing literature which highlights the positive impact that family connectedness has upon desistance from crime and resettlement in prison populations. This echoes the findings of Mills (2005), who reflected upon the role that familial relations play in reducing reoffending, and also suggested that maintained familial support can help to reduce the “pains of imprisonment”. This introduces the

importance of recognising not only the pro-social aspects of familial support, but also the benefit this may have on an individual and person-centred level, in forensic settings. The significance that familial support has upon an individual within the general population is easily assumed. Therefore, one may be inclined to hypothesise that maintained familial relationships within incarcerated forensic populations could hold an even stronger importance to these individuals, due to the often distressing nature of their incarceration and separation from support networks. Some studies have shown visits from family members are experienced as the highlight of prisoners time in prison (Dixley & Woodall, 2011). When attempting to foster a context of recovery and rehabilitation, it should be seen as important to consider individualistic aspects such as the perceived importance of supportive relationships in care planning.

Timko and Moos (2004) suggest conditions required for therapeutic change as being almost precisely opposite to those described by prisoners as being salient within the social context of prison (low perceived support, autonomy and order). Needs (2016) suggests a parallel between Timko and Moos' proposal of the factors required to evoke personal change and the conditions required for a "secure base" for development as proposed in attachment theory (Ainsworth & Bowlby, 1991). With this in mind, we can recognise that the locations within which forensically detained individuals live do little to foster a secure base that offers a remedy to attachment disruptions. Furthermore, individuals from forensic populations are drawn disproportionately from some of the most marginalised groups in society. Considering the fact that there is a strong prevalence of attachment disruptions within these groups, more could be done to work with this knowledge, perhaps by considering the change in relationships during a detention, the impact that different offences may have upon relationships, and the impact that maintained relationships have upon the individual during detention.

### ***Effects of absence of support***

Social exclusion can bring about effects in areas such as antisocial behaviour and poor self regulation (Baumeiser, DeWall, Ciarocco, & Twenge, 2005). When considering forensic populations within a recovery focused framework, it is surprising more is not done to explore supportive relationships as experienced by incarcerated individuals. More specifically in forensic mental health populations where the focus is removed from that of a punitive approach, and lands on a more compassionate outlook to inspire positive outcomes, we still see little research into the experience of support by forensic inpatients.

### ***Existing literature looking at familial support***

When reviewing existing literature, it is clear that research to date has focused mainly on experiences of the families on the outside within the context of imprisonment, as opposed to the individual who is serving a sentence. However, this growing body of information has informed our understanding of the perceived barriers to supporting an individual in such a setting. Furthermore, families can experience direct negative effects from supporting a family member in this context. Families have been shown to experience a lack of sympathy and support from others unlike other contexts of loss (i.e. death or illness) when faced with the incarceration of a loved one (Schoenbauer, 1986; Arditti, 2003). This holds with it the possibility of alienating the family, and indirectly further alienating the incarcerated individual, due to the potential cutting of surrounding ties. Furthermore, it has been shown that families can also be blamed, shamed and stigmatised due to their perceived proximity to

the offence (Condry, 2007). This so called “web of shame” then disperses outwardly from the offending individual. This may impact upon relationships in different ways; for example, the nature of the families relationship with the offender, due to perceptions of blame around why they have also been stigmatised, or indeed a withdrawal from interaction with the offender, with a view to protecting external relationships in lieu of the families relationship with the offender.

### ***Familial support from patients' perspective***

Although existing literature promulgates the notion that familial support is a key factor in rehabilitation in forensic mental health, and despite the fact that literature exists which explores in great detail the experiences of family members who have loved ones in prison, the experiences of individuals in incarceration remains relatively unacknowledged. Furthermore, the experience of familial support by individuals in secure hospitals is almost entirely absent.

### ***Why Interpretative Phenomenological Analysis (IPA)?***

Qualitative methods are understood to be befitting in studies seeking to examine and elucidate relatively unexplored phenomena (Audet & Overall, 2010). Within a forensic context, qualitative research has been accepted as useful way of accessing these phenomena in a sensitive and respectful way. For example, Holligan (2016) used semi structured interviews with Scottish prison visitors to better understand visitation benefits and perceptions of support for prisoners. Similarly, qualitative studies have been used fruitfully to explore experiences from the perspectives of individuals living with a forensic label (e.g Stuart, Tansey & Quayle, 2017). As explained by Stuart et al., IPA seeks to explore and capture commonalities in data, as opposed to explain. As such, it is an attractive methodology when investigating experiences of participants that possess a common context. Interpretative Phenomenological Analysis therefore presents a meritable hermeneutic antithesis to conventional methods of study, allowing the attention to land on new knowledge, instead of the preconceptions of the interviewer (Smith, 2007). Interpretive Phenomenological Analysis is an appropriate methodology for the proposed study, as the topic itself is novel and requires elucidation.

### ***Why this project?***

The State Hospital Clinical Governance Group produced a Clinical Outcomes Monitoring Report (2017), within which the authors state that non-professional visits at TSH have decreased, and the number of patients receiving no non-professional visits has increased. Due to existing literature’s findings about the importance of support on recovery and rehabilitation, exploration into the nature of these visits and the experience of support is necessary. Specifically, it was agreed that familial support in the traditional sense (individuals affiliated by birth, affinity, or historical co-residence) would be explored. This was determined due to the perceived lack of data on this from the perspectives of patients in high secure forensic hospitals, but also due to the scope of the study and to ensure a homogenous sample.

There exists a paucity of research which includes the perspectives of forensic patients (Coffey, 2006), alongside the lack of research exploring forensic patients’ experiences of familial support. This is concerning due to the fact that there is some support for the link

between familial contact and a reduction in recidivism (e.g. Mills & Codd, 2008), and the fact that there has been an abundance of literature exploring the experience of families who have loved ones in incarceration (e.g. Holligan, 2016). In spite of this, researchers have failed to give voice to the individuals on the receiving end of punitive restrictions in this context. Therefore, our understanding of this support is largely one sided.

Furthermore, research has largely focused on prison contexts (e.g. Hutton, 2016), and therefore the experiences of individuals in forensic hospital settings is a novel and imperative area to explore. Whilst one can assume some similarities between prison and hospital settings, the nature of familial support may vary due to the complex array of psychological difficulties that are more prevalent in forensic mental health settings. Additionally, whilst research has highlighted the importance of maintaining connectedness with family members whilst in forensic mental health contexts (Clarke, Lumbard, Sambrook and Kerr, 2016), this may be more salient than in prison populations. For example, if some of the blame of an individual's offense may be assigned to the mental state of that individual, then this perhaps increases the likelihood for the maintenance of supportive familial networks, as the attributions of blame are mildly external to the individual.

### **Aims**

This study sets out to explore the ways that patients within a high secure forensic hospital experience familial support. It will focus on areas such as the perceived importance of familial support, how familial support changes in a high secure hospital, and the values that are placed on familial support, within a sample of patients who have maintained familial support.

The primary aim of this study is to answer the question “what does familial support mean to patients in high secure forensic settings?” Due to the inductive nature of IPA (Reid, Flowers & Larkin, 2005), hypotheses are suspended and an exploratory approach is used. In this study, data will be interpreted using a bottom-up approach, and therefore beyond the principal research question, no further questions or aims are posited at this stage. This is to ensure the findings of the study are not coloured by pre-conceived curiosities or beliefs of the researcher.

### **Plan of Investigation**

#### ***Methodology***

This study will draw upon the phenomenological principles of IPA, due to its exploratory nature and utility within unresearched areas. Participants will be interviewed using semi structured interview questions, focusing on their individual experiences of maintained familial support during admission to TSH, Scotland's high secure hospital. These interviews will be recorded, transcribed and then analysed using IPA methods. Analyses will be grounded in the data, with an attempt to suspend subjectivity.

#### ***Sample and sample identification***

Recruitment will take place amongst patients (all male) at TSH who have maintained familial support in the form of ongoing family visits. The researcher is aware that other forms of

contact may be an aspect of certain patients' experience of familial support for example via Video link for families that live further away. However, as this method may change the nature of familial support, perhaps by removing factors associated with physical closeness that some patients may refer to, the sample will only include patients who receive face to face visitations.

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### **Data collection**

Each participant will engage in a semi structured interview lasting up to sixty minutes. The interviews will take place at TSH in interview rooms to ensure privacy and fewer distractions. The interviews will cover questions around the nature of the patients' familial support, the importance of this support, how this support has changed since admission to TSH and the perceived consequence of this support. Questions will be open ended in nature, to allow for rich data to be gathered and to prevent researcher bias which may be seen in closed questions. Interviews will be digitally recorded to allow for transcription and then analysis.

### **Analysis**

The analysis will be completed using IPA methodology. Due to the relatively unexplored territory within which this study lies, qualitative methodology was deemed appropriate, due to its ability to gather rich data from which one can draw themes and understandings from those experiencing the phenomena.

Themes will be derived through a process of coding, organising and interpreting interview data with a focus on transparency and reflexivity, in line with good practice guidelines (Elliot, Fischer & Rennie, 1999). Interpretations of participants accounts will be made cautiously, so as not to impose significance that has been coloured by the researcher's "natural attitude" (Husserl, [1931] 1967). Husserl popularised the term "epoché" or phenomenological "bracketing", which refers to the suspension of an individual's own subjectivity during attempts to understand the meaning of experience. Therefore, by engaging this phenomenological concept, the researcher will make efforts to set aside natural biases, and examine the descriptions of phenomena as they naturally arise (Langdridge, 2007). This will ensure that themes drawn from interviews will be well grounded in the data.

Despite no prescribed way to conduct analysis in IPA research, the study will follow the steps proposed by Smith, Flowers and Larkin (2009): (1) reading and re-reading; (2) initial noting; (3) developing emergent themes; (4) searching for connections across emergent themes; (5) moving to the next case; and (6) looking for patterns across cases.

### **Timetable of Work**

December 2017	- Complete Ethical Application process
January - March 2018	- Introduction and Methodology Write Up
March - June 2018	- Data Collection
May – July 2018	- Data Transcription
July – October 2018	- Data Analysis
October - December 2018	- Write results, discussion and abstract
February 2019	- Submit Draft

### **Existing Facilities**

The researcher plans to use existing IT equipment and programmes, an encrypted dictation device, a TSH-issued laptop and an encrypted memory stick.

### **Justification of Requirements**

An encrypted dictation device will be required for data collection (during interviews), and a TSH-issued laptop would be required to allow for the researcher to conduct transcription either within or outwith the hospital. An encrypted memory stick will be required for storage of the resultant interview transcriptions.

### **Information/Data governance procedures**

Original data will be stored on an encrypted State Hospital dictation device. This will be kept in a locked drawer in the researcher's office at TSH. Data will be moved onto an encrypted state hospital memory stick using password protected computers within TSH. Data will then be transcribed (by the primary researcher) into anonymous transcriptions either within, or outwith the hospital, on a TSH-issued laptop. All resultant anonymous transcriptions will only be stored (saved) on the encrypted state hospital memory stick. Original recordings will be deleted from both the memory stick and the dictation device immediately following transcription. Consequent data analysis will only utilise and quote from anonymised interview transcripts.

Data in the form of anonymised transcripts (pdf documents) will be stored for 10 years by the University of Edinburgh for the purposes of publication procedures. The university uses a data sync system which is password protected and allows for only named individuals to access data. Following the 10 year period the university will destroy the data. Once analysis is completed and data is stored on the university system, it will be deleted from TSH memory stick.

### **Purpose and Potential for Implementation of Results**

This research project will be submitted in partial fulfilment of the Doctorate of Clinical Psychology at The University of Edinburgh. The project will be constructed as a Systematic Review and a journal article, and both will be submitted to the Journal of Forensic Psychiatry and Psychology upon completion of the study.

It is hoped that the results from this study will help to inform staff at TSH, and indeed in wider forensic settings, about the processes involved in familial support, visits from family,

and the impact of this. This will help to ensure support staff can tailor patient care with a view to promoting the best possible outcomes for individuals within a forensic hospital setting.

**Means of Disseminating Research Findings to Participants, Patients, Colleagues.**

The results will be disseminated to the research committee at TSH, with a view to presenting to the clinical team. Furthermore, presentation at the International Association of Forensic Mental Health Services (IAFMHS) annual conference in 2019 will be considered, depending on funding, the researcher's capacity, and support from TSH to do so.

## Key References

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## Brief Curriculum Vitae of Applicant

<b>Name</b>	Martha Gillespie
<b>Qualifications</b>	MA (Hons) Psychology
<b>Post Held</b>	Trainee Clinical Psychologist
<b>Research Experience/ Publications</b>	<p>Undergraduate level research exploring the experiences of individuals with insomnia, and an IPA study exploring how clients experience therapy.</p> <p>Small scale studies and audits completed as an Assistant Psychologist (see below):</p> <ul style="list-style-type: none"> <li>- Gillespie, M. (2015). An audit of the Intensive Home Treatment Team (IHTT) looking at service efficacy using pre and post intervention measures. Report for NHS Forth Valley.</li> <li>- Gillespie, M. (2015). The Analysis of Clinician Activity in Borders Addiction Service Using Service Improvement Methodology (Demand, Capacity, Activity and Queue). Presented at the meeting of Efficiency and Improvement, Melrose, UK.</li> <li>- Gillespie, M. (2015). The evaluation of the East and Midlothian Psychological Approach Team (EMPAT) in the usage of the Newcastle Model for Stress and Distress in dementia. Report for NHS Lothian.</li> <li>- Gillespie, M. (2015). The evaluation of a pilot transdiagnostic Acceptance and Commitment Therapy (ACT) group in an Older Adult cohort. Report for NHS Lothian.</li> <li>- Gillespie, M. &amp; Davies, K. (2014). An audit of the practice and supervision attendance of Behavioural Family Therapy practitioners across Lothian. Report for NHS Lothian.</li> <li>- Gillespie, M. (2014). Evaluating clients' self rating scores pre and post therapy, using the CORE (Clinical Outcomes in Routine Evaluation) standardized assessment tool within Psychological Therapies. Report for NHS Lothian.</li> <li>- Gillespie, M. &amp; Rose, S. (2013). An Interpretative Phenomenological Analysis Exploring Clients' Experience of Therapy: Making Sense of Therapy. Presented at the meeting of the Undergraduate British Psychological Society Conference, Dundee, UK.</li> </ul>