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# Personal Experiences of EMDR Therapy within Secure Services

A thesis submitted in fulfilment of Cardiff Metropolitan University's

DOCTORATE IN FORENSIC PSYCHOLOGY

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# Abstract

The link between trauma, mental health difficulties and criminal behaviour is becoming widely acknowledged. Secure services primarily continue to offer offence-focused interventions. Little is known about why individuals engage in Eye Movement Desensitisation and Reprocessing (EMDR) therapy, which is neither offence-focused nor mandated, or how it may be beneficial in terms of recovery or risk reduction. This study aimed to develop an understanding of personal experiences of EMDR therapy within secure services. An opportunistic sample of eight services users was recruited from secure services and invited to engage in a semi-structured interview to explore their experiences. Thematic analysis was used to analyse the data. The analysis revealed four main themes that were central to participant experiences of engaging in EMDR therapy within a secure service. The first was the 'Decision to Engage in EMDR Therapy' including 'Accessing Information and the Unknown' along with 'Making a Personal Commitment to Engage in the Therapy'. The second theme was the 'Essential Support Structures' that were in place and identified the 'Challenges of a Secure Environment' and the 'Necessity of the Therapeutic Relationship'. The third theme was the 'EMDR Therapy Process', which involved the 'Functional Aspects of the use of Bilateral Stimulation' and the 'Visceral Impact of Engagement'. The final theme was around 'Identifying Personal Change' that participants observed in relation to 'Changes in Mental Health and Diagnosis', 'Insights and Reflections on Offending Behaviour' and 'Ability to Cope and Experience Hope for the Future'. The study highlights how EMDR therapy was life changing for all of the participants involved and provides a detailed exploration of these aspects. EMDR therapy was not an easy therapy for participants to engage in and a number of relevant factors are identified that should be considered when offering a trauma intervention within a secure service. Further clinical implications are outlined.

# Declaration

I declare that this work has not previously been accepted in substance for any degree and is not being concurrently submitted in candidature for any other degree.

STATEMENT 1

I further declare that this thesis is the result of my own independent work and investigation, except where otherwise stated. Where correction services have been used, the extent and nature of the correction is clearly marked in a footnote(s).

Other sources are acknowledged by footnotes giving explicit references. A bibliography is appended.

STATEMENT 2

I hereby give consent for my thesis, if accepted, to be available for photocopying and for inter-library loan, and for the title and summary to be made available to outside organisations and that I do hereby give Cardiff Metropolitan University the right to make available the Work.

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Date 12.04.21

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# Chapter 1: Introduction

> To raise new questions, new possibilities, to regard old problems from a new angle, requires creative imagination and marks real advance in science. (Albert Einstein)

Many individuals seek treatment for mental health difficulties voluntarily through available mental health services. However, there are cases when people need urgent treatment for a mental health disorder and are viewed as posing a risk of harm to themselves or others. The Mental Health Act (Department of Health, 1983) as amended (Department of Health, 2007), is the main piece of legislation that covers the assessment, treatment and rights of people with a mental health disorder. To be sectioned under this Act, someone would need to be assessed as experiencing a 'mental disorder'. Examples of clinically recognised conditions which could fall within this definition include: personality disorder, eating disorders, autistic spectrum disorders, learning disability and mental illness such as depression or schizophrenia. Alcohol and drug dependence is generally not included, but any mental disorder accompanied by, or associated with, their use may be included. The nature and degree of an individual's mental disorder, as well as relevant circumstances, should be considered.

Forensic mental health services have links with both general mental health services and the criminal justice services. The aim is to manage an individual's mental disorder, reduce their risk to others, and address any offending behaviours. Within the UK, support is provided, whilst also maintaining safety through "high", "medium" and "low" secure services. Each level of security signifies different risk levels that someone may present with and provides a range of physical, procedural and relational security based on this. Typically, individuals within these services will be experiencing longstanding, and often complex, mental health disorders, which may require support and cannot be delivered safely within society. For some, the period of time spent within these services can be lengthy. However, an individual can only be detained for treatment if appropriate treatment is suitable and available.

A Multidisciplinary Care Team (MDT) manages an individual's progress in collaboration with the service user (Mental Health Commission, 2006). MDT members include a psychiatrist, who will often hold legal responsibilities as the Responsible Clinician (RC), a practitioner psychologist, nursing staff and a social worker. Additionally, wider services may be involved, such as creative therapists, teachers and advocacy services. Treatment is often delivered through a care plan, formulated within the Care Programme Approach frame work (Department of Health, 2008). After an extensive assessment period, individuals will usually be offered a combination of pharmacological and psychological treatment, which may in some cases be compulsory (McGuire & Duff, 2018). In addition to the legal responsibilities and powers held by the RC, an individual detained in a psychiatric hospital under the Mental Health Act 1983 (as amended by the Mental Health Act 2007), can apply for a First-Tier Tribunal to review their case with the hope of directing discharge (Gov.uk, 2021).

In recent years, secure services within the UK are moving away from a traditional medical model. For example, the incorporation of the recovery model (Jacob, 2015; South London and Maudsley NHS Foundation Trust and South West London and St George's Mental Health NHS Trust, 2010) aims to promote recovery, as well as reduce risk behaviours. Alternative frameworks have emerged for understanding mental health difficulties, with a move towards incorporating more trauma-informed approaches (Johnstone, Boyle, Cromby, Dillon, Harper, & Longden, 2018; Substance Abuse and Mental Health Services Administration (SAMHSA), 2014a; Sweeney, Clement, Filson, & Kennedy, 2016). This brings to the forefront the possibility that trauma can have wide-ranging implications on an individual's physical and mental health, including the potential for services to retraumatise clients through standard policies, if applied without consideration. Additionally, it highlights the importance of working individually with someone to address their needs rather than applying more general treatment approaches.

In Chapter 2, I will provide an overview of the relevant literature and explain the rationale for the current research. This will explore how trauma has been defined and the relationship between trauma and offending behaviours that are typically seen within secure services. Common treatment approaches within secure services will be

reviewed, alongside the research around the efficacy and applicability of EMDR therapy. Finally, the impact of the therapeutic relationship on therapy will be explored, before outlining the research aims.

In Chapter 3, I will provide an in-depth review of the methodology used, including definition and epistemological grounding and why thematic analysis was chosen.

In Chapter 4, I will present the analysis and in Chapter 5, I will interpret this information alongside the current literature. I will conclude by summing-up the clinical relevance and implications of this research, as well as providing an appraisal of the study's strengths and limitations and directions for future research.

# Chapter 2: Literature Review

> As human beings we belong to an extremely resilient species. Since time immemorial we have rebounded from our relentless wars, countless disasters (both natural and man-made), and the violence and betrayal in our own lives. But traumatic experiences do leave traces, whether on a large scale (on our histories and cultures) or close to home, on our families, with dark secrets being imperceptibly passed down through generations. They also leave traces in our minds and emotions, our capacity for joy and intimacy, and even on our biology and immune systems. (Van der Kolk, 2014, p.1)

## 2.1 Defining Psychological Trauma

Trauma is not a simple phenomenon; there are a multitude of ways that an individual can experience and respond to trauma. Trauma may be the result of a natural disaster such as an earthquake or by human failure or design, such as through accidents or war. It may be experienced on an individual basis, as a one-off event such as a physical assault or a car accident, or involve multiple prolonged events such as ongoing sexual abuse or a life-threatening illness.

Historically, trauma has been associated with combat and with the emergence of "shell shock" during World War I. Soldiers returned with no obvious physical injuries, but with symptoms such as amnesia or the inability to communicate (Tasca, Rapetti, Carta, & Fadda, 2012), a presentation which had previously been associated with "hysterical women" (Tasca et al., 2012). Initially, believed to be caused by physical trauma to the brain through repeated exposure to concussive blasts, it was subsequently observed that many had never experienced a concussive injury and the British Medical Journal changed its understanding to one of weakness ("Shell Shock," 1922). Viewed as needing to be brought to their senses, brutal treatment methods were utilised such as putting hot plates at the back of the throat (Yealland, 1918).

After World War II, Kardiner (1941) wrote the more empathic work on PTSD, which changed how the phenomenon was perceived. Rather than being a character flaw, symptoms were viewed as a psychological injury, which acted as a defensive against trauma experiences that had overwhelmed the personal ability to cope. After WWII and the Korean War, other clinicians offered further legitimacy to the concept of combat trauma.

### 2.1.1 Trauma as a Psychological Disorder

Veterans became activists and in 1967 their campaign helped to include PTSD into the third edition of the Diagnostic and Statistical Manual for Mental Disorders (DSM-III) (American Psychiatric Association (APA), 1980), which was a major American diagnostic resource used by psychiatrists and other mental health professionals. The more updated version, the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5), defines trauma as occurring when an individual is exposed "to actual or threatened death, serious injury, or sexual violence" (American Psychiatric Association (APA), 2013, p.271).

In terms of current diagnosis, Acute Stress Disorder (ASD) may be diagnosed after experiencing a single traumatic event. An individual may experience symptoms which can cause significant levels of distress but which are generally viewed as normal responses to trauma and often time-limited (American Psychiatric Association (APA), 2013). The more commonly recognised trauma diagnosis of posttraumatic stress disorder (PTSD) can also include repeated and unwanted re-experiencing of an event, with many common symptoms and avoidance of anything which may function as a reminder of the original event (American Psychiatric Association (APA), 2013; Anke Ehlers & Clark, 2000; Shalev, Yehuda, & McFarlane, 1999). However, PTSD is notable in that, as observed with soldiers, these experiences can last for years instead of days or weeks (Archibald & Tuddenham, 1965).

It has been argued that PTSD was not meant to differentiate between different types of trauma (Wamser-Nanney & Vandenberg, 2013), nor does it capture the full impact of trauma, such as difficulties regulating emotions, impaired sense of self concept, difficulties interacting with others, sexual problems and somatic complaints (Briere &

Spinazzola, 2005; Cloitre, Stovall-McClough, Zorbas, & Charuvastra, 2003; Zucker, Spinazzola, Blaustein, & Kolk, 2006). It has also been observed that many people with a diagnosis of PTSD may also experience a comorbid diagnosis (Kessler, Chiu, Demler, Merikangas, & Walters, 2005). However, rather than being an issue of comorbidity, Wamser-Nanney and Vandenberg (2013) argue that this may be a problem with the PTSD diagnosis, which does not allow for the range of associated difficulties that may not have been viewed as being directly associated with the traumatic event.

Complex trauma was developed by Herman (1992) to describe the presentation of individuals who have experienced extensive and repeated trauma but this was not traditionally considered under a diagnosis of PTSD (Wamser-Nanney & Vandenberg, 2013). It has later been described as a traumatic event which begins in childhood and is chronic and interpersonal in nature, which results in a loss of someone's fundamental ability to self-regulate and to relate to others (Cook et al., 2005). The severity of symptoms experienced can relate to the age at which someone was exposed to trauma, with earlier onset of experiences being related to more severe symptoms and distress (Cloitre et al., 2003) and possibly significantly altering a child's developmental trajectory (Cicchetti & Toth, 1995) and relationship with a perpetrator (Janoff-Bullman, 1992).

Nearly twenty years later, complex posttraumatic stress disorder (Complex PTSD) was proposed as a distinct clinical entity and subsequently included in the WHO International Classification of Diseases, 11$^{th}$ version, to meet an unmet need (Giourou et al., 2018; Wamser-Nanney & Vandenberg, 2013; World Health Organisation (WHO), 2018). It was reconceptualised and this has highlighted issues around resource implications, as current interventions are unlikely to be effective for some due to complicating factors for which clinicians often require further training (Brewin, 2020).

### 2.1.2 Trauma and Other Mental Health Diagnoses

A number of mental health disorders including those related to mood (i.e., depression and anxiety), substance use and personality disorders overlap with symptoms of PTSD (Substance Abuse and Mental Health Services (SAMHSA), 2014). The experience of trauma is prevalent within a general psychiatric population and complicates the

process of recovery (McFarlane, Bookless, & Air, 2001). Although the relationship between mental health difficulties and PTSD is complex, the co-occurrence of PTSD has been found to result in a greater impairment and more severe symptoms of anxiety, depression and obsessive compulsive disorder, as well as remission of symptoms (Foa, Stein, & McFarlane, 2006; Substance Abuse and Mental Health Services Administration (SAMHSA), 2014b).

PTSD is often misdiagnosed or underdiagnosed when the individuals have not been recognised as being trauma survivors (Substance Abuse and Mental Health Services (SAMHSA), 2014). Whilst some traumas are more easily identifiable, some experiences are more covert. For example, verbal aggression and witnessing domestic violence can have a comparable negative impact on children (Polcari, Rabi, Bolger, & Teicher, 2014; Teicher, Samson, Polcari, & McGreenery, 2006), as can parental interactions with children involving ridicule or neglect which can have significant consequences, including lasting effects on brain development (Belsky & de Hann, 2011), cognitive functioning (Choi, Jeong, Rohan, Polcari, & Teicher, 2009; Harpur, Polek, & van Harmelen, 2015; Tomoda et al., 2011) and emotional processing (Young & Widom, 2014). However, this often does not meet the threshold for direct intervention from services. Interestingly, although many individuals wish to discuss their traumatic experiences (Lothian & Read, 2002), clinicians fear that it may make their difficulties worse (Read, Hammersley, & Rudegeair, 2007) and a trauma screen is not routinely conducted in mental state examinations (Slater, 2004).

#### *2.1.2.i Trauma and Psychosis*

The belief that adverse life events can lead to the experiences commonly associated with psychosis is held worldwide and often seen to be an obvious connection. However, this is not generally the view held by psychiatrists who have tended to favour a medical model and believe that such individuals have experienced biological issues related to genetics (Kingdon, 2004; Miller, 2016; Read & Dillon, 2013; Tarrier et al., 2004). Miller (2016) suggested that this results in people with these experiences feeling passive and incapable. Feeling no responsibility for their difficulties, they are not given the opportunity to discuss any adverse experiences. However, it has been suggested that, rather than having a solely biological or genetic cause (Clementz et

al., 2016; Kesby, Eles, McGrath, & Scott, 2018; Lautenschlager & Forsti, 2001), schizophrenia may be born out of more dissociative mechanisms with trauma at the route of this (Moskowitz, Schafer, & Dorahy, 2008; Read, Fosse, Moskowitz, & Perry, 2014).

There is a significant body of research confirming the links between development and persistence of trauma and symptoms of psychosis (Matheson, Shepherd, Pinchbeck, Lau- rens, & Carr, 2013; Read, Moscher, & Bentall, 2004; Read, Van Os, Morrison, & Ross, 2005; Sarkar, Mezey, Cohen, Singh, & Olumoroti, 2005; Varese et al., 2012). Further exploration of these links suggests that adverse experiences may even causally influence development and persistence of symptoms and that this can have a dose response with more (severe) trauma, resulting in worse outcomes and increased risk of difficulties (van den Berg, van der Vleugel, Staring, de Bont, & de Jongh, 2013). It has also been suggested that episodes of paranoia can be traced back to a trauma event and that hallucinations and delusions quite often have features or themes that can be traced back to the development of traumatic experiences and core beliefs (Bentall, Wickham, Shevlin, & Varese, 2012; Fisher et al., 2012; Morrison, Frame, & Larkin, 2003). For example, the traumas related to sexual abuse and bullying were most likely to be associated with hallucinations (Hardy et al., 2005).

#### *2.1.2.ii Trauma and Bipolar Disorder*

Further research has identified that sexual and physical abuse is common in individuals with bipolar disorder, particularly with those who also have comorbid PTSD, psychosis or conduct disorder (Pavlova, Uher, Dennington, Wright, & Donaldson, 2011; Romero et al., 2009). Additionally, trauma has also been found to impact negatively on treatment outcome (Quarantini et al., 2010). However, bi-polar disorder is primarily viewed as a disease caused by genetics and biological differences to be treated via medication (Hilty, Leamon, Lim, Kelly, & Hales, 2006) and trauma is not routinely enquired about (Shannon, Maguire, Anderson, Meenagh, & Mulholland, 2011).

#### *2.1.2.iii Borderline Personality Disorder*

It has been observed that complex PTSD may often clinically resemble a subtype of borderline personality disorder (BPD) and it has been questioned whether complex trauma is a separate entity or PTSD which is comorbid with BPD. Although clear

personality changes may not be required for the diagnosis of complex PTSD, permanent change in their personalities or life aspirations can occur (Ehlers, Maercker, & Boos, 2000). With this in mind, Giourou et al. (2018) suggest that for individuals who may have experienced complex trauma from an early age, a personality change is unavoidable. This is evidenced to some extent by Johnson et al. (2001), who identified that when exposed to parental verbal abuse within childhood, children are more likely to have a diagnosis of borderline, narcissistic, obsessive-compulsive or paranoid personality disorders (Johnson et al., 2001).

Decades of research has pointed to the frequent occurrence of trauma, abuse and neglect in the childhood experience of individuals with borderline personality disorder (BPD) (Herman, Perry, & van der Kolk, 1989; Ogata et al., 1990; Sabo, 1997) However, in spite of this, the debate over a causal link between trauma and borderline personality disorder prevails (Ball & Links, 2009). van der Kolk, Hostetler, Herron and Fisler (1994) explore this further in light of presenting difficulties, highlighting how prolonged and severe trauma can lead to difficulties in self-regulation and attempts at self-soothing can include clinging to relationships indiscriminately, which may involve the re-enactment of old traumas, as well as more self-directed behaviours including self-harm, eating disorders, and substance abuse.

#### *2.1.2.iv Trauma and Psychopathy*

Psychopathy is more commonly known as a complex personality disorder that has been found to be closely linked to offending behaviour from an early age (Hare, 1998; McCuish, Corrado, Lussier, & Hart, 2014). Somewhat in contrast to a diagnosis of borderline personality disorder, where there is often vacillating or an excess of emotion, psychopathy is often associated with flat affect. Also, unlike borderline personality disorder, which has recognised links with developmental trauma, psychopathy does not. However, Craparo, Schimmenti and Caretti (2013) aimed to explore the impact of traumatic experiences a child may have on the development of psychopathic personality disorder. They found that early exposure to relational trauma, such as abuse or neglect, could play a notable role in the development of severe psychopathic traits. Reference is also made to the suggestion that psychopathy could occur as the result of dysfunctional interpersonal exchanges, adverse

environmental factors (Karpman, 1941; Lykken, 1995; Porter, 1996) or emotional numbing (Moskowitz, 2004). More recently, it has been suggested that it may be the cumulative adverse experiences that children are exposed to which are associated with adolescent psychopathic traits (Baglivio, Wolff, DeLisi, & Jackowski, 2020). There is no research to date that explores the efficacy or impact of treating this population with trauma therapy. This may go some way to understanding public perception and the negative view of those who have this diagnosis (Edens, Clark, Smith, Cox, & Kelley, 2013), particularly in terms of treatability (Olver, Lewis, & Wong, 2013).

### 2.1.3 Trauma as a Common Experience

Some argue that the current diagnostic view is too limiting and that it is not uncommon for those individuals seeking support from mental health services to have been exposed to multiple or chronic traumatic events that are not overtly obvious on initial enquiry. Some of the common responses to trauma have been comprehensively summarised in a document by SAMHSA, (2014) and outlined in Table 1. These may occur quite soon after a traumatic event and are often quickly resolved through the use of appropriate coping and social support, enabled by the ability to maintain relationships. However, others may continue to experience distress and reactions, which is highlighted when problematic behaviours may start to emerge (Briere & Scott, 2006; Foa et al., 2006; Pietrzak, Goldstein, Southwick, & Grant, 2011; Substance Abuse and Mental Health Services Administration (SAMHSA), 2014a).

| | |
|---|---|
| **Emotional** | Too much or too little emotion |
| | Difficulties regulating emotions (anger, anxiety, sadness and shame) |
| | Detached from thoughts, behaviours, emotions and memories |
| **Physical** | Known or unknown medical cause |
| | Somatisation - bodily symptoms express emotional distress (often unaware) |
| | Chronic health conditions |
| | Hyper-arousal - sleep disturbance (including nightmares) & muscle tension |
| | Lower threshold for a startle response |
| **Cognitive** | Altered cognitions and core assumptions about the self, the world and the future |
| | Cognitive errors - misinterpreting a situation as dangerous |
| | Idealisation or justification of perpetrator's behaviour |
| | Triggers - sensory reminder or very general |
| | Intrusive thoughts, memories or flashbacks (including nightmares) |
| | Trauma-induced hallucinations or delusions |
| | Dissociation |
| **Behavioural** | Engage in behaviours to manage intensity of emotions or distress |
| | Reduce tension or stress through avoiding people, places or situations |
| | Reduce stress through self-medication, compulsive and/or self-injurous behaviours |
| | Gain control by being aggressive or subconsciously reenacting aspects of the trauma |
| | Learned helplessness |
| **Social and Interpersonal** | Feel ashamed of emotional reactions and pull away from relationships |
| | A history of betrayal can disrupt forming of relationships |
| | Fear can be protective but leads to difficulty connecting with others |
| **Developmental** | Young children - general fear, nightmares, confusion & physical symptoms |
| | School age - aggressive behaviour, regression, repetitious traumatic play, poor concentration |
| | Adolescents - depression, withdrawal, rebellion, increased risk behaviours (sexual acting out), wish for revenge, sleep and eating disturbances |
| | Adults - sleep problems, agitation, hypervigilance, isolation, increased substance use |
| | Older adults - isolation, reluctant to leave home, chronic illnesses, confusion, depression, fear |

**Table 1: Common responses to trauma (SAMHSA, 2014)**

Rather than seeing trauma as an indicator of a mental disorder, clinicians have started to view reactions as normal and part of the human survival instinct (Turnbull, 1998), which may become problematic when either hindered or left unrecognised (Scott, 1990). Horowitz (1989) offered a much broader definition of trauma, highlighting that trauma does not necessarily have to involve actual physical harm and that it can be equally distressing if an event occurs in conflict with that person's world view and impedes their ability to cope. When moving on from early trauma definitions, statistics suggested that many individuals have been exposed to some form of traumatic event during their life (Anda et al., 2006; Baker, 2018; Frans, Rimmo, Aberg, & Fredrikson, 2005) and it is indeed a common experience. Trauma has also been observed to have a ripple effect onto others, who become aware of this trauma through the event being recounted (Coles, Astbury, Dartnall, & Limjerwala, 2014; Pearlman & McKay, 2008; Sexual Violence Research Initiative, 2015), with similar impact (Morrison, Quadara, & Boyd, 2007).

Further to this, the very environment and conditions that an individual lives in can be traumatic and it has been suggested that there is a need to also understand the social context of trauma and the presence of systems of oppression, which may, as with other traumas, often go on unrecognised and unseen by the individual and those around them (Bell, 2011; Breslau, 2002; Brewin, Andrews, & Valentine, 2000; Brown, 2008; Fast & Collin-Vézina, 2010; Johnstone, Boyle, Cromby, Dillon, Harper, & Longden, 2018).

Adverse Childhood Experiences (ACEs) is an area of growing concern which is gaining increased attention. This started with a study at Kaiser Permanente's San Diego Health Appraisal Clinic (Felitti et al., 1998) and the results indicated a relationship between the breadth of exposure to abuse, neglect and/or difficult family experiences (e.g., domestic violence, substance use, parent in prison) during childhood and risk factors leading to some of the main causes of death (i.e., ischemic heart disease, cancer, chronic lung disease, skeletal fractures and liver disease). The greater number of ACEs that someone experiences during childhood, the more at risk they appeared to be of developing a range of mental, social and physical health issues as an adult, such as

suicide, smoking, substance use and depression. Further to this, individuals with higher ACE scores were more likely to have been a victim of perpetrator violence.

In recent years, the ACE study has been replicated in the UK (Bellis et al., 2015; Bellis, Hughes, Leckenby, Perkins, & Lowey, 2014; Spratt & McGavock, 2014), and all demonstrated similar correlations. Reavis, Franco and Rojas (2013) used the ACE questionnaire with criminals to demonstrate a further association with ACEs and criminal behaviour. Although viewed as moving in the right direction, there has been some criticism and caution regarding the use of ACE as a screening measure in clinical practice intervention (Finkelhor, 2017), and the potential to see this as a simple solution to a complex social issue (Edwards et al., 2017).

## 2.2 Trauma and Offending

Research demonstrates that traumatic experiences and criminal behaviours are fundamentally interlinked (Ardino, 2012) and there is a large body of literature which documents the relationship between trauma, childhood abuse, and aggressive and criminal acts, in both males and females who have offended (Ardino, Milani, & Di Blasio, 2013; Baglivio, Wolff, Piquero, & Epps, 2015; Bender, 2010; Brown & Burton, 2010; Browne, Miller, & Maguin, 1999; Colman, Kim, Mitchell-Herzfeld, & Shady, 2009; de Jong & Dennison, 2017; Fox, Perez, Cass, Baglivio, & Epps, 2015; Frazzetto et al., 2007; Haapasalo & Pokela, 1999; Harford, Yi, & Grant, 2014; Maxfield & Widom, 1996; Moore, Gaskin, & Indig, 2013; Sindicich et al., 2014; Turner, Finkelhor, & Ormrod, 2006; van der Put, Lanctôt, de Ruiter, & van Vugt, 2015). Many of those who victimise others have been victims themselves and then go on to repeat the cycle of violence (Awad & Sounders, 1991; Burgess, Hartman, & McCormack, 1987; Burton & Meezan, 2004; Louise Falshaw, Browne, & Hollin, 1996; Ryan, 1989). This includes the use of severe physical discipline at a young age, which was closely linked with violent behaviour later on (Herrenkohl & Hamalainen, 1997; Smith & Thornberry, 1995). It has also been found that regardless of whether or not the individual was a victim of this violence, witnessing domestic violence can have a significant impact on delinquent behaviour (Haapasalo & Pokela, 1999). It has also been observed that trauma and high rates of PTSD symptoms can increase the risk of re-offending (Ardino et al., 2013).

When attempting to understand this connection, van der Kolk (1989) argued that a major cause of violence was a result of trauma re-enactment, especially when many individuals who commit offences have also been victims. The individual may not always recall the initial trauma or be aware of the process of re-enactment, but may still find it difficult to escape the compulsion to repeat actions related to past experiences or re-expose themselves to similar situations (Freud, 1920). The compulsion to re-enact can be seen in self-destructive behaviours including self-harm, self-starvation and mutilation. With this in mind, Bloom (1999) suggested that it is easy to understand how a victim can become an abuser in terms of their reaction to feelings of powerlessness and that by taking on the role of abuser, a victim is able to prevent feelings of helplessness and regain power and control, which is something also seen in bullying literature (Ma, 2001).

An additional area is outlined by Moskowitz (2004), who suggested that dissociation could predict violence in a wide range of populations. It was noted that dissociative experiences were not always outright denials of any violent behaviours. Some individuals spoke of having amnesia and for those who described depersonalisation experiences, they did not deny they had committed a crime. This is important when considering trauma and treatment and assessment of individuals who may be perceived to be malingering in relation to offending behaviours.

Individuals who have committed a sexual offence were also more likely to have been raised in an environment of neglect and violence and subsequently have experienced attachment issues, parental deviance, discontinued care, as well as emotional, physical and sexual abuse (Burk & Burkhart, 2003; Lee, Jackson, Pattison, & Ward, 2002; Ryan, Miyoshi, Metzner, Krugman, & Fryer, 1996; Starzyk & Marshall, 2003; Thomas & Fremouw, 2009). However, within these factors some differences have been observed when compared to committing other offences. For instance, an individual committing adult-focused offences may have experienced more exposure to general violence and emotional abuse (Simons, Wurtele, & Durham, 2008), whereas a perpetrator of child sexual violence is more likely to have been a victim of sexual abuse themselves (Burton, Miller, & Shill, 2002; Ford & Linnet, 1995; Jespersen, Lalumière, & Seto, 2009; Maniglio, 2010, 2011; Whitaker et al., 2008). It is also of

note that exposure to violence in the home, even if they were not the victim of this abuse, may contribute to becoming a perpetrator in the future (Awad & Sounders, 1991). The relevance of this link was highlighted in a study by McMackin, Leisen, Cusack, LaFratta and Litwin (2002), who found that 95% of youths had experienced PTSD and clinicians identified that prior trauma exposure was related to offence triggers (i.e., intense fear, helplessness and horror) in 85% of youths who had received treatment using relapse prevention approach. This suggested that it is vital to focus on the treatment of the victimisation experiences of those who have sexually offended (Bentovim, 2002).

When considering treatment options, identifying offence-related trauma and resolving any trauma symptomatology could be paramount when providing effective rehabilitation for someone who has offended (Kubiak, 2004) and any treatment that only focuses on crime will be destined to fail and, to reduce offending behaviours, treatment must start to look towards the past (Reavis, Franco, & Rojas, 2013).

## 2.3 Traditional Approaches to Treatment within Secure Services

This section will outline historical and current approaches to psychological interventions within secure services. Although there is a focus on prison programmes, these principles are often reflected in treatment approaches when working within all secure services.

### 2.3.1 What Works and Offending Behaviour Programmes

Psychologists have been employed within prisons since 1947 and an early focus on assessment soon turned to engaging individuals in therapy to address criminal behaviours (Clark, 2010). To begin with, these interventions were broadly psychotherapeutic, unstructured and uncoordinated, and early research indicated that these interventions were of little benefit (Brody, 1976; Robinson, 1971). Soon, ever increasing crime rates brought about the prevailing paradigm that "nothing works" (Martinson, 1974) and the focus of the psychologist moved away from treatment and towards prison management. Thornton (1987) revisited this literature, differentiating between the types of interventions offered and, in doing so, highlighted that some interventions had indeed demonstrated some positive effect.

Gradually, a consensus was growing that some interventions could impact on offending and recidivism rates, which was summarised by (McGuire, 1995), which outlined practice guidelines based on the research up to this point and became known as the "What Works" literature (Andrews & Bonta, 2006; Garrett, 1985; Gendreau, 1990; Izzo & Ross, 1990; Lipton, Thornton, McGuire, Porporino, & Hollin, 2000; Nuttal, Goldblatt, & Lewis, 1998; Sherman et al., 1987). Subsequent programmes were congruent with this literature and became the main means by which psychologically based interventions are delivered in prisons and probation services or community rehabilitation companies within society. These programmes were more focused and skills-based and largely developed from cognitive behavioural therapy (CBT) techniques (Beck, 1995). They eventually became standardised and accredited, which allowed for rigorous monitoring of the quality of programme delivery.

A wide range of Her Majesty's Prison and Probation Service (HMPPS), previously the National Offender Management Service (NOMS), accredited Offender Behaviour Programmes (OBPs) were developed to address a number of different types of offences. They varied in length and complexity and were delivered according to offender risk and need (Bonta & Andrews, 2007; Hollin & Palmer, 2006; Looman & Lewis Abracen, 2013). The initial evaluation of these accredited skills programmes, in terms of recidivism rates, was very encouraging (Aos, Miller, & Drake, 2006; Friendship, Blud, Erikson, & Travers, 2002; Lipsey & Landenberger, 2006; Offender Management and Sentencing Analytical Services (OMSAS), 2009). However, there was some subsequent difficulty replicating these early results (Cann, Falshaw, & Friendship, 2005; Clarke, Simmonds, & Windall, 2004; Falshaw, Friendship, Travers, & Nugent, 2003; Mews, Di Bella, & Purver, 2017).

When evaluations suggested that the programmes were not producing the expected results, various factors were identified that could have contributed to this, including access to services (Briggs & Turner, 2003), quality of delivery (Day et al, 2011), the detrimental effect of rigid manualised approach (Drozd & Goldfried, 1996), as well as sustaining motivation (McMurran, 2009). It was suggested that the individual had become overlooked (Andrews et al., 1990) and that further interventions should start to focus on the whole person, such as the Good Lives Model (Ward & Maruna, 2007),

which offers a strength-based approach to offender rehabilitation and is closely aligned with positive psychology by focusing on offender well-being (Burke, Arkowitz, & Dunn, 2002; Ward & Brown, 2004; Ward & Nee, 2009). Harris (2007) outlines how some of the key areas are being incorporated into revised thinking skills programmes.

Offence-focused programmes have arguably taken an increasingly narrow focus on criminogenic needs (Andrews & Bonta, 2006). However, following the introduction of Mental Health in Reach Teams (MHIRTs), there was a shift in the role of psychologists within prisons and it has been suggested that MHIRTs have broadened treatment provisions to include more generic mental health issues. Harvey and Smedley (2010) suggest that focusing on non-criminogenic needs is an essential part of therapy that allows someone to alleviate distress related to their current environment and aid engagement in offence-focused work. They also highlight how someone's needs can rarely be neatly divided into criminogenic and non-criminogenic needs, as both may be important in terms of overall well-being and impact on likelihood of re-offending.

### 2.3.2 Therapeutic Communities

An approach that has emerged alongside the more formalised interventions has been that of Therapeutic Communities (TCs). TCs were developed from social psychiatry, with an emphasis on the rehabilitative role, encouraging participant involvement and responsibility. The defining components of this approach were therapy groups and communal living. Within a supportive and constructive environment, participants were expected to explore and challenge one another's behaviour. Initially, used with traumatised veterans at the Henderson Hospital, London, the therapeutic community aimed to empower and support those who were vulnerable and psychologically distressed (Shuker & Shine, 2010). These principles were then adopted to meet the needs of aggressive and antisocial individuals, who may arguably be the most difficult in terms of rehabilitation.

HMP Grendon (Category B Prison) opened in 1962, as an experiment to meet the needs of a challenging group of individuals. For some time, it offered the most intensive and consistent treatment option available. It was the only prison within the UK to have effectively reduced reoffending rates (Cullen, 1994; Marshall, 1997;

Newberry, 2010; Taylor, 2000) and, based on its success, further units were opened. However, the impact of these units was questioned (Martinson, 1974) and with the emergence of the "What Works" literature, TCs came under close scrutiny, particularly as treatment principles had been based on psychodynamic principles. Within the last 15 years, principles and techniques have been more clearly defined and scrutinised, thereby achieving a similar level of acknowledgement of more conventional interventions (Craissati, Minoudis, Shaw, & Chuan, 2011).

### 2.3.3 A Need for Trauma Interventions

The importance of trauma when considering risk of future offending has been clearly acknowledged for many years and relevant dynamic risk factors can be found in assessments such as the RSVP (Hart et al., 2003) and HCR-20 (Douglas, Hart, Webster, & Belfrage, 2013). It is also noted that many of these risk factors identified in these measures are subsequently targeted during interventions, including increasing coping strategies, improving emotional regulation, managing mental health difficulties and gaining further insight into offending behaviours (Hollin, 2004; Lindsay, 2009; W. Marshall et al., 2006; McGuire, 1995; Rogers et al., 2000; Ward et al., 2006) Trauma may be referred to within these programmes by exploring how these experiences are linked to offending behaviours or to the development of cognitive distortions (Abel et al., 1989; Finkelhor, 1984; Murphy, 1990) or maladaptive schemas (Mann, 2004; Winter & Kuiper, 1997; Young, 1990). However, these interventions do not tend to address trauma directly or in any depth. One or two exercises in a programme for those who have sexually offended may touch on the types and consequences of abuse and may introduce the abuse/abuser cycle, but not in any significant detail (Lindsay, 2009). Instead, they continue to focus on what is wrong with the person rather than what happened to them (Johnstone, Boyle, Cromby, Dillon, Harper, Kinderman, et al., 2018).

Somewhat unique to forensic services is the possibility that someone who has committed an offence may be traumatised by his or her own actions (Crisford, Dare, & Evangeli, 2008; Duncan & Miller, 2002; Fleurkens, Hendriks, & Minnen, 2018; Papanastassiou, Boyle, & Chesterman, 2004). Rogers and Law (2010) describe how

some of the referrals they receive to their service may involve individuals who are experiencing symptoms that appear directly related to their own offending.

## 2.5 Eye Movement Desensitisation and Reprocessing (EMDR) Therapy

The following sections will outline the emergence of EMDR as a trauma-based therapy, exploring its development and efficacy in treating a broader range of difficulties. An overview of the theoretical framework will be provided along with an exploration of the mechanisms involved.

### 2.5.1 The Emergence of EMDR Therapy

The role of eye movements on cortical function and the connection with higher cognitive processes has been long documented (Amadeo & Shargrass, 1963; Monty, Fisher, & Senders, 1978; Ringo, Sobotka, Diltz, & Bruce, 1994). This literature has acknowledged the connection between rapid eye movements, unpleasant thoughts and shift in cognitive content (Antrobus, Antrobus, & Singer, 1964), as well as the person-specific and idiosyncratic nature of eye movement pattern (Burke, Meleger, & Schneider, 2003). However, rather than being a natural progression from these earlier discoveries, eye movement desensitization and reprocessing (EMDR) therapy was a psychotherapeutic approach discovered somewhat by chance from observation and then further developed by Francine Shapiro in 1987 (Shapiro, 2001).

Shapiro was aware that distressing thoughts can often replay over and over again in the mind, unless something is done to consciously stop them. Within therapy, this repetition could be prevented by employing techniques in interventions such as CBT. However, on one occasion whilst out walking, Shapiro noticed that these distressing thoughts appeared to seemingly dissipate on their own. With some further exploration of this phenomenon, Shapiro observed that rapid eye movements could impact on the negative charge of disturbing thoughts. However, she soon noticed that some people struggled with the muscle control to sustain eye movements for any period of time when asked to look left and right without assistance. Hand movements by the clinician were subsequently introduced to assist with this process. Over time, Shapiro went on to develop and refine the procedure based on the evaluation of hundreds of case reports from qualified clinicians (Shapiro, 2001). The most notable change occurred

in 1990, when EMD became EMDR. This was to highlight the change in orientation from the initial formulation of a simple desensitisation to a more integrative information processing paradigm, reflective of the works of Lang (1977) and Bower (1981).

### 2.5.2 A Theoretical Framework

Shapiro (2001) developed the Adaptive Information Processing (AIP) model to provide a theoretical framework to guide case conceptualisation within EMDR therapy. It is argued that new experiences are assimilated into already existing memory networks, enabling useful information to be learned and stored in the memory networks along with emotions. These memory networks are seen as the basis of attitudes, perception and behaviour, and that when working efficiently, we learn something about ourselves and others which allows us to better understand past situations and similar situations that may occur in the future (Solomon & Shapiro, 2008). When someone experiences trauma, it is suggested that an imbalance occurs within the nervous system and that the information processing system no longer performs effectively. Any information gained at the time of the difficult event, such as sounds, images or affect, is said to be maintained neurologically in its distressing state, which can subsequently be triggered at any point and result in PTSD type symptoms.

Shapiro outlines the mechanisms involved in the procedural elements, which help to facilitate information processing and argues that there is a link established between consciousness and the site where the information is stored in the brain (Shapiro, 2001). It is argued that the dual attention element activates the information processing system and allows processing to take place. Once this has occurred, then individuals are no longer distressed by the initial experience and with greater understanding are able to move forwards and process new information and experiences adaptively.

A further key concept within the AIP model is that we all have a natural tendency towards healing and that when the processing of a memory and any blocks are removed, then healing can occur. It is also noted that Shapiro (2001) argues that processing always moves towards health and healing, often at an accelerated rate but

that it never moves towards dysfunction. This would suggest that you cannot make someone more likely to feel self-loathing or place inappropriate blame on themselves through processing using EMDR. However, this is different to, and does not take into consideration, the powerful nature of the EMDR process and impact that this may have on the individual during processing.

Within EMDR therapy, there is a focus on personal experience, and it is accepted that experiences of many different types can play a role in our life and it is how the event impacted on the individual that is of significance. Further to the previous outlined literature around defining trauma, EMDR therapy distinguishes between big "T" and small "t" trauma (Shapiro & Forrest, 1997). Big "T" trauma is often recognised as being associated with or causing PTSD and includes serious accidents, assaults and natural disasters such as earthquakes. These are often significant events that overwhelm our ability to cope. However, small "t" trauma, is often more innocuous and less memorable. Although it may not meet a clinical definition of trauma, it is an event which has significant psychological impact on the individual and with long-lasting impact. Small "t" traumas include humiliations and disappointments, types of experiences which many children may face whilst growing up that may not be a result of direct abuse (Gold, Marx, Soler-Baillo, & Sloan, 2005; Mol et al., 2005). However, it is often when a negative belief about the self begins and processing can allow the exploration of alternatives for healing.

The AIP model and its use to explain and guide EMDR therapy and its impact is notable when considering the predictive value of uncovering life events that may underlie clinical presentations relevant to forensic services. That is, the relationship between the impact of harsh physical punishment, not just severe childhood abuse, is linked to mood disorders, substance abuse and the presence of personality disorder (Afifi, Mota, Dasiewicz, MacMillan, & Sareen, 2012; Brown & Shapiro, 2006), as well as symptoms of psychosis (Arsenault et al., 2011; Heins et al., 2011; Read et al., 2014) and sexually offending behaviours (Ricci, Clayton, & Shapiro, 2006).

### 2.5.3 The Basic EMDR Protocol

As well as "bilateral stimulation", EMDR therapy involves a number of elements from a variety of other therapeutic approaches, including psychodynamic (i.e., free association, catharsis, abreaction, symbolism), behaviourist (i.e., learning chains, generalisation, conditioned response), gestalt (i.e., removal of emotional static), Reichian (i.e., shifting of physical sensations) and cognitive (i.e., thoughts, core beliefs). To some extent, exposure therapy has also been identified, although this has been questioned as it is not maintained and is argued to involve different mechanisms (Lee & Drummond, 2008; Lee, Taylor, & Drummond, 2006).

The Basic EMDR Protocol consists of eight clearly defined stages (see Table 2), starting with a history taking. It then moves into a preparation phase, when the intervention is introduced more fully before moving on to identify and assess all of the target memories to be addressed in phase three. Traditionally, EMDR has a three-pronged approached looking at the past and present before then moving into the future.

| | *Basic Protocol* | |
|---|---|---|
| 1 | History taking | Including general background, trauma history, resource history. Finishes on assessing suitability for EMDR. |
| 2 | Preparation | Emotional regulation, therapeutic relationship, testing bilateral stimulation, describing the model, addressing fears, choosing targets. |
| 3 | Assessment | Assessment of all target (traumatic) memories. |
| 4 | Desensitisation | Use of bilateral stimulation, observing changes in image, cognition, sound, affect or physical sensations of traumatic memory. |
| 5 | Installation | Use of bilateral stimulation, observing changes in strength of positive cognition. |
| 6 | Body Scan | Observing physical sensations in relation to target memory. |
| 7 | Closure (of session) | Debrief, containment exercise if unresolved material. |
| 8 | Re-evaluation | At the end of each target, following session to track progress, at the end of treatment. |

**Table 2: EMDR Therapy Stages**

Memories, including recent triggers, will be identified at each of these stages and processed before moving on to complete a future template. A more detailed outline of this process can be found on the EMDRIA website (EMDR International Association, 2021). A video demonstration outlining phases 1-8 of a single incident trauma conducted by EMDR therapist and trainer Jamie Marich (Marich, 2017) provides an insight into what this process looks like in practice.

When considering EMDR therapy, the element that is most unique, is the use of "bilateral stimulation", which is predominantly used in phases four and five. Traditionally, bilateral stimulation has involved the therapist leading a client in a series of lateral eye movements as fast as is tolerated by the client. However, other forms of bilateral stimulation include alternating bilateral sounds or touch. Initially, these were physically executed by the treating therapist by moving his or her fingers, tapping on the client's hands or clicking close to the client's ears. Over recent years, devices such as the light bar and vibrating "tappers" have been introduced. An example of this equipment (EMDR kit, 2021) can be seen in Figure 1.

Figure 1: EMDR Equipment

During each series of bilateral stimulation, the client is asked to notice what they are experiencing and then to provide a brief description of this. This appears somewhat

similar to free association, but participants may report experiencing images, thoughts or bodily sensations (e.g., pain of a traumatic event). In addition to the fast-moving bilateral stimulation used in these later phases, it is also used at a slower pace during phase two as a "resource". Instead of being used to "process" distressing memories, the technique is used to enhance positive states, in particular a safe place exercise, similar to guided imagery.

### 2.5.4 Therapy Length

The number of sessions required to meet an individual's EMDR therapy goals can differ quite significantly, dependant on complexity. There is evidence that 83-90% of civilian participants reported an elimination of diagnostic PTSD disorder in under seven sessions (Lee, Gavriel, Drummond, Richards, & Greenwald, 2002; Rothbaum, 1997) and other studies have found significant symptom reduction in as little as three to four sessions (Ironson, Freund, Strauss, & Williams, 2002; Scheck, Schaeffer, & Gillette, 1998; Wilson, Becker, & Tinker, 1995).

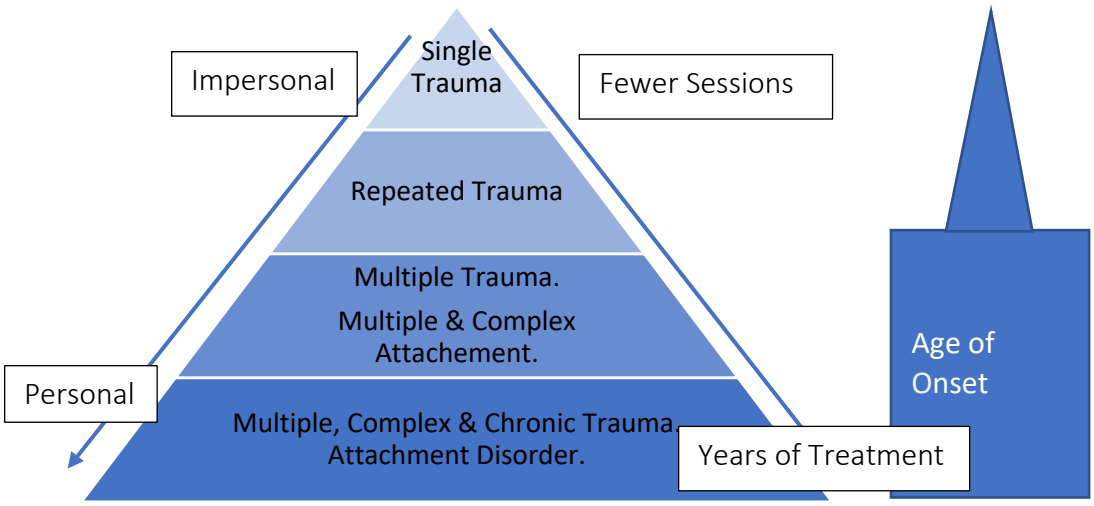


**Figure 2: Expected Treatment Duration (Morris-Smith & Silvestre, 2013)**

When considering multiple traumas associated with combat veterans, a 77% elimination of PTSD was reported after 12 sessions of treatment (Carlson, Chemtob, Rusnak, Hedlund, & Muraoka, 1998), whereas an individual who has a complex history, including multiple and chronic trauma, such as childhood abuse or neglect

alongside an insecure attachment, may require a more lengthy intervention (Korn & Leeds, 2002; Maxfield & Hyer, 2002; Shapiro, 2001). This may also include substantial preparatory work (i.e., within phase two of EMDR therapy), involving the inclusion of additional resources and attachment-focused work (Parnell, 2013). The differences in expected treatment duration and complexity of presenting difficulties is highlighted by Morris-Smith and Silvestre (2013) in Figure 2.

### 2.5.5 Efficacy and Further Application of EMDR Therapy

With a focus on trauma and encompassing cognitions, imagery and bodily sensations, EMDR therapy offers a different type of therapy compared to the talking therapies and has attracted a lot of opposition (Russell, 2008). In spite of this, in recent years, EMDR has become widely recognised as an effective approach for treating trauma outside of secure environments (Bisson, Robert, Andres, Cooper, & Lewis, 2013; Dutch National Steering Committee, 2003; Forbes, Bisson, Monson, & Berliner, 2020; Roberts, Kitchiner, Kenardy, Lewis, & Bisson, 2019; UK Department of Health, 2001; World Health Organisation (WHO), 2013). When compared to a variety of exposure protocols, with and without the use of cognitive techniques, EMDR therapy has been found to be superior to other treatments (Bradley, Greene, Russ, Dultra, & Westen, 2005; Davidson & Parker, 2002; Louise Maxfield & Hyer, 2002; Seidler & Wagner, 2006; Watts et al., 2013). Not only is the approach superior in ameliorating symptoms (Clinical Resource Efficiency Support Team (CREST), 2003), it arguably offers treatment gains in fewer sessions (de Roos et al., 2011), which are long-lasting (Edmond, Rubin, & Wambach, 1999). Further, EMDR therapy does not involve the need to directly challenge beliefs, extend exposure or involve homework (World Health Organisation (WHO), 2013).

Known for its trauma roots, the application of EMDR therapy has broadened to other mental health difficulties. Basic training programmes cover procedures and protocols for working with simple traumas (i.e., one-off events), anxiety, phobias and grief, as well somatic disorders, such as outlined by Luber (2009). However, other applications include treatment of depression and other clinical concerns, such as eating disorders, medically based trauma including birth trauma, as well as increasing performance (Shapiro, 2005, 2009).

EMDR therapy is not limited with its application to adults on an individual basis, but also can be adapted for use within couples therapy (Shapiro, 2005b). There is a wealth of research suggesting EMDR is effective after only one session with groups following man-made or natural disasters, e.g., floods, earthquakes, and war (Aduriz, Bluthgen, & Knopfler, 2009; Jarero & Artigas, 2010; Jarero, Artigas, & Hartung, 2006; Jarero & Lopez-Lena, 2008; Lovell, 2005) and it is used successfully with young children to adolescents following various traumatic events (Fernadez, Gallinari, & Lorenzetti, 2004; Fernandez, 2007; Hensel, 2009; Puffer, Greenwald, & Elrod, 1997; Ribchester, Yule, & Duncan, 2010; Wadaa, Zaharim, & Alqashan, 2010; Zaghrout-Hodali, Alissa & Dodgson, 2008).

As the scope of EMDR therapy has broadened, so has the use of protocols and techniques used. These include ego state interventions (Forgash & Knipe, 2012; Shapiro, 2016) and attachment-focused EMDR resources (Fisher, 2000; Laurell Parnell, 2013), which can be particularly useful when working with complex trauma and dissociation (Twombly, 2005). Additionally, EMDR is being used alongside other therapies, such as DBT techniques (Lovell, 2005), sex offender treatment programmes (Ricci & Clayton, 2009) and other modalities, such as art therapy (Sigal, 2017).

Overall, these additional protocols and adaptions have enabled EMDR therapy to be used with a broad range of difficulties. It is possible that participants who have complex difficulties, which are diverse in nature, are less likely to benefit from a more simplistic single protocol and are less likely to be well-researched when compared to a single event. The application to more varied areas is likely to have limited data.

### 2.5.6 The Mechanisms of EMDR Therapy

Whilst there is a growing body of evidence supporting the overall effectiveness of EMDR therapy, there remains some uncertainty in terms of the mechanisms of action involved. It is the use of bilateral stimulation which has come under the greatest levels of scrutiny and there appears more to this process than exposure (Lee & Drummond, 2008; Lee et al., 2006). Psychophysiological studies all suggest a significant reduction in arousal levels, as well as a decrease in the vividness of associated imagery

(Sharpley, Montgomery, & Scalzo, 1996; van den Hout et al., 2011; van den Hout, Muris, Salemink, & Kindt, 2001) and neurobiological studies have evidenced significant effects following EMDR therapy, including changes in limbic activation patterns, an increase in hippocampal volume and changes in cortisol (Aubert-Khalfa, Roques, & Blin, 2008; Bossini & Castrogiovanni, 2007; Bossini et al., 2011; Frustaci, Lanza, Fernandez, di Giannantonio, & Pozzi, 2010; Lansing, Amen, Hanks, & Rudy, 2005; Levin, Lazrove, & van der Kolk, 1999; Oh & Choi, 2004; Pagini, De Lorenzo, Monaco, & Niolu, 2011; Sack, Lempa, & Lemprecht, 2007; Francine Shapiro, 2001; Stickgold, 2002; Bessel van der Kolk, Burbridge, & Susuki, 1997). Additionally, there is evidence to suggest that the method of bilateral stimulation can have differing effects on efficacy. For example, although tones have been observed to reduce the vividness of memories, overall, eye movements have been found to be superior (Hovarth & Luborsky, 1993).

Various interpretations of the mechanisms involved have been presented for these psychophysiological changes, including the orienting response theory, which proposes that the directed eye movements mimic the saccades of rapid eye movement sleep (van den Hout et al., 2011). Further theories suggest that eye movements tax the working memory (Engelhard, van Uijen, & van den Hout, 2010; Gunter & Bodner, 2008; Maxfield, Melnyk, & Hayman, 2008; van den Hout et al., 2001) and increase hemispheric communication (Christman, Propper, & Dion, 2004; Propper & Christman, 2008). There appears to be support for various elements of these theories and Gunter and Bodner (2009) suggest that although specific proposals, such as the orienting response, working memory disruption and hemispheric communication, lend themselves to testable predictions, searching for one single account of how EMDR works may be misleading and introduces the possibility that multiple mechanisms may be at work.

### 2.6 EMDR within Secure Services

EMDR therapy has been used within secure services for over twenty years. Initially, used to address individual trauma related difficulties (Kitchiner, 2000) and domestic violence (Colosetti & Thyer, 2000), its use has broadened. The following sections will

explore the relevant literature regarding the application of EMDR therapy within secure services, as it relates to offending behaviour and mental health difficulties.

### 2.6.1 Offence-Related Trauma

Trauma resulting from offending behaviour is commonplace within forensic populations and has been linked to the risk of anger, future violence and recidivism (Crisford et al., 2008; Gray et al., 2003). As forensic psychiatry arguably aims to reduce violence and recidivism, Fleurkens et al. (2018) suggest that the treatment of trauma in the perpetrator is paramount, particularly considering the link between homicide, trauma and recidivism (Kubiak 2004).

EMDR therapy has been used to reduce distress in individuals who experienced offence-related trauma. One of the first studies described how someone who had committed an offence experienced frequent and vivid flashbacks of his victim's face, which had resulted in a number of mental health difficulties and a suicide attempt (Pollock, 2000). EMDR therapy was reportedly successful in reducing the individual's distress related to the single event of homicide and it was concluded that EMDR could be successfully used to address trauma caused by homicide. However, such treatment raises significant ethical issues in terms of public perception, criminal justice system aims and overarching societal benefits in terms of recidivism.

Fleurkens et al. (2018) presented a case study which aimed to expand on this. EMDR was used to treat an individual within secure services with a diagnosis of narcissistic personality disorder with antisocial and borderline features. Additionally, he experienced PTSD as a result of a murder he committed. Following treatment, the individual no longer met the criteria for PTSD, which was sustained during eight months' follow-up. However, it remained unclear what impact the treatment had on personality traits or recidivism.

Typically, talking therapies and offence-focused groups involve discussions around childhood histories and important events in the person's life, as well as discussions around offending behaviour. All of these may arguably exacerbate trauma symptoms (Doob, 1992; Mueser, Rosenberg, Goodman, & Trumbetta, 2002) and for individuals presenting with offence-related trauma, conventional therapy in itself may be re-

traumatising (Rogers et al., 2000). Not only could this impact on motivation to engage with treatment, it is possible that any unresolved trauma may severely block the positive benefits of engaging in therapy (Gray et al., 2003; McFarlane et al., 2001).

With this in mind, Clark, Tyler, Gannon, and Kingham (2014) presented a case study of an individual who committed sexual offences within the context of serious mental disorder and subsequently experienced offence-related trauma. Offence-related trauma was measured using the Impact of Events Scale - Revised (IES-R; Weiss & Marmar, 1997), in addition to Subjective Units of Distress (SUDS; Wolpe, 1990), which measured changes in emotional intensity and Validity of Cognition (VOC; Shapiro, 2001), which measured cognitive beliefs. Both of these measures are part of the EMDR Therapy process, providing a baseline and progress towards trauma resolution. A basic EMDR therapy protocol was used to effectively address offence-related trauma lending further support for the application of EMDR in this manner.

Prior to EMDR therapy, the individual had attended two CBT-based treatment groups, but made limited gains, despite appearing to engage well the second time around. It was suggested that his inability to internalise group material prior to engaging in trauma therapy, resulted in the limited, short-term treatment gains from his attendance.

### 2.6.2 Sexual Offending Behaviour

Similar to other offence-focused programmes, for the last 40 years, CBT and Relapse Prevention (RP) models are the foundation of the majority of sexual offender treatment programmes. The primary aim of these is to increase someone's understanding of their sexual abuse cycle and relapse process and, as a result, maintain behavioural changes (Freeman-Longo, Bird, Stevenson, & Fiske, 1995). Common treatment targets include decreasing denial, identifying internal and external risk factors, improving social competence, and assertiveness, increasing problem-solving abilities, reconditioning deviant sexual preferences and restructuring cognitive distortions. There had also been a significant focus on the development of victim empathy (Becker & Murphy, 1998; Salter, 1988). It is noted that, although childhood

abuse is common among individuals who have committed a sexual offence (Seghorn, Prentky, & Boucher, 1987), this is not a traditional focus for intervention.

The first attempt to explore the application of EMDR therapy with those who have sexually offended was conducted by Datta and Wallace (1996) who investigated whether the treatment of childhood trauma using EMDR therapy could increase empathy towards victims and reduce anxiety in adolescents who have committed sexual offences. It was argued that the intervention could disrupt the offence cycle and in turn impact recidivism rates. Their study, although small (sample size of ten, participants), indicated that as little as three EMDR sessions could reduce anxiety-related symptoms and increase empathy towards their victims for adolescents with a history of sexual offending. Further, it was noted that restitution attempts with the victims were made by the participants. This is notable in that a large proportion of time within sex offender treatment groups focuses on increasing victim empathy, viewing this as an important element in reducing recidivism (Carich, Metzger, Baig, & Joseph, 2003). However, there is some subsequent suggestion that within some interventions this can be unnecessary or even harmful (Mann & Barnett, 2012) and that treatment around empathy may be more nuanced than initially understood (Varker, Devilly, Ward, & Beech, 2008).

A subsequent study incorporated EMDR therapy into an adult sex offender treatment programme and found that significant changes were found in relation to justification of offending behaviour, treatment attitudes and paraphilia (Finley, 2003). However, caution was advised, based on the use of the Multiphasic Sex Inventory (MSI) to assess sexual offending behaviour and thinking patterns (Kalichman, Henderson, Shealy, & Dwyer, 1992). The application of EMDR alongside traditional groups was further explored by Ricci (2006) who presented a case study for an individual who had engaged in incestuous sexual offences and who had admitted his crime. The study noted that the offending behaviours paralleled the individual's own abusive experiences, in terms of the victims being a similar age range and following similar patterns of grooming and offending. On reflection, it was argued that it may have been these dynamics that made this a successful intervention. However, the importance of flexibility when processing cognitive distortions was also highlighted

and it was considered that in more conventional treatment approaches, this may have not been possible as providers may have been unwilling to take this perceived risk with their clients.

Ricci and Clayton (2009) reflected that within traditional approaches, it was possible that even if someone appeared strongly motivated to engage in therapy, they may stall at a later point in therapy. In part, it was believed that this was due to unresolved trauma, and related to difficulties with attachment, trust and self-regulation. This echoed the arguments put forward by Clark, Tyler, Gannon and Kingham (2014), regarding an offender's ability to fully utilise talking therapy when traumatised. To investigate this, ten individuals with a reported history of childhood sexual abuse, and who went on to commit offences against children, were engaged in EMDR therapy. This occurred alongside their engagement in a standard cognitive-behavioural therapy-relapse prevention group treatment (Ricci, Clayton & Shapriro, 2006). The results indicated that when compared to the control group, significant levels of trauma resolution were observed. However, somewhat unexpectedly, they also noted a decline in deviant sexual arousal, as recorded by Penile Plethysmography (PPG) and Polygraph examination, which was sustained. This was of significant interest, due to the strong association with sexual recidivism (Barbaree, Blanchard, & Langton, 2003) and difficulties reducing this with other approaches that do not incur ethical issues (Fuss, Auer, Biedermann, Briken, & Hacke, 2015). This decrease in arousal was associated with a reduction in sexual thoughts, increased motivation for treatment and increased victim empathy.

Further case studies outline the application of EMDR for both males and females who have committed sexual offences and summarise typical referrals, participant commitment and beliefs regarding offending behaviours prior to commencing therapy. These offer further evidence for the applicability of EMDR in the treatment of sexual offending behaviours, as well as offering recommendations for clinical practice and application (Ricci & Clayton, 2009).

A further single-case study illustrates how EMDR therapy can be beneficial to someone who was a victim of abuse and then went on to commit a sexual offence and retained

cognitive distortions (Ten Hoor, 2013). The individual had not perceived his childhood sexual experiences as negative and, as such, did not understand the harm in his own offending later in life. After making limited progress after a year in cognitive-behavioural group therapy, cognitive distortions appeared to resolve in as little as nine EMDR sessions. He was also subsequently more open and engaged when he attended further group sessions.

### 2.6.3 Psychosis, Distressing Beliefs and Hearing Voices

Clinicians have been reluctant to work directly with trauma in individuals who experience psychosis with these experiences often being viewed as an exclusion (Spinazzola, Blaustein, & van der Kolk, 2005). This view has been challenged in recent years and trauma work is increasingly viewed as an important addition when working with someone experiencing psychosis (Callcott, Standart, & Turkington, 2001; Frueh et al., 2009).

Miller (2016) highlights the need to look beyond diagnostic labels and look more closely at the individual's experience, explaining that what we see is not the problem, but the result of the underlying problem and that EMDR can help target dysfunctional memory networks that are present. Within his work, Miller describes how the diagnosis commonly known as schizophrenia is grounded in trauma and dissociative roots (Ar & Öztürk, 2009; Burgy, 2008; Moskowitz, 2005; Moskowitz et al., 2008; Read et al., 2004; Ross, 2013; Shevlin, Dorahy, & Adamson, 2007) and also of relevance is the link between dissociation and violence (Moskowitz, 2004). When taking this into account, it is suggested that these experiences may benefit from treatment through trauma-based interventions such as EMDR therapy. Miller (2016) argues that when psychotic phenomena are considered through EMDR's AIP model, they can be understood as resulting from dissociated and unprocessed material.

EMDR therapy had been used to work with "parts" (Forgash & Copeley, 2008; Forgash & Knipe, 2012; Shapiro, 2016) or ego states (Shapiro, 2016) and, based on this work, Miller (2016) started to explore the benefits of using such an approach within the EMDR framework when working with psychosis. At this point, research around the use of EMDR therapy to treat trauma was being conducted in Spain (Gonzalez, Mosquera, & Moskowitz, 2012), Japan (Kikuchi, 2008), Korea (Kim, Choi, & Kim, 2010), Turkey

(Yaşar et al., 2018) and the Netherlands (de Bont, van Minnen, & de Jongh, 2013; de Bont et al., 2016; van den Berg et al., 2015, 2013; van den Berg & van der Gaag, 2012; van der Vleugel, ven der Berg, & Staring, 2012), as well as in the UK and Australia (Helen*, 2015; Laugharne, Marshall, Laugharne, & Hassard, 2014), which was demonstrating some benefits and that trauma work can be conducted safely with this population (van den Berg et al., 2015).

In many cases it would appear that the standard protocol is sufficient (van den Berg & van der Gaag, 2012). However, in some cases a little modification is required. An example of this is given by van den Berg et al. (2013) who clearly outline two methods to approach treatment for those individuals experiencing psychosis. The first method is applied when experiences are clearly and directly connected to symptoms; for example, targeting the first onset of voices, delusions or paranoia. The second method focuses on those past experiences that are considered to exert a more indirect influence on current difficulties; that is, those negative experiences that may have created the formation of negative schema such as bullying, childhood abuse and adversity. Moving on from these minor adaptations, Miller (2016) developed the Indicating Cognitions of Negative Networks (ICoNN) model which outlines four categories of possible presentations of psychotic phenomena. It is based on these presentations that the clinician decides how to approach formulation and treatment planning. Throughout, Miller highlights the importance of a solid foundation in treatment approach and to be clear about their reasons when modifications are utilised.

In summary, this appears to be an area showing promise and highly relevant to treatment options within secure services. However, the application of these interventions and the evidence base at the current time remains in the early stages.

### 2.6.4 Personality Disorder

Throughout the world, individuals diagnosed with a personality disorder, and who commit offences, often challenge forensic systems (de Reuter & Trestman, 2007). As well as those who present with traits more commonly associated with aggression and violence (Fleurkens et al., 2018), secure services also need to address the needs of

those individuals who have received a diagnosis of borderline personality disorder (BPD). Darker-Smith (2016) highlights how the complexity and psychological distress seen in those with this diagnosis may result in behaviours that often break societal rules.

As previously outlined, trauma and childhood abuse are viewed as significant features with someone diagnosed with BPD and, as such, may benefit from an intervention such as EMDR therapy. During a presentation on adapting the EMDR protocol to work with BPD, Darker-Smith (2016) described an 8-stage process with techniques and strategies to be incorporated for each stage. In particular, it was suggested that there needed to be an increased focus on resourcing and validation, as well as a different process for target selection due to the unconscious driver at work. Additionally, it was noted that a Blind to Therapist protocol, a protocol that allows the client to use a standard protocol without revealing the content (Blore & Holmshaw, 2009), is utilised to reduce the possibility of reinforcing care-eliciting behaviours, which may prove problematic during therapy.

Albeit in its infancy, EMDR therapy is being explored with positive results within this group. Brown and Shapiro (2006) specifically highlighted difficulties with impulsivity and affect instability, as well as interpersonal difficulties and identity problems for this group, which can lead to suicidal and parasuicidal behaviours. A case study was used to demonstrate positive effects noted when using EMDR therapy in the treatment of BPD and suggested some preliminary supportive evidence. The outcome was remarkable in achieving symptom resolution and stabilisation, alongside the enhancement of personality functioning within months, as opposed to years. However, it was noted that stabilisation and therapeutic relationship had occurred prior to the EMDR therapy commencing.

The need to make adaptions to the basic protocol was further explored by Mosquera et al. (2014). They noted that individuals with a diagnosis of BPD, who presented with structural dissociation, may benefit from interventions to deal with this (Gonzalez & Mosquera, 2012) and for which EMDR has proved beneficial (Wesselmann et al., 2012). However, many individuals only required limited amounts of stabilisation and

few modifications to the standard EMDR protocol to effectively access and reprocess traumatic material. It was also highlighted that when developing and organising safe and effective EMDR treatment plans, a core issue related to the therapist's skill and need for advanced level of expertise.

Dialectical Behaviour Therapy (DBT: Linehan, 1993) is a well-known evidence-based approach for working with individuals with a BPD diagnosis. Lovell (2005) described using DBT techniques in trauma and abuse recovery groups for women. She suggested that DBT can provide a sound base for the group, but that EMDR and other therapies and resources used alongside complete this process. These results were further supported by the work of Potter, Davidson and Wesselmann (2013) who provided a rationale for, and outlined, a programme which integrated DBT and EMDR. The phase-based programme consisted of a skills-training phase utilising DBT lasting a year, followed by 18 individual sessions of EMDR. Three case studies illustrate the effectiveness and results demonstrated an improvement in mood, behaviour regulation, relationships, psychiatric symptomatology and ability to cope with present-day stressors following the DBT phase. Further to this, participants maintained or continued improvement in the aforementioned areas, as well as showed positive changes in trauma symptomatology and attachment style following intervention using EMDR.

### 2.6.5 Summary

The importance of trauma resolution in those who have offended, with or without specific mental health difficulties, has been raised. This has been explored through case studies, as there continues to be limited opportunity to investigate this on a larger scale with robust and randomised studies. The flexibility and client-centred nature of EMDR can be its strength, with the therapist adapting to the needs of a complex client through the use of additional resources and adapted protocols. However, this does not lend itself to a structured intervention that is easily replicated and researched within secure services.

## 2.7 The Therapeutic Relationship

The following sections outline the literature related to the relevance of the therapeutic relationship when working with individuals who have committed offences and when using EMDR therapy.

### 2.7.1 The Importance of the Therapeutic Relationship

The therapeutic relationship is often viewed as central to gaining a positive outcome (Lambert, 1979; Lambert & Barley, 2001) and in some instances viewed as the most important factor relating to a positive outcome (Hovarth & Luborsky, 1993). Therapeutic outcome has been the focus of extensive research (Bachelor, 1988; Greenberg, Elliott, & Lietaer, 1994; Lambert & Okiishi, 1997; Orlinsky, Grave, & Parks, 1994; Sloane, Staples, Cristol, Yorkston, & Whipple, 1975; Strupp, Fox, & Lessler, 1969) and a summary of more than 100 studies was conducted by Lambert and Barley (2001). However, some caution should be given as, although based on extensive reviews of the literature, the data was not derived from meta-analytic data techniques.

Lambert and Barley (2001) summarised that factors occurring outside of therapy are most highly associated with positive outcome (40%), such as social support, fortuitous events, or spontaneous remission. However, closely following this are the common factors found in most therapies (30%), more specifically, the client therapist relationship, and includes a number of overlapping elements including therapist attributes, interpersonal style, and facilitative conditions (Dai et al., 2016; Feng et al., 2007; Sippel, Pietrzak, Charney, Mayes, & Southwick, 2015; Stephens, Long, & Miller, 1997). Some of the identified attributes including therapist credibility, skill, empathic concern, affirmation, empathic understanding, as well as often using an indirect approach focusing on the client's problems, are very similar to the conditions proposed by the person-centred approach developed by Carl Rogers. Finally, the techniques (e.g., hypnosis, systematic desensitisation) used in therapy were placed at a similar level as expectancy variables including the placebo effect (both around 15%).

For individuals with complex trauma, the therapeutic relationship has been viewed by clients as one of the most important mechanisms for assisting change, with recommendations for observing this in practice (Ward & Maruna, 2007). Terror and safety are incompatible and Van der Kolk (2014) describes how in order to recover

someone needs to be convinced on all levels that it is safe for a person to connect with memories of past helplessness and the relationship is central to achieving this.

### 2.7.2 The Therapeutic Relationship and Motivating Individuals who have Offended

The development of a therapeutic relationship can be challenging for many. However, those seeking support in society often enter therapy when the desire to change overcomes any uncertainty about engaging in the therapeutic process. For those individuals detained within secure services, this can often be a very different experience and comes from a place of resistance and mistrust. Traditionally, those who have offended have been deemed motivated if they agreed with the professional point of view (Seligman, 2017).

#### *2.7.2.i Use of Coercion*

Marlowe, Festinger, Dugosh, Lee and Nenasutti (2007) described how the societal and political system within England and Wales has aimed to reduce offending through increasingly coercive methods. One of the most controversial aspects of service provision within the criminal justice system provision is that of individuals being forced to receive psychological treatment, with a stronger focus on issues of reducing crime than on individual welfare (Garland, 2001). This has resulted in interventions being more offence-focused than client-centred. That is, the offence is no longer the result of a difficulty, but becomes the central problem to be addressed, i.e., sex offender treatment programme, rather than treatment to address difficulties in a range of areas. Garland argues that this shifts the focus from rehabilitative work, being more for the benefit of the victims than the benefit of the individual who has to engage in the work.

Further to this it was noted that sensitive, confidential information may be shared with a number of people working within services and associated agencies, resulting in outside forces breaking the boundaries of the therapeutic relationship. Changes in the approach to therapy and awareness of risk has resulted in clients always being on guard to preserve best interests, which only allows for partial self-revelation, an avoidance of full alliance, with only limited degrees of trust. This judicial involvement when considering compulsory treatment for substance use was argued to have a

harmful impact on the therapeutic relationship and on what information is discussed for fear of it being used outside of the therapeutic space (Castonguay, Constantino, & Grosse Holtforth, 2006).

A systematic review of studies assessing the outcomes of compulsory treatment was conducted by Werb et al., (2017). The result of the review suggested that compulsory treatment approaches offered no benefit and some studies suggested that this could have a detrimental impact. There was also limited scientific literature evaluating compulsory drug treatment, which is of note considering that this can form part of offender rehabilitation and is even mandated by court. When considering the potential for human rights abuses when treatment is made compulsory within these settings, Werb et al. (2017) recommend that non-compulsory treatment options should be prioritised seeking to reduce drug-related harms. Although the study focused directly on substance use, it may be that similar results would be found in other enforced treatments. Further, when an individual is not motivated to engage in an intervention, McMurran and Theodosi (2007) found that it is possible that treatment non-completion may make some individuals more likely to reoffend.

Whether treatment is compulsory or not, Miller and Rollnick (2002) argued that the most effective way to influence behaviour change is through an empathic and empowering approach, enhancing people's intrinsic motivation to change. This approach initially found success when working with substance use but has been applied effectively to a range of clinical problems including sexually offending behaviours (Burke, Arkowitz, & Dunn, 2002).

#### *2.7.2.ii Individual Characteristics*

Individual characteristics may impact on an individual's ability to form appropriate attachment and bonds, and the therapist may have to adapt their approach to respond to this (Constantino, Arnow, Blasey, & Agras, 2005; Day, Casey, Ward, Howells, & Vess, 2010; Gibbons, 2003). In particular, consideration should be given to therapy goals and to ensure that these are not only aligned between the client and therapist, but also that the therapist believes that they are achievable (Lingiardi, Filippucci, & Baiocco, 2005). Additionally, if the client is unfamiliar with the therapy and does not

believe it will be successful, this can impact the therapeutic alliance and subsequent outcome.

The severity of mental health symptoms can also have a significant impact on an individual's ability to form a therapeutic alliance, although there is some inconsistency in the research (Day et al., 2010). Identified difficulties included psychosis, depression and anxiety, as well as more pervasive characteristics such as interpersonal difficulties, high levels of defensiveness or hostility. In particular, it was noted that this would generally make a trusting relationship more difficult. A further difficulty, commonly found particularly within forensic populations, was that of paranoia. This can impact on the ability to form an alliance more so than other personality disorder traits, including borderline or antisocial personality disorder (Lingiardi, Filippucci, & Baiocco, 2005), where strategies should be used to prevent rupture in the relationship (Day et al., 2010).

### 2.7.3 The Therapeutic Relationship and EMDR

There has been some suggestion that the therapeutic relationship within EMDR therapy may not hold the same value when compared to alternative therapies. Edmond, Rubin and Wambach (1999) found that when compared with a more eclectic approach to therapy, participants who engaged in EMDR made little reference to the therapeutic relationship. This was in stark contrast to those participants who engaged with a more eclectic approach and partially attributed the success to the relationship that they had with the therapist. In particular, these participants referred to aspects such as the support, acceptance, validation and non-judgmental approach that they had encountered. In contrast, those participants who engaged with EMDR therapy made little reference to their therapist unless directly asked. Although these participants spoke highly of their therapist, they did not specifically link the success of their treatment to the personal qualities of the therapist, but rather how well they carried out the process of EMDR.

A parent study by Orlinsky et al. (1994) further explored the therapeutic role within EMDR therapy in women's recovery experiences (Marich, 2010). In particular, this was related to assuring client safety, which was viewed as necessary prior to commencing

EMDR therapy. Within this study, a number of qualities pertaining to that of a good EMDR therapist were identified.

> Therapist personality, ability to empower clients, flexibility (regarding rigidity to set EMDR protocols), intuition, a sense of ease and comfort in working with trauma, and a commitment to the small measures of caring that former clients identify as helping them feel safer. (Orlinsky et al., 1994, p.402)

An identified sub-theme was the 'Role of the EMDR therapist', which was further described as feeling that they were in capable hands with their EMDR therapists, which facilitated fulfilling EMDR experiences for the women (Shapiro, 2001). It is noted that two of the participants believed that they needed to change therapists to benefit from the EMDR process. The first of these participants believed that her first therapist was "rigid, scripted and not comfortable with trauma work" (p.411), and that a focus on the scripted protocol and acquiring ratings was carried out at the expense of developing a rapport. However, the therapist with whom the participant was eventually able to progress, was described as "intuitive, natural and very comfortable with trauma work" (p.411). Another participant within this study highlighted the need to have confidence in the therapist and how a seemingly overly anxious therapist can make the client feel like they are at fault. Again, this appears to reflect research around the therapeutic relationship (Orlinsky et al., 1994). A subsequent study by Whitehouse (2021) further acknowledges the link between the techniques used by a therapist, the relationship with the client and the impact of the environment. This study notes that these elements are indeed necessary to effect change when using EMDR therapy.

Although the protocols used within EMDR are argued to be of high importance and strictly adhered to (Shapiro, 2005a), it has been asserted that there is a need for a strong therapeutic relationship due the potential for high levels of disturbance during an EMDR therapy session (Leeds, 2009; Lipke, 2000; Luber, 2009; Mailberger, 2009). Clients need to be able to be truthful about their experiences for EMDR therapy to be effective. Although details of prior traumatic experiences may not be necessary, being able to accurately divulge the nature and intensity of feelings and experiences during

a session is paramount. Premature termination of the target memory may occur if low levels of distress are inaccurately reported. It is argued that this can often occur when there is insufficient trust between the therapist and client. If this occurs, then not only could this lead to ineffective processing, but also clients may be at an increased risk of suicide, as they may feel greatly disturbed but unable to communicate this with the therapist. Shapiro (2001) highlights the particular importance of a therapist conveying safety, flexibility and unconditional regard. It is argued that these aspects should be carefully observed when working with individuals who have experienced severe abuse within their background histories, as they may experience issues around trust and safety. It is noted that building rapport in terms of safety and confidence may take months of regular sessions with some clients, yet only a couple of sessions with others. Regardless of length of time, EMDR therapy should not be attempted without this.

The importance of safety within the therapeutic relationship is also acknowledged by Greenwald (2007), who identified that a client will be unlikely to work with, and divulge trauma memories, to a therapist with whom they do not feel safe. He argued that if a child (or adult) has relatively secure attachments and working on a single incident trauma, then this may not be an issue if they understand the goals and the therapist is not outwardly offensive. However, those with more complex histories will likely have more issues around trust and affect tolerance, requiring more work around relationship building. It was suggested that clients will need to feel safe with the therapist for them to be able to seek emotional support and for the therapist to help them tolerate the emotional pain during the sessions. It was also suggested that the therapist will be tested in small ways and that by passing each test, sufficient trust will be built to work on more challenging and riskier things.

Therapeutic relationship has often been discussed (Leeds, 2009; Lipke, 2000; Luber, 2009; Mailberger, 2009). However, it was Greenwald (1994) and Norcross (2002) who directly acknowledged the relationship and interconnectivity of protocols and procedure with a good therapeutic alliance. Once again, the importance of safety is highlighted, particularly for those clients who may have experienced complex trauma. Parnell (2013) describes how the relationship can be used as an essential resource throughout therapy. However, trust is not only one-way within therapy, and the

therapist must also learn to trust the client and that they are being truthful about their experiences and related behaviours. Until this level of trust is achieved, it is recommended that EMDR does not commence.

Dworkin (2005) also observed how relational issues between the individual and the therapist can indicate whether outcomes from EMDR are positive or negative. He described how the therapist "anchors" the client in the present and in a safe relationship from the beginning and before any bilateral stimulation occurs. He goes on to discuss how the client's traumatic experience can be shared and that they are no longer alone. Dworkin also reflects on how EMDR can be seen by some clinicians and researchers as a standalone method which focuses on the procedural process and argues the importance of always working relationally. He reports that difficulties can arise when clinicians focus more on the techniques and procedural aspects and this relational aspect could be lost. This is not to say that procedure can be dismissed, as this can also result in harm (Briere & Scott, 2006), without which the clinician "could open Pandora's box" (p. 31, Briere & Scott, 2006), suggesting that there is a balance to meet between the relationship and protocol.

## 2.8 Summary and Research Aim

EMDR therapy is not seen as an offence-focused intervention and there are no mandatory requirements for a service user to engage. As such, service user motivation for engaging within EMDR therapy may be different to other offence-focused interventions. It could be argued that a service user engages in EMDR therapy solely for their own benefits, suggestive of a more meaningful engagement. This is of note when motivation has been a pre-requisite and essential component for treatment (McMurran, 2009), with secure services targeting resources towards programmes and clients most likely to benefit (Williamson, Day, Howells, Bubner, & Jauncey, 2003). In recent years, therapists have gradually started using EMDR therapy within these environments. However, there remains limited information about the potential use and role of EMDR therapy within secure services. Currently, little is known about service user experiences of why they engage in EMDR therapy and how it may be beneficial to them in terms of their recovery and/or risk reduction.

EMDR therapy offers a somewhat unique alternative to more traditional talking therapies, which have historically been dominant within secure services, or even the more creative therapies occasionally offered. Furthermore, EMDR therapy has traditionally not had an explicit offence or risk focus and is not mandatory. The overarching aim of this study was to develop an understanding of service users' personal experiences of EMDR therapy within secure services of all security levels. More specifically, this study will:

- Provide the opportunity for participants detained under the Mental Health Act (1983) to communicate their understanding of their current situation and personal experiences of EMDR therapy, whilst residing within a secure service.
- Explore the different ways of engaging in EMDR therapy and how the therapy may have influenced their feelings, attitudes, beliefs or behaviours.
- Explore whether the referral process was a collaborative process and how this therapy may have differed from previous interventions offered.

A further potential outcome of this study will be to inform the utility and application of EMDR therapy within secure settings, in turn informing resource needs.

# Chapter 3: Method

This Chapter will provide an outline of the methodology undertaken with consideration to design, recruitment, participant information, ethics, interview procedure and analysis of data.

## 3.1 Design

The overarching aim of this study was to develop an understanding of personal experiences of EMDR therapy within secure services; how the world is seen and understood from their perspective.

### 3.1.1 Qualitative Methodology

In its most simplistic form, qualitative methodology uses words as data (Kuhn, 1970) that can be collected and analysed in a variety of ways. However, further consideration needs to be given to whether qualitative research is the term being given to a tool or technique of data collection or to a wider-arching framework being implemented (Marecek, 2003). Such a framework could imply the involvement of shared assumptions, practices and values (Zahavi, 2003), thereby highlighting epistemological differences, which would impact on the research orientation. How decisions are made within a piece of research depends not only on the research question, but on the methodological framework. When considering different qualitative methodologies, each has its own specific framework and can approach data differently.

Qualitative methodology is underpinned by ontological and epistemological assumptions, concerning what kind of "truth" the researcher is interested in (Willig, 2013). The current research aimed to explore service user experiences of EMDR therapy, suggestive of an experiential approach. When aiming to understand a specific aspect of our human experience of the world, a phenomenological approach is often adopted (Smith, 2015; Smith, Flowers, & Larkin, 2009). As humans, we experience the world in unique ways, and it is argued that it is not possible to separate what happens in the world from the internal experience of the subject. Phenomenology focuses on the quality and texture of an experience, asking what something was

actually like for the person, involving consideration of thoughts, feelings and perceptions. This offers an alternative to a focus on the structures involved or what might "actually" be happening in "reality". For example, the focus is not intended to be based around exactly what is happening in the brain whilst engaged in EMDR therapy or around any observation changes. The phenomenological process has been likened to that of a person-centred counsellor who empathically listens with positive regard (Giorgi, 1997) and accepts that the same event may be experienced in a number of different ways by an individual.

### 3.1.2 Interpretative Phenomenological Analysis (IPA)

Interpretative Phenomenological Analysis (IPA) is one of the methods, informed by phenomenological philosophy, and developed to explore an individual's personal experience or account of an object or event (Brocki & Wearden, 2006). Moving from a descriptive approach (Smith, 2015) to that of the individual experience, IPA is more closely aligned with hermeneutic phenomenology. That is, IPA seeks to understand the meaning of an account and involves a reflective element by the researcher. It requires the researcher to step outside and consider social, psychological or cultural meanings, placing experience and an individual's account of this in a wider context. IPA research requires the researcher to acknowledge their own personal perspectives, including research interests, theoretical groundings and why they undertook their research (Brocki & Wearden, 2006). When considering this approach, it is further noted that IPA can be particularly useful whereby an experience may involve a novel or complex process and where the researcher can flexibly explore an area of concern or interest (Attride-Stirling, 2001; Boyatzis, 1995; Tuckett, 2005).

### 3.1.3 Thematic Analysis

When considering alternative approaches, thematic analysis (TA) offered a flexible and widely used approach to data analysis that did not require commitment to a particular epistemological orientation. Braun and Clarke (2013) defined thematic analysis as:

> A method for identifying, analysing, and reporting patterns (themes) within qualitative data. TA is useful in the canon of qualitative analytic approaches, because it offers a method - a tool or technique, unbounded by theoretical

> commitments – rather than a methodology (a theoretically informed, and confined framework for research. (p.297)

TA's developmental history is, arguably, less coherent than other qualitative approaches such as IPA, which are viewed to have firm methodological and theoretical underpinnings. There was initially some significant discrepancy with regards to the conceptualisation of what TA is and how it should be conducted (Boyatzis, 1995; Kidder & Fine, 1987). In turn, this has resulted in a lack of clarity and confusion about how researchers approach data analysis and in opening TA approach up to significant criticism, which were both largely addressed by Braun and Clarke (2013).

Unlike IPA, which is a theoretically informed framework for research, thematic analysis is generally considered a method and not a methodology (Braun & Clarke, 2013). In TA, theory is specified at a paradigm level (e.g., qualitative as opposed to positivist paradigm), but flexible beyond this. As such, the researcher is explicitly required to bring further theory to inform their work. This involves an understanding of philosophical basis of enquiry, the assumptions that underpin procedures and to knowingly implement these.

Broadly speaking, there are three styles of TA when considering the application of qualitative techniques. The first of these, 'small q' qualitative research (Boyatzis, 1995; Kidder & Fine, 1987), focuses on coding reliability and shares many values with positivism and what is measurable. Moving on from this, is this use of a code book, which shares a more structured approach, with themes often being developed in advance (Fonteyn, Vettese, Lancaster, & Bauer-Wu, 2008). However, there is more flexibility and fluidity and themes can shift, change or be developed through the process and philosophy. As such this approach is arguably more qualitative than positivist. Finally, there is Braun and Clarke's (2014) more reflexive 'Big Q' qualitative approach. This involves qualitative techniques and philosophy and, in recent years, has become one of the most widely cited of a number of different versions (Clarke & Braun, 2017). It is fluid and flexible in its approach to themes and changes of understanding. It is considered to be an open process, which allows the researcher to conceptualise the data which may shift and deepen.

When conducting applied research, Braun and Clarke (2014) argue that it is particularly useful as a robust approach, where the results can be easily understood by those who are part of the academic community. It is further argued that this approach is effective in giving voice to socially marginalised groups, as in the current study.

One of TA's greatest strengths is its flexibility. This is not just theoretical flexibility, but flexibility within its approaches to data collection methods and meaning generation (Braun & Clarke, 2014). Within TA, the research question is not fixed and can evolve throughout coding and theme development. Often this can occur with deeper exploration and understanding of the data. Sample sizes within TA can also be flexible, with some studies having as little as one or two participants and others being much larger with interview studies of 60+.

Although there are many benefits to TA's flexibility, this has led to concerns that TA is not sufficiently sophisticated or rigorous (Holloway & Todres, 2003). Inconsistency and lack of coherence when developing themes from data, has bought into question the validity of TA as a method for conducting research. However, it is also argued that these concerns about the flexibility and variability of TA often highlight a lack of understanding (Braun & Clarke, 2006) and this can be addressed by making explicit an epistemological position that underpins the study's empirical claims (Smith et al., 2009). For these reasons alone, clarity around process and practice of method is vital (Braun & Clarke, 2013).

With regards to the current research, Interpretative Phenomenological Analysis (IPA) (Braun & Clarke, 2013) and experiential TA (Holloway, 2008) were considered. Both approaches focus on the individual and their framing, as well as the ability to explore the data as a whole and identify overall patterns. However, it was argued that TA offered the greater degree of flexibility to be responsive to the final data content and for the research question to evolve with this. It could allow the exploration of individual lived experiences (e.g., "What EMDR feels like") but also allowing the option, for example, to evaluate and compare EMDR with other therapies if this was present in the data. It is for this reason that TA was used to explore personal experiences of the

EMDR process within a secure service, more specifically, using the more reflexive 'Big Q' qualitative approach used by Braun and Clarke.

### 3.1.4 Data Collection

Interviews are often deemed the most suitable data source when a research question relates to an individual's experiences, (Patton, 2002). In particular, semi-structured interviews allow for participants to be able to respond to predetermined areas relevant to the study, as well as providing participants with the opportunity to raise issues not previously anticipated by the researcher.

When reviewing the various ways in which an interview could be conducted, consideration was given to the possibility that service users within such secure services may experience limitations on their access to computers and phones, when compared with a general population. The extent of this could be hard to predict and would be determined by the level of security within which they are detained and current service provisions. It was also possible that this could fluctuate based on mental state and current risk issues. As such, it was argued that interview via phone or computer may not be the most suitable approach. Additionally, gaining data via computers, in written form, may increase the need for participants to meet a certain level of literacy.

As an alternative to interview, researcher directed diaries could allow data to be drawn out in a similar fashion and provide a rich data source. This approach can be particularly advantageous in enabling participants to write about their thoughts and feelings as near to an event as possible. This means they rely less on memory to recall their experiences (Sandelowski, 1995). However, as the EMDR interventions may have occurred some months before, it was felt that this method was not suitable. Other forms of data collection such as focus groups, were also reviewed, but it was argued that such approaches would not provide the richness required or would not be suitable for the aforementioned reasons.

In summary, although potentially time consuming when compared to other approaches, face-to-face interviews were argued to provide the richness of data required and increased accessibility to this vulnerable group of participants, in addition to being more suited to what could be a sensitive topic.

### 3.2 Recruitment and Research Setting

Since 2001, it is a requirement of UK research funding applications to show service user involvement at each stage of the process (Department of Health, 2001), with active engagement being encouraged at all stages of the research cycle (INVOLVE, 2009; MHRN, 2012; SURGE, 2006). Significant consideration was given to Völlm et al.'s, (2017) study and how to best engage users of forensic services. It was identified how, due to issues of trust, it may take longer to develop working relationships. This was considered during interview design, although the potential for this was limited to some extent in terms of accessing a number of different trusts across the country. This study also highlighted issues around confidentiality and suspiciousness about disclosure of their data to the institutions they are detained in. I was to be based outside of the hospital trusts, but I still needed to comply with certain hospital regulations to ensure that I was granted access to conduct the research. All efforts were made to maintain confidentiality as much as possible and any limits of this were clearly explained (see 'Ethical Considerations').

Security procedures may restrict access to service users and Völlm et al. (2017) described how engagement can be limited due to the limited understanding by staff of the benefits of engaging. Further to this, the complex mental health and psychosocial needs of service users in forensic services may require adaptation to be made to methods of communication and appropriate timescales. They suggest that these practical difficulties should not be overestimated, and that they are such that some researchers may give up as a result of these difficulties. However, in turn, this can further marginalise an already stigmatised group. To overcome this, it is suggested that researchers allocate further time and resources to engaging forensic service users.

In order to recruit sufficient participant numbers, a number of NHS Trusts known to be using EMDR therapy within their services were approached. The Head of Psychological Therapy services within these NHS Trusts was contacted by the researcher, and the feasibility of the project discussed. Of those NHS Trusts contacted, three were able to confirm capacity and capability. These hospitals provided assessment, treatment and care of individuals whose rights were restricted under the

Mental Health Act (1983) and who were detained within conditions of high security and one within medium and low security. Although one hospital offered female services, this service believed that the study would coincide with another study that was due to be conducted on the female services. As such, only male services were recruited for the current study.

The EMDR therapist within each hospital was provided with general information about the study, together with the inclusion and exclusion criteria. In collaboration with the service users' clinical team, potentially suitable participants were identified. Participants were initially approached via the treating EMDR therapist employed at each unit. The researcher did not screen any personal information of the participants. Those participants who were interviewed were deemed as suitable by their clinical team, based on the information study criteria and who had expressed an interest in engaging in the study.

## 3.3 Participants

### 3.3.1 Sampling Strategy

When considering sampling within qualitative research, the aim is primarily purposive as opposed to being generalisable. This is a technique widely used in qualitative research for gaining a depth and understanding of a specific area, as well as selecting cases that are rich sources of information when resources are limited (Patton, 2002). The use of EMDR within secure services at the time of the study was considerably limited and this had a notable impact on the sampling procedure used. Not every service within the UK had trained EMDR therapists and, if they did, this therapeutic approach was either not being implemented or it was still in the very early stages. This meant that the number of suitable participants was limited, making the use of random sampling somewhat unworkable and inappropriate. Although, arguably, a purposive approach can be problematic (Patton, 2002), it was argued that other approaches such as snowballing or theoretical would not be suitable for this participant group. Additionally, it was argued that stratification was not suitable as the potential participant numbers were so limited that it would be difficult to ensure that range or diversity was incorporated into the sample. This is a vulnerable group of participants

who could arguably be a difficult-to-reach population (Patton, 2002). It was for these reasons that a convenience sampling was used.

When considering participant numbers, qualitative research tends to use smaller sample sizes, although there are no clear rules regarding this (Braun & Clarke, 2006). Guest, Bunce and Johnson (2006) made evidence-based recommendations based on their study, using thematic analysis, and their findings suggested that the basic elements for meta-themes were present after as few as six interviews. Reinharz (1992) supports this, suggesting that 12 participants are a suitable number for a doctoral level piece of research using qualitative analysis, whereas Clarke, Braun and Hayfield (2015) suggest 6-15 interviews for such a project. It is argued that this size is large enough to elicit patterns from the data, but small enough to maintain a focus on the experiences of each participant.

The current study aimed to recruit a purposive sample of the last 12 service users who had completed EMDR therapy. It was initially planned that all participants would be recruited through one hospital which had used EMDR therapy for a number of years. Due to changes in clinicians, and service users moving on, it soon became clear that other services would need to be approached in order to recruit the required number of participants. These hospitals were across the country and each within a different NHS Trust. Figure 3 outlines the process of approaching other NHS Trusts and Hospitals in order to recruit the participants within this study.

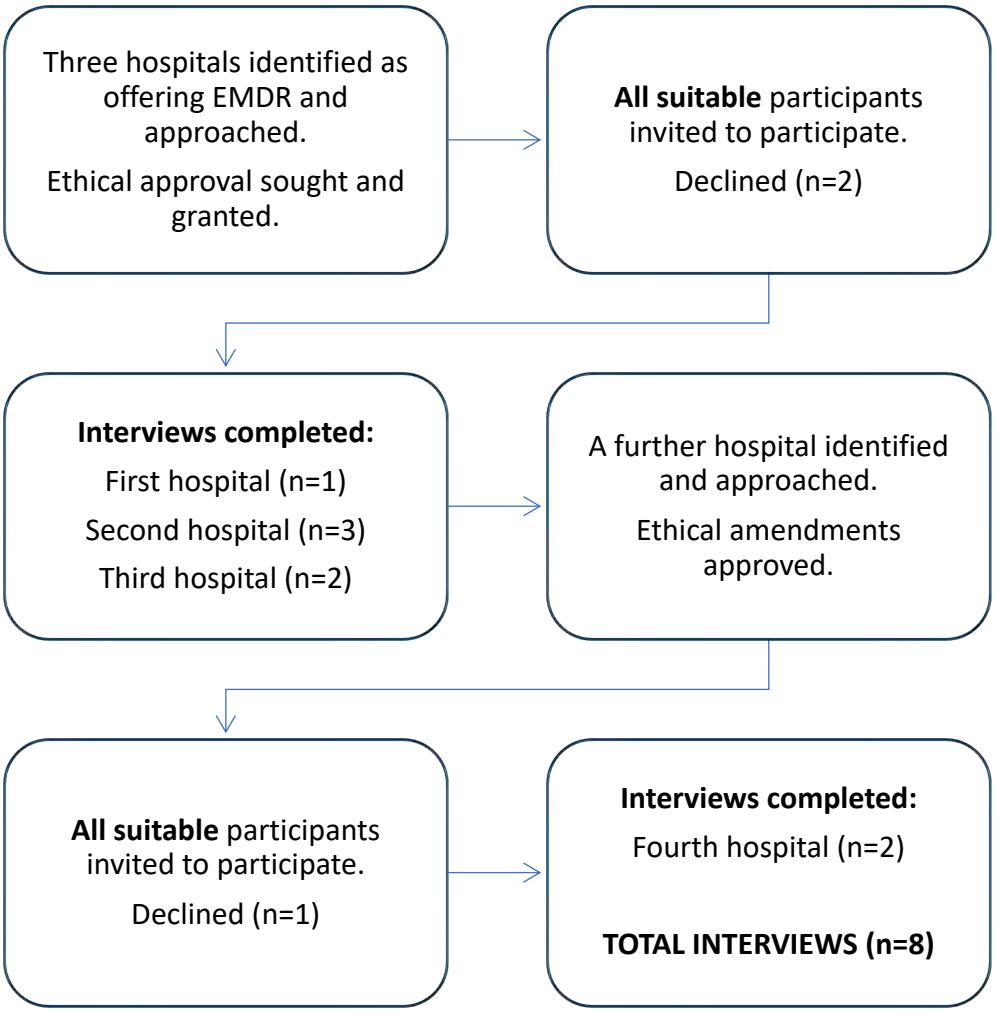


Figure 3: Sampling Procedure

Unfortunately, the study was still only able to recruit eight participants, this in spite of a notable time frame for collecting data. It appeared that this was in part due to the limited number of individuals who had completed EMDR therapy within services and the study was in fact opened to all of those who met the criteria within these hospitals. However, it is argued that this number should be sufficient for the purpose of the current study, as themes should emerge from six participants (Guest et al., 2006) in this very narrow topic. It is also suggested that the sampling changed based on availability and that most suitable participants within these hospitals were invited to take part in the study.

### 3.3.2 Inclusion and Exclusion Criteria

To be considered suitable for the study, the following areas were considered relevant when recruiting participants.

#### *3.3.2.i Engaged in and completed EMDR Therapy*

The current study did not aim to focus specifically on diagnosis or to differentiate whether difficulties had been related to single, repeated or complex trauma. Rather, the study aimed to generally explore service users' experiences of how EMDR therapy was being used within the secure services. As such, participants were only required to have engaged in, and completed, EMDR therapy. Engagement may have lasted as little as three sessions or may have continued for over two years.

It was important that participants must have completed the therapy intervention. That is, they must have met their agreed therapy goals and not disengaged. It was argued that if someone was still engaged in EMDR therapy their understanding and experience may be very different to that of someone who can reflect on the entire process after completion. Although there could be some benefit in exploring why individuals may have disengaged, it was felt that this was more suited to a separate project. Completion included progression through all eight of the EMDR therapy stages. It was noted that the complexity of an individual's difficulties may have dictated that some of the stages may have been revisited more than once during the course of their therapy (i.e., EMDR Therapy stages 3-8). As many participants within secure services were engaged in long-term therapy more reflective of complex trauma, the criteria were clarified to include completion of themes. This would allow the participant to reflect on completed therapy goals, even if they were still engaged in EMDR therapy addressing other therapy goals.

The use of, and inclusion of, EMDR adapted protocols, and/or the use of additional resources, were also not a reason for participant exclusion from this study. These additional protocols have arguably enabled EMDR therapy to be used with a broad range of difficulties and the exclusion of these from the study may have resulted in the exclusion of a number of participants due to the nature of their complex difficulties likely not fitting with a more simplistic single model protocol. As there is currently limited evidence as to the use of EMDR therapy within secure services, and the current intervention aims were to explore its application, including intervention goals, it was considered that the design of the study should not directly impact on this. For example, it could be argued that having limited or set session numbers, could exclude

participants with more complex cases, which are arguably seen within such services. As such, there were no exclusions with regards to the inclusion of additional resources or adapted protocols and no set session numbers were allocated, as this allows the therapy to be responsive to the needs of the individual and does not negatively impact or alter the study aims.

#### *3.3.2.ii Detention and Mental Health Difficulties*

All participants were detained under the Mental Health Act (1983, as amended 2007) and had been residing within a secure service at the time of engaging in EMDR therapy. Participants were invited from different secure services across the country which offered different levels of security (high, medium or low security).

All participants would have experienced complex mental health difficulties. However, specific diagnosis was not used as part of the sampling procedure. This was felt to be too exclusive and not directly relevant to the research aims and the participant pool would likely not allow sufficient numbers to be recruited.

Specific types of offence were not used as part of the sampling procedure, as this was again felt to be too exclusive and not directly relevant to the research aims. Additionally, the participant pool would likely not allow sufficient numbers to be recruited based on offence types.

EMDR therapy is a client-centred, trauma-based intervention. As part of the EMDR therapy process, clients are asked to rate Subjective Units of Distress (SUDs), which relate to the individual trauma memory currently being addressed and informs the treating therapist about the client's progress. When the SUDs have decreased to 0/10, the therapist knows to move to the next stage and possibly a new target memory. When working towards individual therapy goals, a client can identify a number of relevant target memories. Additionally, within this process, a variety of emotions can be worked with and, as such, it is more difficult to specify intervention type as you could in other therapies (e.g., cognitive behavioural therapy for anxiety, depression, self-esteem, anger etc.). Although not impossible, this would be particularly more difficult when considering more complex cases, where you are likely to encounter a variety of emotions and psychological difficulties. For example, grief and associated

target memories may elicit both feelings of sadness and anger, in addition to emotions such as shame or guilt. Once again this was felt to be too exclusive and not directly relevant to the research aims. Additionally, the participant pool would likely not allow sufficient numbers to be recruited.

#### *3.3.2.iii Language*

Participants were required to engage in interview and, as such, needed to be able to communicate using English to a level where they could express their views about their engagement in therapy. Due to time and possible financial restraints and resources beyond the remit of this study, non-English speaking service users were excluded from this study. Further, it was argued that information and nuance may be lost in the translation process.

#### *3.3.2.iv Gender*

EMDR therapy is currently used with male and female service users. To gain a broad understanding of the overall service user experience of EMDR therapy, it was decided that this study would not differentiate based on gender. However, no female participants were recruited during the study.

### 3.3.3 Key Participants Characteristics

Key participant information that was gained via interview is outlined in Table 3. This information includes diagnosis and participants' description of presenting difficulties, as well as a brief overview of engagement in prior therapy and in EMDR therapy. All but one of the participants was recruited from high secure services.

| | Name | Age | Diagnosis/ Presenting difficulties | Previous therapy? Type? | EMDR Therapy | BLS Used |
|---|---|---|---|---|---|---|
| 1 | John | 50+ | • Schizophrenia<br>• Personality Disorder<br>• Detained for 10-15 years<br>• Violence<br>• Admitted from prison | • Social Skills<br>• Anger Management<br>• Substance Misuse group<br>• CBT/DBT<br>• Schema Therapy<br>• Counselling | 2 occasions with a break (unknown time):<br>• Offence-related trauma<br>• Childhood and later abusive experiences - Ongoing | • Eye movements - fingers<br>• Tappers with lights |
| 2 | Sydney | 50+ | • Personality Disorder<br>• Substance Use<br>• Weapons<br>• Violence/aggression<br>• Admitted from prison | • Group work (PD service)<br>• Mental health awareness<br>• CBT/DBT<br>• Schema Therapy<br>• Relapse Prevention<br>• Substance Use | Completed on 2 occasions (10 years in between), the last being 2 yrs prior<br>• Childhood experiences (12 sessions)<br>• Prison experiences (12 sessions) | • Physical Eye movements - fingers<br>• Auditory headset<br>• Electronic Eye Movements |
| 3 | Joseph | 18-30 | • Self-Harm/Suicide attempts<br>• Substance use<br>• Hearing Voices<br>• Hallucinations/flashbacks<br>• Violence<br>• Detained in prison from early age | • DBT<br>• CBT for psychosis<br>• Schema Therapy | 2 occasions. Needed a break before completion 1 mth prior to interview<br>• Childhood abuse, being in care – PTSD and offending | • Tappers |
| 4 | Lee | 18-30 | • Admitted from prison | • Schema Therapy | 1 occasion<br>Prison experiences | • Tappers |
| 5 | Samuel | 30-50 | • Personality Disorder<br>• Mental illness – voices/flashbacks<br>• PTSD (nightmares/flashbacks/paranoia) and associated depression<br>• Substance Use<br>• Been in hospital for 15-20 years | • Mentalisation Based Therapy<br>• CBT for Psychosis<br>• Understanding Personality Disorder<br>• Substance Misuse<br>• Relationships and intimacy | 1 occasion<br>Childhood abuse, PTSD and more recent traumatic experiences. 8-9 mth duration. Completed 4 years ago. Refresher sessions | • Eye Movements - fingers<br>• Tappers |
| 6 | Al Jazeera | 30-50 | • Personality Disorder<br>• Anger/violence<br>• PTSD<br>• Hospital for nearly 15-20 years | • CBT/DBT<br>• Mindfulness<br>• Trauma-focused CBT | 2 occasions:<br>• 1st very short time as not ready to admit memories - disengaged. Gap of over a year between trying again<br>• 2nd completed childhood abuse but ongoing with offence focus | • Eye movements - fingers<br>• Lightbar<br>• Tappers |
| 7 | Sky | - | • Psychosis<br>• PTSD<br>• Depression<br>• Multiple hospital admissions<br>• Transfer from prison<br>• Anger and violence<br>• Long-standing difficulties – 20+ years | • No therapy in prison<br>• CAT formulation<br>• CBT<br>• Long-term violence reduction program<br>• Recovery of psychosis | Engaged for over 12 months<br>Completed 12 months prior<br>Childhood experiences – flashbacks and nightmares | • Eye Movements - fingers<br>• Tappers |
| 8 | Percy | 30-50 | • Schizophrenia (paranoid beliefs, voices)<br>• Substance Use<br>• Time in prison | • Substance Use<br>• Long-term violence reduction groups | 1 occasion. Completed goals with offence focus<br>Childhood experiences and "deeper issues" ongoing | • Eye movements using finger<br>• Tapping knee<br>• Auditory - machine |

Table 3: Key Characteristics of participants

### 3.4 The Interview Schedule

Research has not previously been conducted in this area and, as such, a semi-structured interview was specifically designed for the purpose of this study. The interview opened with introductory questions aimed to build trust, rapport and to open up a conversation with a participant (Hepburn & Bolden, 2013; Jefferson, 2004). Once topic areas and questions relevant to the research aims were identified, consideration was then given to the sequencing of these questions so that the conversation would flow through these topic-based areas (Braun & Clarke, 2013). Three main topic areas were identified and are outlined in Appendix 1. The first area related to exploring the background of the EMDR referral and the EMDR process in general (questions 1 to 4). The next area aimed to explore the EMDR therapy process itself, including the therapeutic relationship (questions 5 to 7). The final area aimed to explore an individual's understanding of the therapy process and explore any impact or outcomes identified by a participant as a result of engagement in EMDR therapy (questions 8 to 10). The final question in the interview aimed to allow the participant to raise an issue that had not been anticipated by the researcher (question 11). As necessary, prompts and probes were used to expand on the answers provided by participants to the main questions. These are identified as bulleted points within the schedule.

All of the interviews were designed to be completed with one hour. An hour is often the standard time allowed for a therapy session and, as such, likely to be familiar to many of the participants. Additionally, consideration was given to the possibility of concentration difficulties due to mental health difficulties or side effects from medication. Longer interviews may have opened up the possibility of gaining richer data. However, it was felt that this benefit did not outweigh the potential burden for this vulnerable group of individuals when concentration and frustration levels may be taxed. Interviews took between 10-60 minutes, the average being 40 mins. This interview time did not include discussions around providing information about the study, answering questions or gaining verbal and written consent, which often took an additional 10-15 minutes.

To ensure that all areas within the interview schedule would be discussed within the one-hour time frame, a standard statement was included at the start. As well as

including a basic verbal introduction to the researcher and prompts to gain informed consent, its primary purpose was to orientate the participants to the basic interview structure. It was hoped that this orientation would highlight the main areas of interest within the study. If a participant was talking at length on early questions, it was decided that the researcher would intervene and move the interview along. This would allow all areas to be addressed. Although this could limit some of the richness of data in one area, it was considered of greater importance to gain an understanding of all topic areas within this time. It was hoped that the inclusion of this statement may help move the participants forwards without prompting any negative responses from participants.

The semi-structured interview was piloted with an EMDR therapist who was experienced in the EMDR process and in working in secure services. This process did not result in any subsequent changes being made.

### 3.5 Procedure

The researcher undertook six of the eight semi-structured interviews conducted within the study. This was for reason of access to the hospital for security reasons (see 'Ethical Considerations'). Prior to the interviews being arranged, issues around consent and capacity had been addressed (see 'Ethical Considerations') and all participants were viewed by their clinical team to have met the inclusion and exclusion criteria (see 'Participants'). The Clinical Team Letter and Information Sheet can be found in Appendix 2.

Suitable participants were approached by either their treating EMDR therapist or a member of their clinical team and provided with information about the study. If a participant expressed any interest after reading the information sheets provided by their treating EMDR therapist (Appendix 3), then they were invited to engage in an interview and sign a consent form (Appendix 4). Due to the introduction of GDPR regulations (Information Commissioners Office (ICO), 2018), participants were also given information about transparency and their data (Appendix 5).

Arrangements were made with each of the hospitals, to find an interview time suitable for each participant. Where the researcher had to travel a distance, then interviews were offered over consecutive days to be flexible to participant preference and mental state. Interviews took place between September 2018 and December 2019. The length of time taken to conduct interviews was due to navigating the various issues relating to the diverse hospital security procedures in the different NHS Trusts.

Verbal and written consent was gained at the start of each interview by the researcher. The interview then provided consenting participants with the opportunity to communicate their understanding of their current situation and experiences of EMDR therapy via the semi-structured interview. This enabled participants to talk as widely as possible about the referral process, what EMDR therapy was like for them and about how the different ways of engaging in EMDR therapy may have influenced their feelings, attitudes, beliefs or behaviours.

At the end of the interview there was a de-briefing process with the interviewer. This allowed the participant to reflect on the experience of undertaking the interview and to establish whether the interview had evoked any difficult issues for them. Support for the participant could then be ensured if required. This could have been arranged with a member of their nursing team. Additionally, they were provided with the name of a psychologist who they could contact.

Due to difficulties recruiting participants, another hospital was identified and relevant amendments made to the ethical approvals (see' Ethical Approval'). However, due to security constraints within this hospital, the researcher was unable to personally conduct these interviews. As such, training was conducted so that researchers linked to the hospital, and who had undergone relevant hospital security training, were able to conduct the interviews, and further ethical approvals were sought (see' Ethical Approval'). The interview content appeared to illicit similar themes to those interviews conducted by the researcher and, as such, they were included in the current study.

### 3.5.1 Data Analysis

The interviews were audio recorded using a Dictaphone. This model had encryption capabilities and was in line with guidance from the hospitals approached to participate

in the research. Two of the hospitals required the use of their own recorder. The data was transcribed and the transcripts were checked by the head of psychological services. This was to ensure that data had been sufficiently anonymised before the transcripts were then taken outside of the hospital grounds.

The audio recordings were subsequently transcribed by the researcher using an adapted version of Jefferson transcription notation (Braun & Clarke, 2006), which can be found in Appendix 6. All names and identifying information were removed from the recorded data in order to protect anonymity. Participants were asked to identify a pseudonym at the time of interview, which was subsequently used during analysis and write up. Interview data was subsequently analysed using the six recursive phases (Braun & Clarke, 2006; Freeman & Sullivan, 2019) as found in Figure 4.

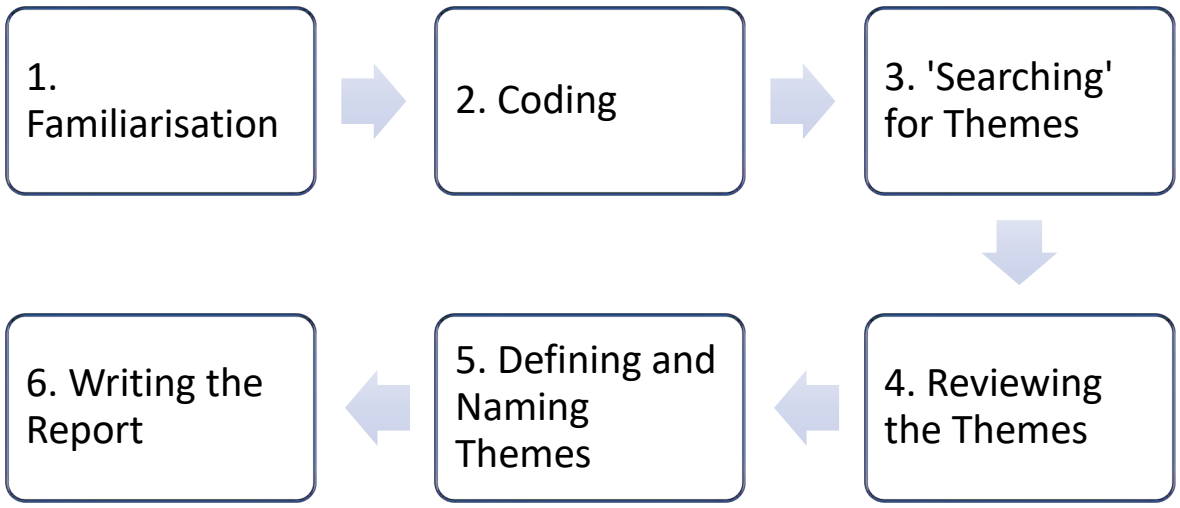


Figure 4: Six Phases of Thematic Analysis (Braun & Clarke, 2006)

An example of the coding for one of the transcripts can be found in Appendix 7. In one of the hospitals the transcription was carried out by the researchers who had conducted the interviews. It is noted that the researcher was not able to access the original data for these participants as access to this was denied. However, the transcription would suggest that all questions were covered sufficiently and were in line with the researcher's aims. A reflexive journal was kept throughout the study to

record thoughts, feelings and reflections about the process (Braun & Clarke, 2013). An example of these entries can be found in Appendix 8.

## 3.6 Ethical Considerations

### 3.6.1 Ethical Approval

Ethical approval for the research was granted by an NHS Research Ethics Committee and the copy of the final IRAS form (dated 06.02.18) can be found in Appendix 9. After attending an ethics review meeting, the study received a favourable response (Appendix 10), although further conditions and documents needed to be met (Appendix 11). Subsequent HRA approval can be found in Appendix 12, along with the substantial amendments relating to the inclusion of another hospital (Appendix 13) and changes to transcription methods and use of a recording device (Appendix 14). The study was sponsored by Cardiff Metropolitan University and ethical approval was sought following HRA approval.

In addition, the study was discussed at a 'Patient experience meeting' within one of the hospitals to raise awareness and inform service users about the study prior to it commencing. This meeting occurred after NHS ethical approval had been granted, but prior to participants being individually invited to engage in the study. At another hospital, the study underwent further peer review prior to consent being given (Appendix 15 & 16). All of the trusts and hospitals had specific requirements in addition to the original IRAS form and ethical approval. These concerns in the original procedures outlined in the IRAS, were often highlighted just prior to admission to the hospital, which caused significant delays in data collection. Once all of these separate conditions were met throughout all of the trusts and hospitals, then access was granted to all the hospitals (except one) via a research passport (Appendix 17). In the other hospital, a researcher undertook these two interviews. An example of an access letter can be found in Appendix 18 and consent to bring in a Dictaphone to one of the hospitals can be found in Appendix 19.

The results will be disseminated via an easy-read format for participants and related services (Appendix 20 and 21).

### 3.6.2 Capacity and Consent

Service users within secure hospitals are often some of the most vulnerable in society. Within a forensic environment, individuals are placed under greater restrictions when compared with the general population, and their choices are often limited. Great care was taken to ensure that truly informed consent was obtained before involving them in research. That is, participants were fully aware that they had a choice to refuse to engage in the research and that their engagement, or refusal, would have no impact on their current/future care or ability to progress.

Participants were able, during the data gathering phase, to freely withdraw or modify their consent and ask for destruction of all or part of the data that they have contributed. They were verbally informed of this process prior to signing the consent form and provided with written instructions about how to do this. This also included a reminder that withdrawal would have no impact on their access to treatment or detention. Participants were given two weeks to decide if they wanted to engage.

The privacy of participants was respected, and individuals were not to be personally identifiable. Confidentiality was respected, and any information and data collected were appropriately anonymised so that other parties would be unable to trace this information back to them. Participants were informed of the basic limits to confidentiality and the need for safeguarding where appropriate, for example, if they discussed information related to crimes that they have committed which no one knew about, or about issues relevant to safeguarding (e.g., abuse of a child or vulnerable adult). If something was disclosed, then procedures were in place to terminate the interview for the purpose of research. The reasons would have been discussed with the participant and subsequently raised with the relevant people within the hospital. The interviewer is a psychologist and is experienced with discussing issues around confidentiality and the need to discuss disclosures of further offences with the care team. Also, the interviewer has attended safeguarding training.

Consent to research protocol was critical to the ethical conduct of the research project and was compliant with the requirements of the Mental Capacity Act (2005) and The British Psychological Society's (BPS) code of ethics (British Psychological Society,

2014). Eligibility and capacity to consent to engage in the research was discussed, and agreed, with the service user's team, which included the treating EMDR therapist, as appropriate, and Responsible Clinician (RC). Participant consent was monitored by the researcher and the service user's clinical team who were observant of verbal or non-verbal signs that the participant may not be completely at ease or willing to continue. Any changes in the participant's capacity to consent would have prompted a review of their eligibility to contribute to the research. Any suggestion that the participant no longer consented would have resulted in their data being withdrawn from the study. Data would also have been withdrawn if the participant's care team recommended/requested this for any reason.

The nature of the research, and a participant's contribution, was made clear from the outset. Standard ethical procedures were used in terms of the participants being given written and verbal information about the study, of their right to withdraw and ways to contact the researcher. Giving potential participants sufficient information about the research in an understandable format required careful drafting of the information sheet, particularly as some participants may have experienced some level of literacy difficulties. A pilot test of the process for informing and debriefing was carried out with EMDR service users who did not engage in this study. No changes were made based on this.

### 3.6.3 Risks and Potential Burden for Participants

All participants had the opportunity to engage in EMDR therapy as part of their primary treatment plan. The therapy was not introduced as a new therapy being offered to the service as part of the research study and the research did not impede participants' ability to access services.

To be included in the study, participants must have successfully completed therapy. This would suggest that their distress in this area should have been reduced prior to interview. The interview primarily focused on the process of EMDR and not specifically on exploring their mental health difficulties. Although reference is made to this in the initial questions, this was to be brief and its purpose was simply to provide background around the EMDR referral. However, it is acknowledged that discussion of any mental

health difficulties may be a relevant aspect of the interview and could be distressing for a participant. As such, it was made clear that participants only need to discuss topics to the degree in which they are comfortable.

Individuals were only approached to take part in the study if their mental health was such that the treating clinicians deemed it safe. Treating clinicians used their clinical judgement to decide whether someone was emotionally and psychologically stable enough to engage. Following the interview, procedures were in place to support participants. These included informing the participant verbally and in writing that a review session would be available with their therapist or another member of the team, following the interview.

Participants had the opportunity to talk about sensitive, embarrassing or upsetting information and it was possible that criminal or other disclosures requiring action could occur during the study. The aforementioned procedures were in place with regards to limits to confidentiality and consent to address this.

### 3.6.4 Potential Benefit for Research Participants

There were no direct benefits for the participant, but it was explained that their contribution could help further understanding about service user experiences of EMDR and may inform thinking about what treatment options are considered in the future and how they are offered. Additionally, the process may have offered an opportunity to be able to reflect on their experiences.

### 3.6.5 Personal Investment

As a practitioner forensic psychologist with over 15 years' experience of working within secure services, I have worked with, and witnessed colleagues work with, a number of complex clients with a range of difficulties. Early in my career, I became interested in the impact of trauma on a service user. This was particularly apparent when working with service users who had come into the service and had reportedly "unsuccessfully" completed treatment programmes or interventions, often on more than one occasion. When reviewing these service users' needs on admission to the service that I worked in, I observed that often these individuals had significant trauma histories for which

they had not received any intervention. When talking about their offences, their own trauma was often apparent in the narrative.

I recalled EMDR therapists discussing the positive impact they witnessed, in spite of their initial misconceptions about using EMDR and not fully understanding how the process worked. After training in EMDR therapy, I noticed that I was being approached by service users to be referred for treatment when I would go onto the wards. This was something that I had not previously experienced. These discussions also seemed to suggest that service users were discussing this treatment between themselves. When reviewing the literature, I noted that there was little to no research on EMDR within forensic services, which identified a potential gap within the research literature.

When conducting the interviews, I needed to be mindful that not all experiences of EMDR may be positive and how I might react to this information and be able to gain an understanding of their experience without influencing this with my responses. Additionally, I needed to consider my role as a researcher as opposed to that of a clinician, and the limits of this.

# Chapter 4: Analysis

This Chapter presents the key themes identified in the data obtained from eight interviews with service users. The four main themes and subthemes identified through the analysis of participant experiences of EMDR can be found in Figure 5. The subsequent sections offer further details of these themes and quotes are used to offer further definition.

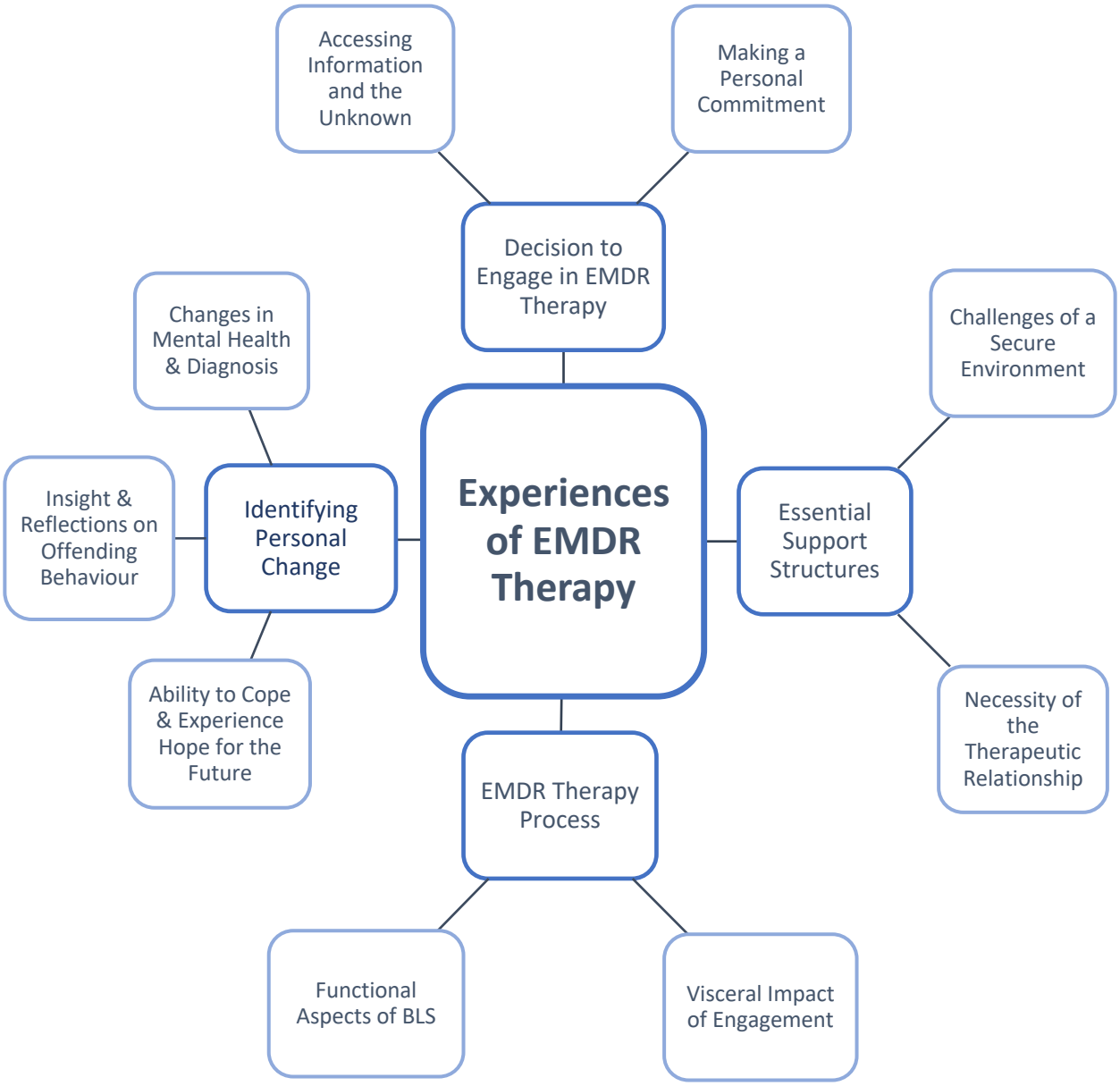


**Figure 5: Key Themes**

## 4.1 Theme 1: Decision to Engage in EMDR Therapy

This theme illustrates the decision-making process in terms of how and why participants chose to engage in EMDR therapy and is separated into two subthemes: 'Accessing Information and the Unknown' and 'Making a Personal Commitment'.

### 4.1.1 Accessing Information and the Unknown

This subtheme explores the information given to, or sought by, participants during the EMDR decision-making process of whether to engage. More specifically, this includes how participants heard about EMDR therapy, including their initial thoughts and discussions, their own personal research, and participant reflections on future needs.

When the process was initially explained, some participants had a somewhat similar reaction, albeit ranging from sounding "a bit far out" (Samuel, line 199) to believing their therapist was "completely off their tree" (Sydney, line 321). Some participants thought it sounded "crazy" (Sky, line 230), or even "mystical" (Sydney, line 347), "hokum pokum" (Sydney, line 458) or like "witchcraft" (John, line 577). This would suggest that when something is not well understood there is a temptation to doubt its efficacy and/or refer to the process as magical, mysterious or even a little crazy.

Percy was a little different in his response and although he recognised that this would not be a typical talking therapy and stated that he was intrigued, he was also clear that he did not want to be hypnotised. It is possible that this fear is linked with concerns that he will no longer be in control during the therapy and may reflect hypnotherapy as seen on TV, where participants are made to do embarrassing actions without seemingly being in control or being aware of this. It is also possible that the use of bilateral stimulation reminds participants of a swinging pendulum, classically used in the hypnotherapy process.

With the exception of Lee, the other participants had engaged in a number of other therapies and some had been detained within secure services for a number of years. In spite of this, participants such as John and Sky had never heard of EMDR therapy before it was suggested by their therapist.

> Basically I've never heard of it before because you hear about certain courses in here and stuff and in prison but I'd never heard of EMDR and then my psychologist she was like I think you fit the criteria like basically you know because I was visibly so upset every time I had a psychology session that she said you know it's clear that you're suffering and EMDR will be like very beneficial to you. (Sky, line 201)

It is possible that this may be because EMDR therapy is a relatively new addition to secure hospitals. This is supported by both John and Aljazeera speaking of the pioneering nature of the introduction of EMDR and of their therapists becoming trained, which they also appeared to be quite proud of.

For the majority of the participants (Percy, Aljazeera, Sky, Sydney, Joseph and Lee), the subject of EMDR therapy was broached by their therapist. For Samuel, the topic was approached during a Care Plan Approach (CPA) meeting by the doctor. Samuel said that he had heard the letters EMDR before and was aware that other people in the hospital had engaged in it, but he was unaware of any further details. It was also noted that Samuel's need for the intervention, based on PTSD symptoms, had already been flagged up by a therapist, and an EMDR therapist was specifically invited to the CPA meeting to explain about EMDR, including how long it might take. This would suggest that Samuel's needs had been identified by the therapist, discussed with his clinical team and finally raised at a meeting which aimed to plan future care.

John highlighted how the EMDR process was explained to him in great detail. This included what the therapy could address, how the therapy would happen, how it could impact him, and what to watch out for. John appeared grateful that this time had been given to breaking it all down so that it was understandable. Joseph also said that he initially did not understand what the therapy was and, as such, his therapist spent time with him and gave him a leaflet about EMDR. Overall, this would suggest that great care was taken by the clinical teams to ensure that the participants were fully informed and able to consent to the EMDR therapy process. For some participants, this process included information being given to them and then providing them with

the opportunity to talk about this further with the therapist and their team. This allowed them to discuss what changes they would like to happen and what they would like to get out of EMDR. For example, initial information was given both verbally and in writing to Joseph and he stated:

> You know my psychologist came to me and gave me a leaflet to what will happen in the EMDR what you know what we'll talk about how it's going to affect you and stuff like that so you do before you start EMDR you do get a you know a lot of information before you start it. (Joseph, line 551)

This information-giving approach appeared to help participants such as Sydney, John, Sky and Percy feel that this was a collaborative process and joint decision.

Although participants may have initially heard about EMDR therapy via their current therapist and clinical teams, they then engaged in further discussions with their wider clinical team, and participants again reported that the process appeared to be very collaborative. In particular, John detailed discussions between his therapist and his clinical team and how his consent to engage was explicit and involved a therapy contract which clearly outlined issues relating to confidentiality, so that everyone was clear about this.

It seemed that much of this information could be similar to that given in other talking therapies in terms of the purpose for the referrals, what it might involve and how long it might last. However, Aljazeera also spoke about other elements which surprised him. He said that it was only when his therapist started to ask about his health issues and the need to consider this that he started to view EMDR differently.

> I did think it was a load of crap but then she started going on about health issues have you got any health issues I need to know about I was saying yeah she said well if you've got this we need to think about having BLS [Basic Life Support] bags nearby just in case because this will arouse certain emotions and

> I thought that's a bit strange I've never heard that for therapy before. (Aljazeera, line 338)

It is unclear what medical conditions Aljazeera had that his team may have been concerned about, but for Aljazeera, EMDR therapy suddenly became different to the usual therapies he had engaged in as, although he may have been informed that therapies could be emotionally taxing, this was not to the extent that he might need a basic life support (BLS) bag. Interestingly, he did not report being fearful or that this revelation put him off engaging; rather, this discussion seemed to result in him taking it more seriously.

Sydney had engaged in EMDR therapy on two occasions and spoke about the differences in how he engaged in EMDR therapy on these occasions. He noted that the first time, it was suggested to him, but the second time, with an awareness of the process, he approached his team. He said that he asked for support with issues that he had been experiencing and believed that "in terms of collaboration my psychologist interpreted succinctly what I took to the table and suggested that I do that" (Sydney, line 292). This would suggest that once aware of the process and its efficacy, participants may be more likely to volunteer and refer themselves.

Although all of the participants reported that they had the EMDR process explained to them, it was noted that some of the participants also engaged in their own personal research. For example, John researched EMDR on the internet and described how it had been discovered by Shapiro whilst out walking. Samuel also looked it up on the internet through support from his family. It is unclear if he required family support due to limited internet access or due to ability. He then decided that he would like to give it a go as "it makes a lot of sense". Samuel also spoke with friends who had engaged in EMDR and they told him more about the emotional impact.

> I was reassured that EMDR would help with that and I learned from friends that it will be hard so I was prepared that it would get worse before it got better. (Samuel, line 881)

This suggests that personal experience of what it is actually like to engage in EMDR therapy is of benefit, although this experiential element of the process is further explored in Theme 3 around the importance of providing this information prior to engaging.

Aljazeera spoke about being "fascinated by how something so simple can be so effective" (Aljazeera, line 417) and, as a result of this, bought books on the subject. Although Aljazeera spoke about having had a difficult first experience of EMDR, he reported that he had suggested that his subsequent therapist get trained, suggesting that he had recognised the benefits of engaging, although he had not been ready the first time. It is noted that his second therapist did in fact become trained and this is when he engaged for a second time. This would suggest that individuals can have some influence over what therapies they are able to engage in, demonstrating an ability to express their preferences which are heard by the clinical team. Aljazeera was also keen to raise awareness but also to increase the budget for this type of therapy to be offered to others in a similar situation. It would appear that, as for Aljazeera with the potential physical impact it may have or of the emotional intensity that Samuel was told to expect, this information can help participants to prepare and reduce the impact of the shock.

In spite of the care and attention that clinical teams appeared to give to providing information to participants prior to engaging, some still felt that this was an area that could be improved. Sky spoke about wanting EMDR therapy to be promoted more and suggested that this could be done as a leaflet. He also thought it could include accounts of personal experiences and quotes about how they felt. He also hoped that this might make the therapy a bit less "scary" (Sky, line 477). Samuel believed if he had known about EMDR therapy earlier he would have "bitten the doctor's arm off […] as it's so worth doing" (Samuel, line 811). He said that because EMDR therapy was so new, he believed that it could help if individuals could hear about success stories from others. However, he also spoke about how the information that he had received from peers had made him nervous as "the only answers I got from them is

it's hard so you do go in a little bit nervous" (Samuel, line 831) and had a negative impact on him.

> There are horror stories you hear of EMDR that it really affects you and things like that that […] it needs somebody like you to put a book out there to say to say these are the horror stories […] but these are also the facts that this is how the person has benefited and this is how it's changed this person's life […] and compare that with OK you might have a couple of months of not being able to sleep or there is that bad side of it but there's a really good side that clearly outweighs any detrimental any bad side to it. (Samuel, line 1082)

As such, Samuel suggested that this could be done through some sort of advertising that offers an informative and realistic account that does not scare people and clearly presents the costs and benefits of engaging. Samuel goes on to say that this might be difficult as EMDR in a "private" (Samuel, line 1066) process but that the secrecy around the process needs to be lifted. This suggests that there is a balance needed between demystifying the process and maintaining privacy.

Aljazeera also wanted to highlight the importance of having a leaflet to explain how you might feel after a session, to fully explain the possible side effects and offer advice as to how to manage this. He also recognised how the process can be scary and that people need to be explicitly told about this and to "explain[ing] to people that it's normal […] to feel that way after EMDR because it's quite scary" (Aljazeera, line 381). Once again, this suggests that more is needed when providing information, as the usual level does not appear to be sufficient when engaging in EMDR. It is possible that it is this experiential element of the process that needs to be further highlighted and normalised. Perhaps this is because it is a new experience which can cause changes in the thoughts, feelings and body, which can happen at speed and be highly intense and could be sufficient to provoke fear and uncertainty. Interestingly, this is a therapy which is not taught by only role-play but by the therapist engaging and working on their own low-level traumas. This is to allow an experiential element of how the process works. As such, all therapists should have an insight into this process, although it may not be common practice to draw on this or discuss this with a client.

It does not appear that any of this experiential information was provided to the current participants.

As well as increasing information about EMDR therapy to service users and management about the potential benefits of EDMR, Samuel felt there should also be more advertising to the wider public.

> Just to put it out there because a large percentage of the people in this hospital are I know that we're seen as monsters and that in the press but a lot of people here are because of severe trauma major life events that have led up to what they've done. (Samuel, line 1114)

By highlighting the potential benefits of EMDR therapy and working with trauma within secure services, Samuel hoped that public perception may change from seeing people as monsters and may increase the understanding of the impact of trauma and offending.

### 4.1.2 Making a Personal Commitment

This subtheme observes the personal commitment that participants made to engaging in EMDR therapy and includes their goals, motivation and what kept them going when the intervention became challenging.

When considering personal motivations for engaging in EMDR therapy, participants spoke of their experiences of distress and difficult emotions that they wanted to change. For example, John spoke about his feelings of anxiety, worthlessness and continued issues around rejection, which could be triggered by a member of staff leaving, whereas Sky's difficulties appeared to be more directly related to his experiences of trauma and he stated that he was unable to talk about trauma without getting "dizzy and really upset" (Sky, Line 31). Arguably, these issues could be addressed by other therapeutic interventions and both Sky and John, along with other participants, had engaged in other therapies. However, it appears that these were not sufficient to meet all of their needs.

Interestingly, Joseph spoke about how he struggled to focus on interventions that were offered to him when he first came to hospital. He also spoke about how he "wasn't a good person you know I was always fighting I was taking drugs I was in the wrong crowd I didn't care about anything" (Joseph, line 196) and how this was linked to problematic and offending behaviours. He believed that this changed when he started to engage in courses such as DBT and CBT for psychosis, and he started to realise that with these skills he could look at things and cope differently. After spending half his life in institutions, this helped him to reevaluate his life and to not be stuck in the system any longer. He wanted to understand and change how "his mind operated" by his voices, why his difficulties were happening and why he behaved in the ways he did. He "wanted a fresh life I just wanted a new life" (Joseph, line 323). However, to do this, he felt like he needed to understand and come to terms with what had happened in the past and learn about his trauma symptoms.

> I said I want to learn all these trauma symptoms I've had from when I was a kid I wanted to change all that and understand why I was in and out of jail I was always in care homes you know and I wanted to understand why that was happening and why is it making me feel like you know I just didn't care. (Joseph, line 389)

There was some suggestion that Samuel felt that these goals were selfish and personal as they were about getting himself better, stopping his voices and getting out of prison. This could suggest that EMDR therapy was seen as an indulgence. However, he also recognised the knock-on effect that this had for his family and that he no longer wanted to be a disappointment. Sydney also spoke about the personal nature of the EMDR process, which greatly helped with his wish to engage in a therapy that he was aware would be very challenging.

> Very personalised so it was really my issues things that came up for me things that I wanted things that I identified that I still struggle with rather than it being these are the things that the team have noticed and want to work on […]

> as it was a couple of years ago there were things that I wanted that I want support with and that he then indulged as well. (Sydney, 267)

This suggests a difference in beliefs about the therapeutic interventions traditionally offered to individuals within secure services, that these services are primarily aimed at punishment and rehabilitation, and where the focus is exclusively on past victims' needs. It would further indicate that the needs of the individual who committed a crime are less of a focus and are seen as an indulgent extra to the necessary services.

When reflecting on his reasons for engaging, Sydney reported that it was "believing it to work or wanting it to work stood out for me" (Sydney, line 498). This suggests a level of need, or even desperation, in wanting the therapy to work. When completing EMDR therapy for a second time, he observed that "EMDR seemed to be both the quickest and most appropriate way to do something with the emotional turmoil that I was experiencing […] and to help placate […] those feelings" (Sydney, line 221). This would suggest that this time he recognised he had difficulties and that he actively chose EMDR therapy believing it would be the quickest and most effective way to do this. This is of note when he has engaged in an extensive programme on individual and group therapies and was seen to be coming to the end of what was to be offered therapeutically in services.

Joseph also spoke about feeling stuck but how internal motivation is needed to stick with therapy and to change. Previously, he said that he didn't care about change and didn't want to engage in courses offered. He needed this level of internal motivation to identify a personal goal and to want to achieve it.

> It's up to you at the end of the day if you want to change no one else people saying you need to do psychology work and that's that it's you and yourself that you want to change yourself the only way you can do that if you just go hard at it […] and determination that you want to do […] I had a while off and then I thought you know what if I want to change then I need to do it and I just done it. (Joseph, line 472)

However, Joseph suggests that there is more to it than identifying a goal; that you also need self-belief and faith in yourself to be able to change. It is possible that gaining an understanding of how past trauma can impact on early behaviour can increase the belief that change is possible, rather than not knowing why and believing that he was born bad.

> And with the EMDR I knew that it was focused on something that was so much engrained in me something that that dominated my life […] something that that had been hanging over my head for just so many years I knew that I to release these demons if you like. (Samuel, line 871)

Lee spoke about wanting to understand why his difficulties had occurred, whereas Sky spoke about how engaging in a violence reduction group had changed his attitude. Sky felt that as a result of this change, he wanted to "conquer" his illness and overcome his emotional distress and upsetting memories. The timing of the EMDR intervention for Sky was key: "like I was just at that stage where I thought to myself you know I am gonna give it all I've got" (Sky, line 485).

Another impact of engaging in groups and therapies was highlighted by Samuel. He explained that his engagement in offence-focused groups may have increased the impact of increasing trauma.

> There's a lot of the groups the homicide group that I do a lot of difficult stuff is brought up and I found myself having more nightmares I didn't understand what was happening to me […] it was a culmination of things that started the posttraumatic stress disorder it had been underlying for years […] it had been there mild but with the therapies in these surrounding they got more intense and more intense to the point I had to seek help about it […] I was at the end of my journey almost with therapies and I was fully aware that ninety percent of the therapies worked. (Samuel, line 163)

It is unclear how much Samuel's clinical team were aware of this at the time or how much time and support was given as a result. For Samuel, trauma therapy clearly appeared to be one of the last interventions offered as he was nearing the end of his recovery journey. This also appeared to be the case for John, Sydney and Joseph, who were also moving or had moved on. It is possible that this is because it is a new therapy, but it may also be seen as an available afterthought, a luxury option if there is time, rather than a core aspect of treatment.

## 4.2 Theme 2: Essential Support Structure

This theme focuses on the impact that the environment had on participants' ability to engage with the EMDR intervention, as well as the support that participants experienced from staff. This includes the following subthemes: 'Challenges of a Secure Environment' and the 'Necessity of the Therapeutic Relationship'.

### 4.2.1 Challenges of a Secure Environment

Participants were recruited primarily from high security and also low security. John had initially engaged in EMDR therapy whilst detained in a secure service. However, he had also engaged whilst residing in society. This placed him in a somewhat unique position to be able to compare this experience and the impact that the environment can have on the therapeutic process.

> Where I am now if I'm feeling emotional I can just pick my coat up pick my jacket and go for a walk […] if you are an in-patient you can't do that […] because as soon as you feel emotional the first thing that you are told by the nursing staff is you are too emotional you are too unsafe to go out you are not going out. (John, line 775)

Mental health services are often seen as a safe place for people who are struggling with mental health difficulties, with an increased ability to offer support and observe service users and intervene as necessary. However, John suggests that sometimes space is necessary and that going outside for a walk may be the coping strategy that is beneficial. However, clinical staff must weigh up the risk to the individual if they are allowing someone that they perceive to possibly be distressed on local community leave, particularly if an individual has demonstrated a previous inability to cope and/or

the use of maladaptive coping strategies prompted their admission or ongoing detention in secure services. It is likely that as security levels decrease, the individual is viewed as better able to adaptively cope, although, as John suggests, their ability to use these strategies may be hindered.

John also spoke about the potential for peers to be less than supportive and "ridicule" (John, line 771) service users for engaging in therapy. He suggested that being able to leave the unit allowed further use of coping resources and to take himself away from these individuals. This again highlights the need for services to recognise the strengths and weaknesses of institutional care in terms of coping resources that many people may instinctively engage in.

Aljazeera also reflected on the impact of the secure environment on therapy and spoke of his belief that it may have slowed the process.

> It can be slowed down by what's going on outside of the room […] because you can be literally in a memory and there's banging there's shouting outside the door and it can pull you out or just make that a bit heavier because it might relate to some of the things that have been going on so […] that makes it trickier the environment of being here which might be very different if you were in a community setting with a quieter room potentially. (Aljazeera, line 61)

This would suggest that noises outside of the therapy room can be distracting. This can be compared with therapy within society and finding an appropriate room, or choice to engage with another therapist or in another environment, if you find this challenging. It was also noted that, depending on the hospital and individual restrictions, sometimes therapy happens in a room on a ward and that a potentially violent or aggressive incident could be occurring within a space that should be safe. Not only could this act as a trigger, but the service user must then return to an environment and mix with peers which may continue to be volatile.

Some participants believed that there was a difference between prison and hospital environments. For example, Sky believed that there was more support available in hospitals and that this was an important factor in feeling ready to engage in therapy.

Whilst in prison, Sky spoke of feeling "overlooked" (Sky, line 168) and did not believe that the prison environment was set up for therapy and he felt that he was "given up on and you are left in the cell 24 hours a day and just forgotten about" (Sky, line 495). Sky believed that this was in contrast to his experience of being in hospital where he identified that there were courses on offer but that he needed to accept and trust staff and that they knew how best to help him. Sky described having had a "prison mindset" (Sky, line 157) on arrival to a secure hospital from prison and that this meant that he initially found it difficult to open up about his problems and to work with the staff to help him to get better.

Percy also spoke of these differences between prison and hospital and how these observations were made very early on following his transfer.

> Well I was on a bus I was brought down here with six/seven staff members as they thought I would kick off and stuff because you know I didn't mean it it's all stigmatised you know and I was thinking oh shit what am I going to what are they going to do to me I got myself right down you know what I mean because I was thinking I should have spoke to staff so I was thinking that way they had a talk to me and stuff I was put in a super seclusion room locked up and on the first night I was starving I said is there anything to eat and they said oh give us one second they went and when they came back they brought cheese on toast for years and years I had never had cheese on toast so for me I was like oh it's not that bad it's not that bad you get cheese on toast. (Percy, line 77)

This suggests that it may be small gestures and actions by the staff team that can change people's views and ability to trust and engage. There were concerns expressed by Aljazeera that if he was returned to a prison environment then he would be unlikely to complete any outstanding EMDR therapy interventions. As such, he felt like he was on a "time limit" due to the potential of a forthcoming transfer.

Other participants spoke about the importance of the support they received from the staff team as a whole within a hospital. For example, for Samuel this included the

perseverance and help from staff in his clinical team who he felt were there to reassure him that the therapy would help. Aljazeera spoke of the fact that he believed that his clinical team genuinely cared for him, how it made him feel when they expressed their concern for him and how this helped motivate him to continue to engage in therapy, whereas Sky spoke of how staff were flexible and willing to work around his timetable. This suggests the hospital environment allows individualised and personal care that larger services with fewer staff may struggle to provide.

Sky was also appreciative of his staff team and spoke about the great job that they do and how thankful he was for them not giving up on people and that they "were dealing with difficult and troubled people" (Sky, line 494). He acknowledged staff input isn't always appreciated but "I think once people come through the dark times and they can think rationally then everyone would be thankful" (Sky, line 497). This would suggest a recognition that staff are able to persevere and show compassion and hope when working with individuals and this supportive environment can spark a self-belief in a person's ability to engage and benefit from therapy, especially one as challenging as EMDR.

### 4.2.2 The Necessity of the Therapeutic Relationship

Many of the participants spoke about how they were familiar with their EMDR therapist before engaging in EMDR therapy. This was either because they had been engaged in therapy with them using a different modality, through engaging in previous interventions and groups, or as a member of their clinical team.

All participants spoke of the importance of the therapeutic relationship and the necessity of this. Aljazeera stated that "it's not just about EMDR it's about the therapist that you work with because if you're working with someone that you don't trust there's no point in doing EMDR" (Aljazeera, line 112). This would suggest that this relationship was crucial and, in particular, the element of trust. The importance of the relationships was also echoed by John, who highlighted the need to be open and honest with them.

> Well I'll be honest with you now that I don't think for one minute if I didn't have the therapist relationship with my EMDR therapist I wouldn't be the person I am now I know because it wouldn't have worked […] because I wouldn't have

> been able to be so open and honest and engaged in such intense therapy. (John, line 939)

John said that he trusted his therapist "implicitly" and it seemed that part of this was linked to a feeling of safety, for example, his awareness that at the end of a difficult session, "I know that I feel safe and the therapist knows that I feel safe". It is likely that without this, he would in turn not feel able to be open and honest. It also appeared that he trusted his therapist to guide him through the EMDR therapy process. For Sky, the element of trust seemed to be a turning point for continuing, stating that "I just put my trust in her and just went for it" (Sky, line 204), suggesting that this was similar in some ways to a leap of faith into the unknown, that he didn't know the way forward, but John and Sky trusted that their the therapist did.

Many participants including Lee, John, Percy, Samuel and Joseph identified the need to know someone before feeling able to open up and how the ability to trust may need time to build. John spoke about how a therapist can't just walk in and expect the person to open up and engage in such an intense therapy like EMDR.

> There's a point first of all you need to build that therapeutic working relationship up […] and that's very important […] if you want therapy to work as intense as that you've got to have a therapeutic relationship […] if you don't have that therapeutic relationship I'm wasting my time and the therapist's wasting their time. (John, line 968)

This would suggest that timing is important and that if the processing in EMDR therapy is attempted too soon then it may not be as effective, as the person may not be able to open up with a therapist they do not trust. In terms of building this trust, Joseph spoke about how, for him, the relationship had to grow slowly until a bond has developed and he felt able to open up. Interestingly, Joseph also noted that once this has been done, the process became easier to deal with. He appreciated being able to share any distress by talking with his therapist and also found comfort in knowing that they are there if he needed them.

Samuel also said that he knew the therapist really well and he went into the therapy very motivated. He said that he felt able to trust her and that it helped that his therapist was already aware of the difficulties he had experienced. Not having to revisit background history with another clinician was welcomed. He believed that revisiting history meant "eating up months" (Samuel, line 1010), particularly when this information could be a source of distress and possible shame, which could in turn impact on engagement. Samuel stated that without prior contact with his therapist, the EMDR process would have taken longer as he would have had "to build up that trust" (Samuel, line 965), which could take months.

Samuel also spoke about how traumatic events can impact on someone's ability to trust and how trust levels can go right down.

> A lot of people that have gone through trauma a lot of people that have gone through major life events things as simple as closing your eyes when you are trying to go back to something as simple as that you need to you need to trust that other person to do things like that and you need to have trust in that person first. (Samuel, line 970)

This highlights how as clinicians we may ask them to engage in tasks or activities that we view as somewhat innocuous; however, these may actually cause fear and anxiety that may not be appreciated and may even be a trigger. Within secure services, this may be more apparent, whereby it is commonplace not to show vulnerability or weakness.

Sydney offered a slightly alternative view of the importance of the therapeutic relationships and EMDR therapy. He initially highlighted the process of bilateral stimulation as being the most important element. He considered how it was this process that caused change and that it may not matter who this was done with.

> I guess with anybody […] just because it really is about my brain processing and my brain processes whether I am with somebody or not […] perhaps if it is somebody that I have known for a while where I have an established rapport relationship with then there can be more willingness on my part to engage fully

> and to be off guard and allow myself to be a bit more spontaneous […] which then choosing issues that will be perhaps maybe more objective rather than subjective is possible for myself so I think perhaps I guess my memories would still be able to function with you for example this conversation would happen as it would with someone that I have known for long. (Sydney, line 715)

However, Sydney went on to reflect that although technically the process could be done with anyone, the therapist could impact on whether he was able to fully engage with the process and not hold back. This would suggest some ambivalence about this view of the need for a good relationship and to be able to trust.

As well as being supportive and helping participants to feel safe during therapy, John and Sydney also spoke about the therapist's "enthusiasm" and the belief that the therapist had in the efficacy of EMDR therapy. This would suggest that if they trusted their therapist, then service users could believe that the therapy, of which they had limited knowledge, could work and that change was possible. Sky also spoke of the "persistence" (Sky, line 436) of the psychology team and his therapist who "doesn't give up on you" (Sky, line, 436). This would suggest that when things get difficult, the support remains and that the team will stay with him throughout difficulties and challenges.

When Joseph spoke about how it is not always an easy process during EMDR therapy, he highlighted that the relationship with the therapist had a greater role and impact. Joseph spoke about how his therapist "constantly got on at me" but that this felt good as "it was getting all that anger and frustration and upset and everything out and as he was doing that it changed to something positive" (Joseph, line 234). However, this was not an easy process for him. This also did not come quickly and easily and Joseph spoke about how he had tested his therapist before being able to open up and trust him.

> At first personally for me I set little targets for them without them knowing I was setting targets to see how trustworthy they could be […] and obviously my psychologist he had that trust […] you know and obviously you know that's

> what you need when you're doing EMDR you can't just come up to a normal psychologist and start talking you know like client centred without knowing you have to have that relationship with your psychologist and that bond with your psychologist to get through it you have to have a good relationship with your psychologist […] yeah get it once you've got that you'll sail through it at first the first five six months […] he's raw he will strip you down. (Joseph, line 300)

Again, this would suggest that the therapeutic relationship needed time to build, but once this was achieved, it made the rest of the EMDR process easier to cope with, even when it becomes increasingly challenging. Samuel spoke about his therapist assuring him that she would "get [him] out the other side", suggesting that he was aware that what he would embark on would be challenging and hard but that this person he trusted would see him through it. Although participants clearly refer to the relationship with the therapist, it is arguably very difficult to separate out the impact, and potential benefit, of prior therapeutic approaches in this.

So far, the process of developing the therapeutic relationship has focused on the participant's ability to trust the therapist. However, as with many relationships, this appears to be a two-way process in that the therapist also gets to know the individual. Samuel spoke about the awareness and flexibility of his therapist and how she would adapt sessions to how he was feeling.

> She would see one day that I wouldn't be up for it or she'd see one day that I'd be a bit down […] and she would take the subject away from it and we'd talk more about relaxation problems and we wouldn't do the EMDR we would just have a discussion […] and then there would be days we would do it she was very good at reading me […] as a person when I came in whether I would be up for it or not. (Samuel, line 293

To feel that someone can be this attuned to your emotions and well-being could further impact on the individual's ability to trust in the therapist. This may also apply to feelings of safety, particularly when the therapist demonstrates an awareness of what the individual either hadn't recognised within themselves or shared. This was

experienced by Aljazeera, who described how his therapist had been very aware of changes within him that he wasn't aware of. He also recollected that his therapist was conscious of the impact the intervention could have and wanted to check in with him that he was well. He went on to discuss that engaging without this alliance could be dangerous.

> In my personal opinion it would be dangerous to do if you don't have a therapeutic alliance because the therapist needs to be able to recognise certain signs within you […] and I don't think you're going to be able to discuss target memories with someone you don't trust. (Aljazeera, line 714)

The importance of the therapist's skills level was also highlighted by Aljazeera, stating that his therapist was "highly specialised" and that she was very "serious" when it came to EMDR therapy. Sky also recognised this level of attention and insight from his therapist and how it was a very positive experience for him. He appreciated her professionalism and how well everything was communicated to him, including what he may experience, whereas Percy spoke about the ability of the therapist to maintain clear communication and boundaries with the therapy. As well as being able to talk to you calmly and, at times, "have a bit of a chat" (Percy, Line 423), the therapist was also able to focus on the content and maintain boundaries.

## 4.3 Theme 3: EMDR Therapy Process

This theme represents what the process of EMDR therapy was like for participants and is broken down into two subthemes differentiating between the 'Functional Aspect of Bilateral Stimulation' and the 'Visceral Impact of Engagement' in the EMDR process.

### 4.3.1 Functional Aspects of Bilateral Stimulation

The use of bilateral stimulation is what makes EMDR therapy unique, when compared to the traditional talking therapies which are more commonplace within secure services. Participants experienced various types of bilateral stimulation during the EMDR sessions, including those manually conducted by the therapist (i.e., hand movements) or via a machine (e.g., tappers that vibrate, electronic eye movements). Even in the early stages of therapy, this option impacted on the legitimacy of the way

bilateral stimulation was delivered and could have an effect. For example, Sydney believed that the use of a machine added more legitimacy to the approach.

> I suppose because the machine with the lights flashing and the sounds sort of seemed a bit more authentic because something had been devised just for it [...] so when one doctor was telling me it worked and another was telling me the hand signal worked but the machine really indicated for me that there was more substance to it because something was dedicated to solely as to this purpose so it must work. (Sydney, line 486)

It is possible that for Sydney, the scientific nature of machines made this new, unusual and somewhat difficult-to-understand therapy more relatable and increased his trust in the process.

After engaging in EMDR therapy, participants were aware of the functional and direct therapeutic impact of the bilateral stimulation. Most obviously in the process, this is in terms of reducing levels of distress. Some participants observed that although distress may initially increase during processing, "eventually it will just fade away" (Joseph, 642). On other occasions, it appeared that the therapist needed to highlight and reflect back these changes in distress levels, as they might not have been directly acknowledged at the time of processing. For example, Aljazeera spoke of how his therapist had to highlight that his distress had been gradually reducing, according to his self-reported Subjective Units of Distress (SUDS). That is, during the EMDR therapy process, participants are intermittently asked to rate their levels of distress (0-10). In spite of providing lower SUDs, he did not initially acknowledge his self-reported reduction in distress. It is possible that this is because the process often involves working on the most distressing elements and once distress related to a target memory is achieved, the next memory, with often high levels of distress, is identified and targeted. As such Aljazeera may have needed further support to reflect on the gains he was making before moving on to the next target memory and associated increase in distress levels.

When processing memories, Aljazeera explained that the process was not linear, and he described himself "getting pulled away from it into something else […] and then something else something else something else […] they do jump around sometimes" (Aljazeera, line 482).

This suggests that Aljazeera is making necessary connections that he needs to be able to heal and move on. EMDR therapy does not focus on details of events per se; any detail accessed in processing will depend on the individual and what they notice. All target memories will be assessed but information will tend to be minimal and detail is generally not needed, especially with respect to what the therapist needs to hear.

> Currently I'm using the EMDR because not because the other things didn't work but it actually speeds up the time is in my view more effective […] and allows me to go through my memories without actually having to go into great detail with them with the therapist. (Aljazeera, line 28)

Aljazeera appeared to appreciate that he did not have to talk in detail with his therapist about his past trauma, although he had also spoken about the need to be open with his therapist, so that he was able to receive the support that he might need. This would suggest a difference in level of exposure when talking about traumatic experiences - the ability to feel vulnerable in the room with someone and for them to witness this experience of processing, whilst being able to keep some of the specific details of this personal.

Without consciously analysing or changing the narrative of their memories, participants discussed specific changes they observed with bilateral stimulation. Sydney spoke about changes in his early childhood memories and, in particular, the memories of isolation. This change not only included a noticing of the visual presence of others but also of the sounds that would have accompanied this memory that were not previously present.

> It was I believe were more of the noises of the room some of the kids were playing at different areas of the room and there was a cacophony of sounds the teachers talking and the children playing and the bottles and the cups and things so there was more noise than I remembered. (Sydney, line 101)

Some participants experienced differences in the delivery of the bilateral stimulation, with John and Aljazeera expressing a clear preference for the use of tappers, and Aljazeera also believed they were more powerful.

> We had to really stop the eye movements because it became quite overwhelming in terms of I was getting really dizzy […] and then with these things closing me eyes I was still feeling a little bit of nauseous and other things with it but it's if anything the bilateral stimulation from them […] is more powerful than the in front of the eyes. (Aljazeera 423)

This preference is of note considering the current research suggesting that eye movements are more effective (Sharpley et al., 1996; van den Hout et al., 2012). However, both participants seemed to believe that it helped them, and comfort appeared to be impacted when eye movements were used.

Aljazeera described how the set-up, which is very specific in the EMDR process, as well as the equipment used, can directly impact on the function of EMDR processing. When equipment was used instead of hand movements by a therapist, Aljazeera highlighted that this means that you don't have to look at your therapist. However, this seemed to be more than not having to see his therapist, which could be related to anxiety or other emotions elected by memories and feelings of being watched or even judged. This may be closely linked to feelings of personal preference and comfort.

> You don't get an interference from your therapist because one of the things that I think I found very unhelpful was that you've got your therapist sat there which the hospital doesn't like anyway [….] therapists too close to patients […]

> and then you've got a kind of focus on that and every time if goes back that way you're seeing your therapist not necessarily full on seeing your therapist but just in the blurriness […] and the therapist processed into that. (Aljazeera, line 458).

Aljazeera also introduces how the therapist may actually become involved in the processing by accident, as they are within eyesight when processing. This is an area that does not previously appear to have been documented, nor what impact this may have on the EMDR process.

Another element raised by Aljazeera was his proximity to the therapist. This is something that both service users and therapists are acutely aware of when working within secure services and that "the hospital doesn't like anyway" (Aljazeera, line 459). During induction training within secure hospitals, all staff are instructed on safety and positioning within the therapeutic space and the traditional "ships in the night" seating arrangement commonly used in EMDR goes against this. Aljazeera did not elaborate on this discomfort in terms of close proximity, but it is worth consideration that this proximity to a member of staff, male or female, would be highly unusual within a secure environment and is likely to further impact on feelings of strangeness. Additional issues could occur around offence history and type of trauma work that is being conducted, including possible offence trauma, in line with triggers of trauma and safety issues.

### 4.3.2 Visceral Impact of Engagement

This subtheme explores the emotional impact that engaging in EMDR therapy process had on participants. This includes the emotions experienced at the time of the intervention, as well as the associated thoughts, bodily sensations and related challenges.

Within the current study, all participants described how their therapists and wider clinical teams had provided both verbal and written information about the EMDR process. This included some discussion about the potential emotional impact of engaging in EMDR (further explored in Theme 1), which appeared to follow

appropriate guidance relevant to working with trauma (Shapiro, 2010). However, it was observed that, in spite of this, participants experienced some "initial shock" (Sky, line 350) and did not appear able to fully comprehend the extent that this emotional impact would have on them, until the process was commenced and they had lived experience of this.

Participant experiences of therapy somewhat varied in number and the type of therapy they had engaged with before. It is noted that Lee was rather different in that it was his only experience, and he was possibly one of the only participants who did not comment on this area. However, he reflected that he has nothing to compare his experience with.

Percy stated that he initially engaged in EMDR therapy thinking that "it would be like another course" (Percy, line. 324) and he was surprised to discover that it took him to places that other therapies did not. He elaborated on this, saying that "it makes you go a little bit deeper than on a superficial level […] a little bit deeper and different feelings thoughts emotions will come out" (Percy, line 371). This would suggest that there is a depth to the EMDR process which caused him to experience different thoughts and feelings, which may come as a surprise. However, to some extent, this could be expected, as Percy had primarily been involved in long-term offence-focused interventions and groups, which had possibly not focused on personal issues in the same way as some types of interventions nor when these are individual sessions.

Aljazeera was in a somewhat different position, having already engaged in trauma interventions before engaging in EMDR therapy. As such, it could be argued that he had experience of trauma interventions and so was aware of the possible impacts of this. However, he also described his surprise the first time he engaged in EMDR therapy, stating: "The first time I did it I thought it was oh here we go a load of old crap it's not going to work just doing that […] but I was quite taken back and shocked." (Aljazeera, line 126). As Aljazeera had recently been engaging in a trauma intervention, he was able to directly compare his experiences of CBT for trauma with EMDR.

> So the exposure work was unbelievable it was painful it was embarrassing it was a lot lot worse [...] when you're explaining these things and you have to do it again and again and again […] and then you have to listen back to it on a daily basis and I'm like this is just screwing me up […] so the EMDR has a more for time between sessions which is normally a week […] more of a subtle effect yes it hits you after you've left the room and in the evening you're thinking about it but it's subtle during the week for the next session. (Aljazeera, line 229)

For Aljazeera, his difficulty with trauma-focused CBT therapy appeared to focus on the pain and embarrassment of talking about his personal trauma experiences, as well as the repetitive nature of revisiting this, both with his therapist during session and alone when completing in-between session tasks. It seems that the continued nature of the CBT intervention meant that he did not have a conscious break from this emotional intensity, due to in-between session tasks.

Overall, Aljazeera expressed a personal preference for engaging in EMDR therapy over CBT. However, his experience of EMDR therapy was not without its challenges, albeit they seemed different. Aljazeera explained how the EMDR process evoked strong emotion within him. In particular, he described how it caused the most fear within him, especially the first time he participated in it.

> Like I said the first time was the scariest […] because you started to feel […] but not quite ready to go there […] well I went there a little bit in the DBT but in the EMDR you obviously go places […] memories and at that time I hadn't admitted to things so they became blocked […] because I wasn't prepared to say them when she said right so where are you and I'd have to say well blocked she said why and I'd say well can't say so it was difficult now it's I can say. (Aljazeera, line 345)

It is possible that this reaction was linked to the experiential shock of the process of using bilateral stimulation, and in particular the emotion this elicits, which is different

to other therapies. Joseph described EMDR therapy as the hardest thing that he had ever done and spoke of the "really raw subjects" (Joseph, line. 96) and how for him "you're breaking down because it strips […] it pushes to the bone" (Joseph, line 148) and how "you can be the strongest mind in the world you do EMDR it will crush you". (Joseph, line 140). It seems the very nature of the process can feel like "you're baring your soul to somebody" (Samuel, line 1065). The language used suggests a visceral exposure, which leaves participants feeling open, vulnerable and somewhat intrusive.

It is possible that EMDR may be difficult to describe, as it is so different to the usual talking therapies. These therapies do not tend to involve bodily sensations and it also suggests that to some extent individuals may have more control within a talking therapy. Clients can control what is discussed and bring discussions to a close if they find it difficult. Speaking and communication with others is commonplace and we as humans arguably have more practice in how to manage this. Further, some interventions are based on psychoeducational elements or learning about aspects and applying these to their own difficulties, which may arguably be less taxing. Other therapies function through discussion and analysis, as observed by Sydney: "I suppose it's different because most therapies we talk and we analyse and we look at things" (Sydney, line 298).

Joseph and John had also previously engaged in many different therapies, both in group and individual formats. Some of these interventions would most likely have explored any difficult early experiences, i.e., schema-focused interventions. Again, it could be argued they may be better prepared for this type of intervention. However, John also described engaging in EMDR therapy as "one of the worst probably most intense psychological therapies that's done" (John, line 949), and as leaving him "in absolute bits" (John, line 476). Again, this would suggest that there seems to be something about the process that means that it is more emotionally challenging.

This visceral exposure could also be linked to the ability to be open both with yourself and your therapist and, as Joseph suggested, this may even be an essential part of the process, that "you have to open up to yourself you have to be true to yourself"

(Joseph, line 69). For some participants such as Aljazeera and John, this has meant facing events that have been long hidden or avoided. In the case of Aljazeera, he started "seeing things and I didn't like it but obviously the blocks started because I started seeing and feeling my offending" (Aljazeera, 150). In many situations, a therapist will often be unaware of the details of dissociated memories, but needs to be aware of this possibility. This is especially relevant when individuals such as Aljazeera may in the first instance be shocked by these memories and unprepared to face them.

Following EMDR sessions, participants then described physical impacts, which included feeling "drained" (Sky, line 292) and also causing intense headaches (John, line 485). It wasn't only immediately after the sessions that participants felt these effects; Sky spoke about how processing continues between the sessions.

> Probably the most difficult was that it was still processing for a long time so on the days that I did it or the days after it happened I would like struggle to get to sleep and to switch off (Sky, line 345)

Again, this processing did not appear to be in a conscious manner, such as engaging in a homework task in CBT, but occurring at a more primitive and unconscious level. Although this could be more taxing when distressing memory processing continues, this works in a positive manner for those resources such as a safe place, which can be consciously or even unconsciously utilised.

For Aljazeera, the emotional difficulties he experienced related to past events (i.e., abreactions), were very intense and happened very quickly and early in the processing. However, for other participants, such as Samuel, Joseph and John, the process of EMDR therapy became increasing more difficult.

> I would just start off with coping skills first because you don't just go into EMDR full force you have to build yourself up so you talk about safe place […] you start all off and build it up and go slowly slowly build it all up and it gets harder

> and harder and harder until the main thing you want to work on the main thing that traumatises you and stuff like that then that's the difficult part. (Joseph, line 576)

Joseph described how the intensity gradually built up to the point in therapy where he was working on his most challenging memories and difficulties. It was unclear if these differences were related to the process and sequencing of target memories by the therapist, or more specific to the individual and their trauma.

Participants wanted to highlight this potential to others wishing to engage in EMDR in the future, so that they did not underestimate the emotional impact of the process, as they had done. Samuel called this point in therapy "a real doozy" (Samuel, line 845) and Aljazeera offered a warning "just to be ready you are going to experience things you can you can think you're not but you are going to be ready for that (Aljazeera, line 818).

Interestingly, participants seemed to accept this emotional challenge as part of the process that you needed to go through.

> You know when it was getting too much of it like and I was thinking to myself I'll just stop forget about it and I'm like no I want to do this and once you push yourself for the first couple of months and it is hard it is hard it will be the hardest thing you ever do you know and once you've battled through that and come out the other end. (Joseph, line 333)

Although a personal "struggle" (Samuel, line 660) and the hardest thing that they had done, most of the participants were able to work their way past this point. For other participants like Joseph and Aljazeera, they felt the need to have a break from the therapy before feeling sufficiently "mentally prepared" (Joseph, line 495) or emotionally ready to recommence.

> That wasn't the case you know I started off small which was you know rumbling a bit in my head and I was crying a bit and it got harder and I said I'm not doing this anymore […] I had a while off and then I thought you know what if I want to change then I need to do it and I just done it. (Joseph, line 503)

It seems that this break allowed sufficient time to come to terms with their heightened awareness of the process and emotional impact, allowing them to prepare to continue with their journey. It also suggests that having a break from EMDR therapy may work well for some.

The emotional challenges that the EMDR therapy process presents for participants should not be underestimated, particularly when teams are likely to encourage continued engagement. For some, the process was so significant that they considered "suicide" (Joseph, line 229). However, this individual had a long history of suicide attempts and this was one of his ongoing difficulties prior to engaging in EMDR therapy. However, he was eventually able to work safely with his team to manage these feelings and engage in EMDR therapy to the point where these thoughts and feelings are no longer an issue for him.

Aljazeera observed the importance of communicating distress and discomfort with the clinical team and that you need to "be willing to talk about it because if you are experiencing that like I was and then you don't talk about it you are going to have problems" (Aljazeera, line 819), and he clearly recognised the potential for harm if this communication did not happen effectively: "I suppose if it's done wrong it can be so negative if it's done wrong" (Aljazeera, line 418). This would suggest that if a therapist and clinical teams were not vigilant and supportive, then the potential for harm is great, which participants were acutely aware of.

Samuel spoke about how he went into EMDR wholeheartedly and was aware that it would be challenging. However, for him this was worth it if, in the long term, his distress related to PTSD symptoms came to an end.

> When I first started doing EMDR I was assured that this would help stop the flashbacks it would help stop the nightmares and things so I went into it whole heartedly but the downside is it got worse before it got better and it's the same with a lot of therapies […] you go into the therapy with sort of with an open mind and it gets worse you have to go through difficult subjects and it gets worse before it gets better I've noticed over the years that if you stick with it and you keep going on with it then it usually turns out alright in the end. (Samuel, line 110)

It seemed that Samuel's previous experience of therapy helped him to get through and maintain motivation. He was able to draw on previous experiences that things can get harder before they will eventually get better, and drew hope from the fact that they had in the past.

Arguably, there are some therapies which may be more psychoeducational or skill-based that individuals can attend but engage with minimally. However, the process of EMDR requires someone to embrace the process wholeheartedly to gain any benefits; they need to follow the rabbit down the hole. John further highlights how "there's no point doing EMDR if you're not going to stick at it or use the skills during there's no point […] it would be a waste of time". (Joseph, line 442) This would suggest that there was no point in continuing with EMDR if, as a client, you are not able to give everything to the intervention (see Theme 1) and that it was better to stop and regroup than continue without being fully engaged. However, it is unclear how much of this inability to proceed was an active choice. For example, Aljazeera spoke of not wanting to fail, nor wanting his difficulties to keep impacting on his life. He recognised that the process would be hard but did not want to walk away from it.

As bilateral stimulation in the EMDR process appeared to some degree to increase the intensity of emotions during processing using fast sets, they also appeared to serve to boost the intensity of using EMDR resources using slow sets. A number of participants spoke of the use of the safe place (Sky, Samuel, Lee, John and Joseph) during the EMDR therapy process.

> We would go into safe places and things like that and sort of put me really at ease and giving me that sort of balance of giving me that sort of armour to fight off any bad that might come from it so I had that few months of the reassurance the what to do if this happens or that happens before we got to the pulse things. (Samuel, line 219)

It seems that this was a necessary element to achieve balance and feel able to tolerate and continue to work on the more distressing material, without feeling overwhelmed.

Once again, the EMDR process appeared to be able to efficiently access different senses. As Samuel reported, he was able to "go away in my mind I was able to use smell and cherry blossom" (Samuel, 911). Participants reported how these resources provided relief during and after the sessions, offering a sense of relaxation and even resulting in a feeling of euphoria. Again, this is of interest as many participants will have learnt various types of coping skills, including DBT which specifically focuses on helping individuals manage distress.

As well as the basic safe place exercise, participants spoke of the use of additional resources exercises such as containers (Joseph), and how they were used to help participants cope with direct processing.

> We were able to go to a safe place but also to a place that was around that event and then make up an escape route […] and make up a sort of way out of that area so that if it got too intense the vivid memories of it then I could go to this little place I could take my little brother and run away from it. (Samuel, line 639)

This appeared to allow Samuel to change the narrative of his memory and escape when the intervention becomes too intense. This may have increased his sense of control in a process that is ever-changing and somewhat unpredictable. It is unclear

from the interview if this was guided by the therapist or initiated by Samuel, but suggests that it was effective for him.

## 4.4 Theme 4: Identifying Personal Change

For many participants, engaging in EMDR therapy was a personally significant time in their lives: "A massive turning point in my life" (John, line 322), which "changed my life […] or changed the way I see the world I see my life" (Joseph, line 442). Albeit it to differing degrees, all participants spoke of the changes that they recognised within themselves, which they experienced as lasting. These changes occurred in relation to their thought processes, emotions or behaviour. This theme reflects the personal impact and change that participants observed as a result of engaging in EMDR therapy and on their recovery process, and has been broken down into the following subthemes: 'Changes in Mental Health and Diagnosis', 'Insight and Reflections on Offending Behaviours' and 'Ability to Cope and Experience Hope for the Future'.

### 4.4.1 Changes in Mental Health and Diagnosis

This subtheme explores the various changes relating to their mental health difficulties. John spoke broadly of the changes he experienced in relation to reducing feelings of anxiety, worthlessness and rejection. He explained how the longer he had lived with his trauma, the worse it became, but also identified how, on reflection, this became normal for him and how for "the majority of the day like ninety-five percent of the day that I was awake I'd feel rejected worthless unloved uncared for" (John, line 65). However, after EMDR therapy, he found that he was no longer "living on a day-to-day basis feeling so traumatised and feeling like I couldn't go throughout the day without feeling absolutely traumatised and absolutely I can't cope with the day basically" (John, line, 370). This suggests that, for John, EMDR therapy clearly reduced levels of distress related to experiences of trauma but also changed his thought processes. Lee also observed changes, such as being better able to sleep, as his thoughts no longer raced as much and he felt less preoccupied by the traumatic event that he worked on.

Some participants such as Samuel, John, Joseph and Sky experienced a reduction in symptoms of psychosis. However, it is noted that it seemed difficult to differentiate some symptoms which were viewed as psychosis and PTSD symptoms. Joseph and

Samuel spoke about their adverse experiences in their childhood, including being in and out of care homes and residential schools, as well as experiencing significant abuse at the hands of someone in a position of trust. This suggests some recognition of the link between adverse childhood experiences, including trauma, and their mental health difficulties. Joseph had recognised that he could be triggered by these past experiences but also acknowledged that he did not talk about them until he came to the hospital in which he was currently detained. It is noted that this was in spite of accessing psychiatric services from a very young age. This would suggest that, although there is some underlying recognition of this link, something was stopping him from talking about it and exploring this further or receiving treatment for it. It is unclear if services ever sought this information or were aware of what to do with this information, particularly if more focused on a medical model of intervention.

John spoke about the connections between his experiences of childhood trauma, mental health difficulties and related problematic behaviours that had been with him from an early age. During this discussion, he highlighted the impact that engaging in EMDR had on his mental health diagnosis and on addressing this early childhood trauma. John had been diagnosed with "chronic schizophrenia" for many years and more recently recalled his family being invited to attend a meeting with his consultant psychiatrist. During this meeting, the psychiatrist informed them that he was stopping all of his antipsychotic medication, as his doctor no longer felt that schizophrenia was an appropriate diagnosis.

> I turned around and said and my parents turned around and said you can't do that I'd been on medication like for thirty odd years […] he said we can don't worry and stopped all of my medication and said I don't believe that I have schizophrenia […] literally stopped all of my meds like that worked very closely and changed my diagnosis to personality disorder and said you never had schizophrenia it's the lifetime you have led. (John, line 189)

Although John recognised some advantages in this change in diagnosis, more specifically in no longer having to take medication, he also reflected on the difficulties.

For example, it was believed that he no longer needed medication to manage a mental illness. However, he spoke about how after this he had to learn to deal with stressors differently and more things directly. He was no longer to "use medication to block out reality […] and that at time was very difficult very difficult the fact that you are trying to deal with everything you can't just take a tablet and feel better" (John, line 207). Not only does this bring into question the purpose of medication for John, when he had taken it for all of those years, but also that there seemed to be a clear and direct link between his early adverse experiences, his subsequent symptoms and diagnosis of schizophrenia. This could suggest that his early difficulties weren't fully understood and that he may initially have been misdiagnosed or that this therapeutic approach offers a different understanding of these difficulties.

In an attempt to understand and come to terms with his emerging mental health difficulties and symptomology, Samuel initially believed that he must have done something wrong and that God must have been punishing him for something that he had done: "My mentality was I had done something so terrible something so awful that I deserved these symptoms and it was my sort of comeuppance" (Samuel, line 522). This was his understanding of what was happening to him. He reported that eventually others around him, such as friends, were able to recognise that he was experiencing "symptoms" of a mental illness.

> There's quite a lot of traumatic events throughout my life some at childhood some in adulthood so I think it was one day it was a culmination sort of snapped something in me that I just couldn't handle it any more […] well when I was about seventeen I started hearing screaming in my head […] and I was first put into a psychiatric unit and in that unit they talked about it could be schizophrenia it's the start of hearing voices that at the time it was different because I was a voice hearer I am not now because of the medication and that but back then it was the early signs of posttraumatic stress disorder I was hearing things that were happening at the times I was sort of starting to get flavour of flashbacks […] I was starting to hear screaming and then I would sort of be in the place where I was and things would progress from there and

> they didn't sort of understand it back then […] this was going back to the mid-90s I know that I know psychology psychiatry has come a long way since then but back then they didn't really know what was going on so I was sort of put back out into the community again […] where I became really unwell after a number of years and then of course my index offence happened. (Samuel, line 4)

Once again, this demonstrates that the difficulties Samuel may have been experiencing may not have been fully understood by care providers and professionals at the time. Alternatively, this could be a different way of understanding mental health conditions. It is of note that there appear to be clear links between Samuel's "symptoms" of psychosis, in terms of his experiences of auditory and visual hallucinations that he was experiencing, and symptoms (e.g., flashbacks) of trauma.

> I've stopped having flashbacks I used to have flashbacks where I'd go into the bathroom and I'd be transported back to a bathroom in my childhood and there would be blood in the in the bath and I'd see that going in there and that was quite common […] to the point where I could almost ignore it the feeling of feeling physically sick when I am having these flashbacks or hearing screams from the past […] that's nonexistent now I had a little blip a few months ago […] and I've been as right as rain since […] going on for four years. (Samuel, line 393)

This would suggest that for these participants, their experiences of visual and auditory hallucination in combination with high levels of distress, resulted in an initial diagnosis of schizophrenia, rather than identifying these experiences as being a result of trauma, whether this is a clear flashback of previous experiences, as with Samuel or John where diagnosis may be changed, or psychosis triggered by past events.

Aljazeera highlights the need to recognise trauma further and that this can be challenging in its own right, stating: "It just needs to be recognised more that's all […] because to me it is a full-on illness and people just don't recognise it as that"

(Aljazeera, 789). Based on his current treatment, Samuel believes that experiences of trauma are now better understood by professionals. However, it is unclear if this is the reality in general, as all of the participants had access to trauma-informed treatment which is not commonly used in secure services. As such this could demonstrate a shift in clinical approach which may not yet be common practice.

When looking at symptom presence more closely, Samuel observed that, for him, different symptoms stopped at different times, for example, the "feeling of somebody being in my room being afraid that stopped almost instantly" (Samuel, line 936) after he started using bilateral stimulation. However, he observed that his nightmares decreased more slowly until they eventually stopped and that the flashbacks stopped near the end and, as such, was very gradual, but that these changes have been longstanding.

To some extent, there appeared to be a knock-on effect with the changes observed by participants, and in part, this appeared to be linked to a greater understanding of their mental health difficulties. For example, when Samuel's nightmares and flashbacks stopped, he was better able to cope and to interact with people. John also found he was more able to cope and felt less angry when he was no longer controlled by voices and, in turn, the suicide attempts and self-harm stopped. Less troubled by his experiences of psychosis and flashbacks, Sky was more able to manage his emotions, cope with events and interact with others. Aljazeera felt that he no longer needed to suppress emotions or carry around baggage and become upset all the time. Sydney similarly felt less distressed by emotions relating to his earlier experiences and also felt less lonely. Percy found it easier to deal with what happened when he was younger, as well as his own offending behaviours, which resulted in him feeling more able to relate to people. This would suggest that some symptoms and problem behaviours that professionals may witness may in fact be a direct result of the individual trying to actively manage their distress. EMDR therapy offers a solution and end to distress and pain. His means that participants no longer have to cope with this, and no longer have to exert energy and personal resources to defend themselves against further pain.

### 4.4.2 Insight and Reflections on Offending Behaviour

It was through engaging in EMDR that Samuel believed that he developed a better understanding of his early difficulties and how this had resulted in his offending behaviours. He described the events and circumstances in his life as being like a combination lock. He recognised that he had experienced a number of adverse experiences growing up and he then experienced a time in his life when he thought he was finally "safe". However, in a short space of time, he was once again challenged by various difficult life events, which caused him significant distress that he did not feel able to manage.

> So it took all these numbers and as I said a combination and an explosion of all these things happening to make me explode and do what I did […] just that combination lock I know now that in the future that I will never hurt anyone again because I know them numbers will never fall into place […] never been violent before my index offence and I've never been violent since […] it needed all them events them traumatic events to all fall into place and for all them numbers to fall into place for that murderous rage to erupt. (Samuel, line 689)

Although it can be argued that other therapies may also offer the opportunity to explore these triggers and increase personal understanding, it is possible that they may not be able to address the trauma response that may come with this increased depth and insight. It is possible that whilst exploring these early difficulties, there is an element of desensitisation occurring which makes the process more tolerable and, in turn, Samuel was more able to explore what happened and develop insight, rather than turning away from and avoiding the pain.

Sky also spoke about his increased insight following engagement in EMDR therapy. He believed that he had grown up having to deal with childhood experiences and not knowing how to cope with this trauma. He thought that this had resulted in him "lashing out", getting into trouble and going to prison, which suggests a link between his early experiences and subsequent offending behaviours. Until this point, Sky had not understood why he behaved and reacted in this way and that he was carrying

with him so much "emotional baggage" for over 20 years. This is again of interest as he had previously engaged with a number of interventions which could arguably have done this, including CAT formulation and a long-term violence reduction programme.

Aljazeera also spoke about how he learned to recognise the links between his offending behaviours and the abuse that he had experienced in his formative years. For him, this created difficulties where he felt trapped between his own offending and the abuse that he experienced. He believed that EMDR therapy helped him to gain a clearer understanding about these links but wanted to emphasise that this clarity was not an excuse for his past behaviour.

> I know that being abused is part of who I am and part of the fact that I didn't know any different and that all of the emotions that I've been feeling a lot of that is related to childhood […] and some specific things and they've been no excuses but they've been triggered by certain things in the future […] and I'm an adult but I should have made different choices but it just it happened and it's hard to accept but I'm trying and this is making me think more clearly about things I've never had this amount of clarity in any other therapy. (Aljazeera, line 100)

Aljazeera spoke of guilt for his offences and that he did not want this to be taken away completely, but that he realised that he must stop punishing himself and to be more compassionate towards himself. This is what he was currently working on in ongoing sessions of EDMR therapy, moving on from what he had done before.

Aljazeera also spoke about the impact that EMDR had on his offending behaviour or more specifically, his views of offending and that he no longer felt the need to suppress his emotions which had caused him difficulties. He also noted that he was in turn more caring towards others than he had been in the past. This would suggest that for him, perspective-taking is more than empathy and suggests that Aljazeera needed to be able to tolerate his own emotions before being able to apply this to others. This would suggest a focus on the individual in terms of treatment planning and then broadening

this out to others and, more specifically, the individual's offending behaviour, otherwise running the risk of guilt feeling impacting on a person's ability to engage. This would suggest that by engaging in this work, addressing his trauma, helping him to gain an insight into his past offending behaviour and helping him to reduce distress related to past events and possible trauma around his own offending, he may in turn feel less distressed and less likely to reoffend.

For other participants, the link between EMDR therapy and the impact on offending behaviours was less direct or obvious. On enquiry, Sydney initially states that he did not believe that his trauma experiences were linked to his offending behaviours. However, he went on to discuss some of the changes that he had observed as a result of engaging in EMDR therapy. He spoke about how, after therapy, he was able to recall difficult memories but leave them in the past and distance himself from some of the associations that he used to make from these memories with his current situations, which had in turn caused him problems. He explained how, for him, the EMDR process had helped him to be more rational and that "I think the less automatic terrors those automatic sort of memories that trigger anxiety and anguish for me" (Sydney, line 534) had dissipated. This suggests that EMDR therapy helped Sydney to understand and stop the automatic response he used to feel in certain situations. These responses included the sweat on his brow or sweaty palms when thinking about past distressing memories, as well as the emotional distress.

> The inability to deal with that situation and those sensations and the whole knot that every time in numerous ways and all my senses then that were triggering off those knots of experience that the EMDR helped me to untangle some of that and then think of and separate that into component parts […] which meant that I wouldn't have such poleaxed fear and dread about prison […] as stupidly maybe as I had yeah so it just meant then that I could just tease apart some of the issues that caused me such terrible dread. (Sydney, line 566).

For Sydney, this was important, as it was possible that he may have to return to the same place that had previously created this distress. As a result, anytime this was mentioned, he would experience this automatic physical and emotional response. He recognised the "sensations" when he thought about possibly returning. In the past, he said that he previously would have built himself up to make him feel more muscular, so that he presented "a more opposing figure". He also referred to making weapons to defend himself in this environment: "I don't automatically begin that process of disengaging and building weapons and thinking about defending myself and the environment taking and taking drugs" (Sydney, line 639). Sydney elaborated that, for him, rather than adding to or changing his behaviour, an omission occurred: "It didn't make my behaviour any different it just stopped me behaving in certain ways I had before" (Sydney, line 596). This meant that he was no longer engaging in behaviours that he felt he needed to do to stay safe, which included the use of violence and weapons. As such, this would suggest a less direct link between trauma and offending behaviours.

Through engaging in EMDR therapy, Percy found that he was better able to talk about what had happened to him when he was younger, as well as about his offending. He found that the more he talked, the easier it was to deal with and to be able to accept what had happened to him: "I think one main thing is that being able to come to terms with what I have done and vocalising it makes it a bit more real" (Percy, line 367). He felt more understanding when speaking with others and more able to relate to them; he found that he was subsequently less judgemental. These changes in ability to interact with others was also noticed by other participants.

Sky spoke of the impact of "carrying around all this baggage and getting upset all the time and low moods and stuff and not realising that it's because I hadn't dealt with the situation" (Sky, line 67). His inability to manage distressing emotions had a negative impact on his ability to engage with others. For Sky, this has meant spending long periods of time in segregation, both in prison and hospital, and he reflected, how after engaging in EMDR therapy, he was subsequently able to engage with peers on a large ward.

Sydney also recognised that he used to experience feelings of isolation and had difficulties socialising. He observed a reduction in tension following EMDR therapy and believes that it helped him to "forget that far off lonely place" (Sydney, 117). In addition to this, Sydney also spoke about how EMDR therapy had changed his beliefs about engaging with staff.

> I thought about being sent to prison then that would cause all sorts of problems for me like not being so friendly with the staff withdrawing from them because I wouldn't like to seem like I'm a (scrooge boy) or that I am a grass or a snitch so I wouldn't be able to be able to have one to ones and access people and talk to people friendly and to associate with staff and just because in prison that would be a big no no. (Sydney, line 628).

With this belief, Sydney is arguably less likely to seek support from staff if needed, and more likely to resort to previous maladaptive behaviours in order to protect himself and cope with difficulties. These changes in ability to trust others was also observed by Joseph and Samuel.

> I wouldn't talk to people I would shut myself away I would hide away from people from being paranoid about this that and the other and since that's all been taken away I've been more forward and open and more approachable really. (Samuel, line 516)

This would suggest that trauma appeared to have a significant impact on his ability to form and maintain relationships. This further suggests that after engaging in EMDR therapy, participants were able to seek and accept support that may previously have not been possible.

#### 4.4.3 Ability to Cope and Experience Hope for the Future

As previously outlined, many participants reported engaging in EMDR therapy to be life-changing. However, as well as experiencing a decrease in distress levels and

related symptomology, this theme outlines how participants experienced increased feelings of strength, ability to cope and increased hope for the future.

Prior to engaging in EMDR therapy, participants described how they often struggled to cope with difficulties, and they were often "bottling it up and taking drugs and stuff to block my mind" (Joseph, line 49) or this resulted in maladaptive coping strategies. Joseph, Samuel and Sydney also spoke about taking drugs to cope and "block" it out of their mind. However, it appeared that through processing in EMDR therapy, participants no longer felt the need to do this. For example, Sky reflected how he felt in a better place both mentally and physically and how this enabled him to cope better with his current circumstances: "I address things like much more easier now I can talk about I still get upset sometimes when I think about stuff but I process things completely different now" (Sky, line 267).

As a result of EMDR therapy, Sky was no longer weighed down by experiences of nightmares and related distress surrounding his previous trauma. In turn, this has increased his ability to cope with day-to-day events, as he was no longer constantly feeling overwhelmed with emotions or suffering flashbacks, nightmares or lack of sleep. This change was also something that John recognised and that he no longer has to wake up every morning feeling so traumatised within himself and that he can now "just function like a normal human being living like a normal day-to-day living a normal day-to-day existence which to me was good". (John, line 341)

Sky, John and Aljazeera also felt more able to use the skills that they had learnt to cope. For example, Aljazeera felt more able to use his DBT skills and John was also more able and was less reliant on medication as a result. It is possible that this may in part be due to a reduction in levels of distress, bringing it to a level where these skills can have a noticeable impact. Alternatively, they might look at their difficulties differently: "My whole mind set has changed like in like three or four years I just think about things totally different now" (Sky, line 412). However, for Joseph, it appeared that he had never experienced the possibility of being able to cope and that "I never knew about how I could handle things" (Joseph, line 149). This would suggest that

he realised that he could cope even when this may have involved very distressing events from the past. Once he realised that he was capable of coping and managing, this seemed to open everything up for him and give him hope. He was more confident in his abilities to cope with events that occur in the future. Somewhat similarly, John spoke about how understanding and increased insight into his difficulties gave him confidence in his ability to cope moving forwards: "I thought hang on a minute if I've done that I can do all the things then so it just built up" (Joseph, line 123).

Up until the point of engaging in EMDR therapy, it would appear that many participants were living in the past. In terms of moving forward, Sydney spoke about how he was able to reflect on the past and put memories into perspective, let go of feelings and in turn, perhaps "that memories hold me back and weigh me down and make my life complicated so that was more noticeable for me" (Sydney, line 181). This is further exemplified by Percy who spoke of no longer letting "the past like be a chain around your neck" (Percy, line 476).

Further to this, participants felt like they were able to look to the future in a way they had previously not been able to. Samuel spoke about previously not thinking about the future, such as education, but is now considering that he would like to continue with his education, get a job and start a family.

> The American dream I want to have my own place a car family kids […] all of that and because of EMDR and the positivity that it's given me that focus for the future and I'm going to do whatever I need to do to get to that point to do these therapies that will be difficult to move on to different places to just to because as you can imagine it's near the end of my time here. (Samuel, line 765).

John also described his pride in his ability to engage in such a challenging therapy and to have completed it. However, he also mentioned that he felt "very very privileged that I've not only been given the chance to have it once but twice […] so I feel incredibly privileged to do it" (John, line 689). This had in turn made him feel that he wanted to give something back and suggests a move from egocentricity of being

engulfed and overwhelmed by their own distress to being able to look more outwards to the future and to others.

As well as being a turning point for them psychologically, many participants believed that engaging in EMDR had directly impacted on their ability to progress within, and through, the hospital system. For example, Joseph was now ready to step down into conditions of lower security and John had been able to move on from the hospital environment.

### 4.5 Summary

The thematic analysis revealed four main themes that were central to participant experiences when engaging in EMDR therapy within a secure service. The first theme was related to the 'Decision to engage in EMDR therapy' and included subthemes around the 'Accessing Information and the Unknown' and 'Essential Support Structures'. Participants spoke about their understanding and knowledge of EMDR therapy, including their initial thoughts and discussions, undertaking their own personal research, collaboration with clinical teams and what might help others in the future. Participants also spoke about their motivation for engaging in EMDR therapy and when this occurred in their treatment pathway.

The second theme explored the 'Essential Support Structures' that were in place and this included the subthemes of 'Challenges of a Secure Service Environment' and the 'Necessity of the Therapeutic Relationship'. Participants spoke of the impact of having treatment within a secure environment and how this impacted on their ability to cope. It was reported that this slowed therapy process, but that the prison environment was more challenging than a hospital one. Overall, staff were seen as a positive and supportive element. In particular, the necessity of a good therapeutic relationship with their therapist was highlighted, which included trust, being understood and feeling safe. Due to the challenging nature of EMDR therapy, this relationship may need time to develop and this was important to maximise therapy benefits.

A third theme explored the 'EMDR Therapy Process' and included the subthemes of the 'Functional Aspects of Bilateral Stimulation', as well as the 'Visceral Impact of

Engagement' experienced by participants. The use and preference of various types of bilateral stimulation used in secure services was outlined, along with participants' experience of this process. The emotional impact of EMDR therapy was visceral and shocking, and left many participants feeling exposed and somewhat unprepared. In spite of this, participants accepted this emotional challenge as part of the process that they needed to go through. For some, the impact was so significant that a break from therapy was required, although they were able to successfully return.

The final theme around 'Identifying Personal Change' included the subthemes of 'Changes in Mental Health and Diagnosis', 'Insight and Reflections on Offending Behaviour', as well as 'Ability to Cope and Experience Hope for the Future'. Participants described the changes that they had observed within themselves, which they believed were long-lasting. Such changes included feeling less anxious, less worthless, a reduction in racing thoughts and better sleep. Participants also reflected on how long they had lived with trauma symptoms and how this had become normal for them. Some participants experienced a reduction in symptoms of psychosis and highlighted the difficulties in differentiating symptoms of psychosis with trauma. This was notable, particularly in terms of diagnosis. Increased insight into offending behaviours was also experienced and some participants no longer felt the need to engage in problematic behaviours. Relationships with others improved due to their increased ability to trust and participants generally reported increased feelings of strength, ability to cope and hope for the future.

# Chapter 5: Discussion

Trauma is "an ineradicable aspect of life" (Epstein, 2013, p.3).

This Chapter will provide a summary of the overall analysis, with reference to the research aims, and will be contextualised within existing literature. The overarching aim of this study was to develop an understanding of service users' personal experiences of EMDR therapy within secure services. More specifically, this included the opportunity for participants detained under the Mental Health Act (1983) to communicate their understanding of their current situation and personal experiences of EMDR therapy, whilst residing within a secure service (high, medium and low), and is reflected across all of the identified themes. Discussion relating to the personal experiences of participants is organised under the four main theme headings.

Research aims around exploring the collaborative nature of the referral process and how this may have differed from previous interventions offered, are strongly reflected in themes 'Decision to Engage in EMDR Therapy' and 'Essential Support Structures'. A further aim was to explore the different ways of engaging in EMDR therapy and how the therapy may have influenced their feelings, attitudes, beliefs or behaviours, which is reflected in the themes around 'Identifying Personal Change' and the 'EMDR Therapy Process'.

In addition to exploring personal experience of EMDR therapy, this Chapter will address aims relating to informing the utility and application of EMDR therapy within secure settings and identifying resource needs. Finally, this Chapter will discuss aims related to clinical implications of the analysis, as well as identifying limitations and directions for future research.

## 5.1 A Personal Experience

This section focuses on the personal experiences of EMDR therapy and is primarily organised by the main themes, with relevant subheadings to highlight emerging discussion points. This section also explores the utility and application of EMDR

therapy within secure settings, alongside some of the observed difficulties that may arise.

### 5.1.1 Decision to Engage in Therapy

The 'Decision to Engage in Therapy' theme illustrates the decision-making process of engaging in EMDR therapy and is separated into two subthemes: 'Accessing Information and the Unknown' and 'Making a Personal Commitment'. Participants' understanding and knowledge of EMDR therapy will be explored, alongside current literature. This will include initial thoughts and discussions, undertaking their own personal research, collaboration with clinical teams and participants' reflections on future needs. Motivation for engaging in EMDR therapy will also be reviewed with respect to when therapy was offered on their treatment pathway.

#### *5.1.1.i The Ability to Explore Therapy Options whilst Detained in a Secure Service*

There are reported benefits of providing information about engaging individuals in healthcare more generally and in relation to psychological therapies (Coulter, 2011). In terms of the latter, it could be argued that this is relevant to achieving informed consent (British Psychological Society (BPS), 2017). As a relatively new therapy, the mechanisms present in EMDR therapy are still not fully understood and it sounded quite mystical to participants in the current study. Although a therapist can provide clients with information about possible mechanisms (Gunter & Bodner, 2009), this remains an area of ongoing research.

In line with good practice guidelines, participants were provided with information by the treating therapist, prior to gaining consent to engage in therapy (Health and Care Professions Council (HCPC), 2016; Francine Shapiro, 2001). The process was explained verbally and in writing, with the opportunity for further questions and often occurred alongside the clinical team which took a supportive role. It appears that services within the current study closely adhered to guidelines which highlight the importance of recognising power imbalances and obtaining informed consent, where "every attempt should be made to emphasise individual involvement and choice and to avoid coercion" (BPS, 2017. p.31), and with specific reference to detained populations. However, in spite of this, and possibly due to being an emerging and

slightly different therapy, a significant amount of mystery remained around EMDR therapy and its effects.

To address this lack of knowledge, some participants engaged in their own personal research, which included speaking to peers and via the internet. This included discussing personal experiences of EMDR therapy with peers and purchasing books on the subject. The seeking of knowledge occurred prior to, and after, personally engaging in the therapy. Currently there is no research which explores how service users might conduct their own research into therapies and if this impacts on future engagement with therapy.

Within general society, information is becoming increasing available, with reference to celebrities such as actress Jameela Jamil (Brand, 2019). Some of these resources can be found on the EMDR UK website, including the actress Evan Rachel Wood speaking about their experiences engaging in EMDR therapy, as well as depictions on TV shows such as 'Grey's Anatomy' (EMDR UK, 2020). All of this arguably serves to raise awareness of EMDR therapy within the general public. Sources are also found more generally on social media, with links offered to further websites or organisations for further information. However, these sources are arguably more difficult for participants in secure services to access, especially without the support of hospital staff. Within the current study, some participants asked their family for advice, who in turn accessed information from the internet. This highlights an important issue for those in forensic services who may be reliant on the information that professionals within the service give them or sources from peers and family. Although internet access is increasing, in line with guidelines, the level of access, freedom and privacy will be directly relevant to the service and level of security. As such, it is likely that environments of higher security and increased restrictions will have limited or no access.

The analysis also highlighted how misunderstandings could occur due to lack of information and subsequently impact on engagement. For example, Percy did not wish to be hypnotised and this is not a surprising reaction in that the mechanisms in EMDR therapy may be assumed to be similar to other comparable approaches such as

hypnotherapy. However, literature suggests that although EMDR therapy and hypnotherapy could both be described as methods that can move therapy along more quickly and deeply than talking therapy alone - reaching parts of memories and experiences that may be elusive at an unconscious level - there are clear differences, and any effects in EDMR therapy are not due to hypnotic suggestion (Fine & Berkowitz, 2001; Frischholtz, Kowell, & Hammond, 2001; Philips, 2001; Shapiro, 2001). It may be important for service users to be clearly informed of these differences, as this may increase the feeling of being controlled and powerless as well as relevant to issues of consent. This also could suggest that the trust involved in the relationship may need to be greater to undergo a therapy that is not fully understood.

#### *5.1.1.ii Trauma Therapy, Public Perception and an Ethical Dilemma*

Further advertising about the application of EMDR therapy may also be relevant for other professionals and to the general public. Trauma-informed services are relatively new and, although there is research exploring professional differences in general towards those who commit offences and those with mental health problems (Glendinning & Keeffe, 2015), there is currently no research into the benefits of working with trauma in those who have offended.

Public perception is an important and potentially political aspect in terms of tackling treatment and community reintegration, which reflects the work of Rogers and Law (2010). This includes how comfortable society may feel about reducing distress in someone who has committed offences. This may be particularly relevant when related to trauma around a perpetrator's offence, as well as beliefs regarding the purpose and function of incarceration and of any differences between prisons and hospital settings.

Miller and Najavits (2013) investigated the application of trauma-informed care within a correctional setting and emphasised that staff attitudes and behaviour are crucial to a therapeutic environment. This subsequently led to the suggestion of training, staff support and supervision to support those working within this approach (Bryson et al., 2017). More recently, Niimura, Naknishi, Okumura and Nishida (2019) investigated the effectiveness of educational training sessions in trauma-informed care within psychiatric hospitals. They suggested that a brief one-day training session that

highlights the profound effects of trauma on an individual, could bring awareness to the ways institutions can re-trigger this trauma and significantly improve attitudes towards a trauma-informed approach.

Within secure services, treatment can be mandated by bodies such as First-Tier Tribunals. This would suggest that the offence-focused approaches to offender treatment will need to be broadened and the need for such trauma-based interventions more widely recognised. It is arguably easier to recommend an intervention for an offence-focused intervention as a result of such behaviour, e.g., anger management or substance use. However, the recommendation of a trauma intervention could be viewed differently, even if this may be the underlying reason for difficulties managing anger or using substances to cope, as the association is less clear. It is also possible that services may see the behaviour separate to the underlying cause.

None of the participants in the current study were mandated to engage in EMDR therapy but, as awareness increases, there may be ethical issues in mandating someone to engage in trauma-focused intervention. Currently, this would not be commonplace within secure services. Trauma intervention remains somewhat specialist and niche, and secure services focus on presenting issues and criminogenic behaviours. It is arguably easier to mandate therapy for an offence-focused behaviour as this has a clear reasoning. However, this becomes more complex if offending behaviours are driven by trauma symptomology or their experiences are better understood as trauma symptoms in the first place. It could be of interest how society views incarcerated individuals who have been victims of trauma, even if they may have gone on to commit offences themselves, as this may in turn impact views on societal support of offender interventions.

#### *5.1.1.iii Exploring Motivation*

Participant goals and motivation were explored in terms of personal commitment to engaging in EMDR therapy. Some participants identified feeling stuck and they may have felt this way for some time. However, some also described how, at certain points during their detention, they had no motivation to change and didn't care what

happened to them. This would suggest that punishment has limited effect (Brody, 1976; Robinson, 1971) and also supports the need to develop internal motivation (Garland, 2001; McMurran, 2009; McMurran et al., 1998). This involves more than identifying a goal, but is about self-belief and that the goal and change is possible (Burke et al., 2002; Miller & Rollnick, 2002).

Some participants simply wanted their distress and difficulties to end, whereas others wanted to come to terms with what had happened to them in the past and to learn more about trauma symptoms. These reasons are arguably not dissimilar to why individuals seek support within general society. However, some participants believed that wanting their personal distress to end was selfish and indulgent, even if they were somewhat placated in the recognition that it would have a positive impact on those around them. This could suggest individuals who have committed an offence may experience guilt around healing. Although this could be a motivational factor to engage in therapy, it is also possible that under some circumstances this would be an obstacle to engagement. For some participants, EMDR therapy was the last intervention offered during their time in secure services. This either reflects EMDR therapy as being a new therapy in this environment, and suggests the implementation of a more progressive approach being implemented, or that it was indeed viewed as a lesser priority.

There is increasing focus on trauma within forensic services and a recent study found that all service users had experienced at least one traumatic event during their life, which often occurred during childhood (McKenna, Jackson, & Browne, 2019). Although research suggests trauma and offending are linked, it is questionable whether the understanding of this link is fully understood or communicated by services to service users. For example, could someone in hospital be reluctant to receive therapy for personal distress, believing that they deserve this distress due to offending behaviours? If so, this could result in their distress continuing, which may result in a continued risk of problem behaviours and maladaptive coping mechanisms. The implementation of trauma-informed service would more closely address this.

#### *5.1.1.iv Recognising Trauma – A Personal Indulgence?*

For some participants, the need for trauma intervention was highlighted by a growing insight into their difficulties and changed their attitudes to therapy. For others, past trauma was triggered by engaging in offence-focused groups, which is reflected in current literature (Johnstone, Boyle, Cromby, Dillon, Harper, Kinderman, et al., 2018). Group therapy can be a powerful modality, which offers an opportunity to explore interpersonal deficits (Jennings & Sawyer, 2003; Marshall, Anderson, & Fernandez, 1999), as well as for challenge and feedback by peers (Frost & Connelly, 2004; Salter, 1988). In some cases, group therapy may be as effective as individual therapy, as well as being generally more cost effective (Ware, Mann, & Wakeling, 2009). However, it is unclear how much awareness and support there is for the potential for triggering of past trauma or trauma related to past offending behaviours. It further suggested that if someone is distressed by such groups, it is likely that their engagement and motivation to continue will be impacted if neither they nor the facilitators understand what is happening. Individuals may start avoiding sessions, drop out of the group, or not fully contribute, all of which are arguably a natural response to trauma being triggered and not a simple lack of motivation. Abreactions may be experienced, including emotional outbursts, increase in mental health symptoms (i.e., voices), increase in maladaptive coping (i.e., increase in substance use or self-harm) or even dissociation. Depending on the individual facilitating these groups, it is questionable whether these behaviours will be observed as lack of motivation and disengagement or as abreactions. This may be more relevant when considering that some groups in prison are run by prison officers who are even less likely to have experience of trauma symptoms.

When considering the availability of trauma therapies within services, there does not appear to be clear guidance on this in terms of when, how, or even if these interventions are offered or are even available. There seem to be further differences between prison and hospital provisions. This depends greatly on the individual institution, services available and possibly the clinicians employed within. The current study showed increased use in high secure hospitals, which may suggest an increase in funding and resources, combined with clinicians who were passionate about this

and about the possible benefits. However, it is unclear if trauma interventions are available within prison settings and how someone might be referred.

A study by Kitchiner (2000) highlights the potential benefits of EMDR therapy for a prisoner experiencing symptoms of PTSD following the miscarriage of his partners baby. The importance of providing healthcare services within prisons which has a similar range and quality to that found within the community is raised. However, it is unknown how commonly such decisions are made and whether trauma-focused interventions are currently viewed by professionals and service users as a "personal indulgence" or a core need which should be offered as soon as possible. This is of particular note if completion could enable increased engagement and responsivity in offence-focused work, as they may no longer be triggered by currently distress, including their own or others' offending. Traumas and adverse experiences could be assessed early on for those held within secure services with consideration given to treatment needs.

This also brings into question whether staff working within forensic environments need to be fully trained to be aware of these symptoms or abreactions to trauma and if behaviours such as avoidance or dissociation are interpreted as purely behavioural issues or pathologised. We often see this as training need when working with victims, but is consideration given to the fact that many individuals who have committed offences are also victims, which may have further complications?

### 5.1.2 Essential Support Structures

The 'Essential Support Structures' theme included subthemes relating to the impact and 'Challenges of a Secure Environment' on participants' ability to engage with the EMDR intervention, and the 'Necessity of the Therapeutic Relationship', which included the support that they receive from hospital staff and in particular the relationship with their therapist. These elements will be explored alongside current literature and in relation to the study aims around exploring participants' experiences of EMDR within the secure environment, collaboration with their clinical team and the need to build a therapeutic relationship.

#### *5.1.2.i In Search of a Healing Environment*

By their nature, psychiatric hospitals incarcerate, restrain and control and are often far removed from an envisioned peaceful sanctuary to allow healing and recovery. This may arguably be more so in forensic services, where possible risks are paramount. Service users are required to live in close proximity to others who may be experiencing a variety of significant mental health difficulties. Some of these experiences may be bizarre in nature, causing distress for those witnessing this, or individuals could be outwardly aggressive or violent. Wards can be busy places, full of noises and distractions, and where access to outdoor space and broader coping strategies is limited. To some extent, this was experienced during the current study. Some of the interviews took place on a ward and I was aware of the bustle of life there. As well as generally distracting, it was clear that any incident or activity on the ward would be heard in, and enter, the therapy space. This view was supported by the participants' experiences of the impact that the environment had on therapy, for example, when Aljazeera spoke of hearing banging and shouting on the ward, whilst in the middle of processing a traumatic memory. Within secure services, access to off-ward areas may be difficult due to security or resource issues. Therapy can be conducted in a room on a ward and then if an incident occurs which is potentially violent or aggressive, this is occurring within a space that should be safe. This could directly act as a trigger for trauma, or the service user must then return to an environment and mix with peers which may continue to be volatile.

NICE guidelines suggest that clinicians should be vigilant of the potential for continued exposure to trauma (National Institute for Health and Care Excellence (NICE), 2019). This included avoidance of triggers which may impact negatively on symptoms or engagement. The guidelines also clearly state that assessing or treating people in noisy or restricted environments should be avoided, such as an inpatient ward or where others may be restrained. However, it is noted that within secure services this is often close to impossible. Therapy often takes place on the wards or wings, as experienced in the current study, and the institution's rules and regulations often govern the time and length of sessions.

Many units have interview rooms on the ward, which are often multifunctional, with transparent viewing panels. Although required for issues around safety, this arguably raises confidentiality issues, as both clinical staff and service users on the ward may be able to see in. This would leave a participant vulnerable if an emotional reaction is provoked during therapy, possibly triggering further feelings of vulnerability. Additional concerns could be raised that relate to the use of light-bars which may cause interest in peers to observe. When such levels of confidentiality cannot be guaranteed, this should be considered in line with research that indicates links with decreased participant self-disclosure (Holahan & Slaikeu, 1977) and the impact this will have on therapy outcome.

Even when therapy takes place off the ward, restrictions in movement in terms of ability to leave a therapy space without escort should be considered, as should the possibility of still hearing attack alarms within the therapy room. During EMDR therapy, the impact of sound may be particularly notable, given the periods of silence during bilateral stimulation sets. Noise has been found to have a negative impact on therapeutic engagement, especially if connected with meaning, such as an alarm or shouting that was experienced by a participant in the current study (Pressly & Heesacker, 2001).

A further issue identified in the current study was that of concerns of being moved back to prison and fears that they will no longer get the therapy they need. This questions the viability and perception of conducting EMDR therapy within a prison environment, as well as the potential for moving individuals whilst in the middle of therapy, highlighting differences between the focus of prisons and hospitals.

The prison service has provided short-term, crisis-focused interventions, which use a cognitive-behavioural approach (Hollin & Palmer, 2006). Treatment is often provided via small groups, which have a set number of sessions and a specified content which addresses specific areas of difficulty, such as drug addiction, anger management or sex offender programmes (Towl, 2003). Some have suggested that therapy within prisons simply cannot work and even is an unethical endeavour and should not be routinely offered (Schlesinger, 1979). The reasons for this include lack of appropriate

rooms, the predominance and subsequent impact of security on time boundaries and confidentiality, as well as the potential for prisoners to be transferred at short notice (William-Saunders, 2001). However, Bertrand-Godfrey and Loewenthal (2011) acknowledge the difference between HMP Grendon and other secure settings which appear to be more dedicated to therapeutic interventions, but outside this environment, the situation was considered to be very different and to involve a number of challenges. Broderick's (2007) study reflected some of these challenges, most notably the basic need to provide a contained space which is viewed as safe by those currently detained. This raises the questions regarding secure hospitals and if they are able to provide the dedicated therapy space required. Currently, this is unclear, as is the potential impact of varying levels of security.

Hinshelwood (1993) argued that if an institution does not support therapy, then a lone therapist will be unable to provide efficient therapy. He suggests that positive and negative attitudes towards therapy are related to the whole cultural system shared by prisoners, officers and even therapists. It was proposed that if an environment like this is replicated, individuals with a trauma history are more able to learn new skills or retain information that promotes recovery. Support for a trauma-informed environment within institutions comes from Dahan et al. (2018), who suggested that good correctional practice necessitates highly structured and safe environments, which have predictable and consistent boundaries. As such, it is suggested that further training in the importance of individualised care may be needed if it is to be successfully offered within institutions.

Percy, Aljazeera and Sky spoke of the differences between prison and hospital on therapeutic engagement. Many find prison to be a difficult and destabilising place, which presents social, practical and psychological challenges. This can elicit a variety of feelings, such as loneliness, anxiety, depression, trauma, injustice and powerlessness with uncertainty and, on occasion, violence being a part of this experience (Liebling & Maruna, 2005). For some, the criminal justice process and the prison system itself can have a traumatising effect (Goff, Rose, Rose, & Purves, 2007; Rogers & Law, 2010). When reviewing the mental health provisions for prisoners within the UK, Rickford and Edgar (2005) summarised that isolation can be increased

and people can be subjected to residing in "inhumane" conditions which may be dangerous and fails to respect human dignity. Residing in prison does not only deprive someone of their liberty, but also of their autonomy, safety, access to relationships and to basic services and goods. Although arguably an element of prison is to punish through deprivation, Sykes (1958) suggests that some of these aspects can have a more profound impact, as a direct threat or attack may have.

Large numbers of individuals within prison experience some form of psychological distress (Harvey, 2007; HM Inspectorate of Prisons, 2007; Liebling & Maruna, 2005) and significant research has been conducted around self-harm and suicide attempts within prison. Fazel and Danesh (2002) reported that prisoners are five times more likely to commit suicide than someone in the general population. Rather than aiding rehabilitation, the pain of imprisonment can extend into someone's life long after completing a sentence, with suggestions of longer-term changes to personality (Jamieson & Grounds, 2005). For someone with a pre-existing mental health difficulty, the environment can contribute or alleviate someone's psychological distress (Liebling & Maruna, 2005), which suggests that this should not be underestimated in understanding rehabilitation and factors that impact on successfully engaging in therapy. Additionally, prisoners who may have been experiencing difficulties with emotional regulation prior to entering prison may experience the greater difficulty and also be more reluctant to seek support (Harvey, 2007; Liebling, 1999). When considering EMDR therapy in such an environment, this reluctance to seek support should be recognised and understood.

When engaging someone in trauma therapy, care must be taken that distress is not inadvertently increased and the person re-traumatised. The environment may mean that trauma interventions are not possible, as the system can impact on the practicalities of meeting for sessions and render the traditional therapy space an unrealistic expectation. Even if sessions are possible, timescales within secure services may mean that therapy is not finished, which is problematic when it is suggested that warning times for ending therapy should increase and be dependent on the length and depth of work being undertaken (Bostic, Shadid, & Blotcky, 1996), particularly with individuals who have insecure attachment styles and have experienced a number

of losses (Penn, 1990). Because of this, Rogers and Law (2010) suggest that clinical judgement is required regarding the benefit and potential harm of undertaking trauma interventions and to remain open and honest, whilst constantly balancing risk and confidentiality. Further to this, reference is made to adhering to the principles outlined by Briere and Scott (2006), arguing that it is futile to work individually with a client on these principles without taking the environment into account and especially those staff who are responsible for providing day-to-day safety and care.

#### *5.1.2.ii Staff Support and a Contained Environment*

Participants in the current study also spoke about the positive impact that staff could have on their recovery. The differences in staff attitudes from a prison to a hospital environment was often quickly observed by Percy and was the starting point to building trust and effective relationships. Additionally, Samuel spoke of the perseverance and reassurance he received from his team. This highlights the importance of a staff team and a culture that nurtures this approach.

However, it is noted that working within secure services can arguably be both physically and emotionally demanding for staff, with 72% of prison staff being affected by mental health issues (Kinman, Clements and Hart, 2016). In addition to general work stressors (Viswesvaran, Sanchez, & Fisher, 1999; Xanthakis, 2009), staff working within this environment have to deal with aggressive and sometimes violent situations, which are often directed towards ward staff. Gudjonsson, Rabe-Hesketh and Wilson (2000) showed that during a 17-year period in an MSU hospital, there were 2,180 violent incidents. In the majority of these incidents, assaults were more likely to occur towards staff than other individuals on the ward, with incidents being more likely to be aggressive in nature and potentially involve the use of weapons. Such incidents can leave staff often feeling emotionally shaken after an event (Cheung, Schweitzer, Tuckwell, & Crowley, 1997), increasing the risk of PTSD and emotional difficulties (Wright, Borrill, Teers, & Cassidy, 2006).

When considering the exposure to violence, Rogers and Law (2010) suggest that the system may present with posttraumatic stress responses, such as anxiety and hypervigilance. This may result in staff being less likely to be attuned to providing a

sensitive and care-giving response or provide the safety and containment necessary for trauma work to proceed effectively and that was experienced by participants in the current study. In light of this, it is suggested that efforts should first be made to work with the staff team to develop an environment where trauma can be acknowledged and addressed (Bremness & Polzin, 2014; Golding, Dent, Nissim, & Stott, 2006; Miller & Najavits, 2012; NHS Education For Scotland, 2017; Substance Abuse and Mental Health Services Administration (SAMHSA), 2014c; Sweeney et al., 2016).

A somewhat related issue is when the psychological impact of being detained is not just connected to residing within a secure environment, or even as a result of intentional harm. To illustrate this, Van der Kolk (2014) described an occasion where a decision was made to force feed a patient who the care team feared would become unwell. This involved a physical restraint that was to some degree reflective of the early abuse the patient had experienced at the hands of family members and led to the consideration that "if you do something to a patient that you would not do to your friends or children, consider whether you are unwittingly replicating a trauma from the patient's past" (p.25). It is suggested that a more trauma-informed approach should better highlight the areas of practice that may cause unintentional harm. However, this is an area within secure service which is minimally understood or researched at present.

#### *5.1.2.iii Building Relationships and Expertise*

The current study supports previous literature around the importance of the therapeutic relationship (Lambert, 1979; Lambert & Barley, 2001) and with motivating those who have offended and having aligned goals (Seligman, 2017). Participants in the current study relied on the relationship to enable them to feel safe enough to engage in EMDR therapy. More specifically, this related to their ability to trust in the therapist to bear difficult and challenging interventions, and for them to be able to carry them through. Without this support, some participants felt that they would not have been able to have engaged in the intervention and one felt that it could have been dangerous. This supports the work of Dworkin (2005) and how the therapist can impact on whether the EMDR therapy outcome will be positive or negative. Shapiro

(2001) also emphasised the importance of a therapist conveying safety, flexibility and unconditional regard and how this needs to be achieved before any bilateral stimulation occurs. The need for trust and the ability to be vulnerable in therapy was also clearly highlighted by participants such as Aljazeera and John, and reflected in literature related to trauma (Janoff-Bullman, 1992; Substance Abuse and Mental Health Services Administration (SAMHSA), 2014b).

When working within secure services, it appears that separate institutions have differing approaches to referrals and how EMDR therapy referrals are allocated to therapists. It also appears that there are differences in the way therapists work within secure services. Different procedures within the service affect whether a service user remains with the same therapist or if this changes dependent on their ward, therapist availability/caseload or therapist expertise. When considering trauma interventions and the importance of the therapeutic relationship, this appears to be of particular relevance. However, there is limited research to date which has explored the potential impact that a change of therapist may have on the success or length of the intervention, or if a pre-existing therapeutic relationship is beneficial. As a new therapy, the choice of therapist will likely be limited due to training, making it more likely that in larger services a therapist may not be known to someone prior to therapy. This may have a significant impact on therapy success and length.

Sky and John spoke of the therapist having the expertise and skill to recognise what might be going on for them when they are unable to see this themselves. This enabled the therapist to adapt the intervention as appropriate to the client's presenting needs. It is argued that without this insight and observation, it is possible that participants may have continued when they were not ready. It is also possible that if pushed too hard and too soon, then this could become problematic in terms of engagement or adverse reactions. For this client group, the ramifications of this could be severe with personal experiences of managing difficult emotions and situations via violence, aggression or suicide and self-harm.

A somewhat different view of the therapeutic relationship was offered by Sydney, who stated that the EMDR process could be done by anyone, as it was the EMDR process

that caused the change and not the therapist. However, he also spoke of feeling able to fully engage and not hold back, which would suggest that the relationship was important for him to be able to do this. This is reflected in the work by Greenwald (1994) and Norcross (2002), who acknowledged the synergy between the protocols and procedures of EMDR therapy with a good therapeutic alliance. It suggests a trust in the professional or of a technique for this individual or possible personality type may be sufficient. However, this implies that trust is necessary, whether this is in an individual or of their qualifications. The professionalism and experience of their therapist was something else that participants such as Aljazeera and Sky highlighted and that further increased their feelings of trust that this individual could cope with what they were experiencing.

For the therapist, it should not be underestimated that secure services can be a challenging context for practising psychological therapies. The complexity of an individual's needs, alongside the impact of imprisonment, can be challenging for the therapist, drawing on their aptitude to resilience and flexibility (Huffman, 2006). A qualitative study by Bertrand-Godfrey and Loewenthal (2011) found that therapists experienced feelings of guilt and observed a tension between the prison system and their ability to meet therapeutic commitments. These therapists reflected on their ability to function in conditions that others found too challenging. It is suggested that the therapist needs to be aware of personal limitations and ability to offer the therapeutic relationship which seems to be a core element when offering EMDR therapy in a secure service.

### 5.1.3 EMDR Therapy Process

This theme included two sub-themes which explored the 'Functional Aspects of Bilateral Stimulation' and the methods used within secure services, as well as participants' personal experiences of the 'Visceral Impact of Engagement' and how this may be understood alongside current literature.

#### *5.1.3.i The Mechanics of EMDR Therapy*

During the current study, participants experienced a variety of methods of bilateral stimulation, including those manually conducted by the therapist (i.e., lateral hand

movements) or via a machine (e.g., tappers that vibrate, electronic eye movements). Research to date has focused on the efficacy of these different approaches and eye movements have generally been found to be superior (Hovarth & Luborsky, 1993; Sharpley et al., 1996; van den Hout et al., 2011). However, this research has primarily focused on the efficacy of the type of bilateral stimulation, rather than on the personal preference and comfort of the client. Further, it should be acknowledged that for some, the use of an aid such as a tapper or light bar may back up its efficacy and seem more professional, thereby increasing trust in the process which could arguably impact on efficacy overall. This is reflective of the work of Nadelson et al., (2014), who found that trust in science varied by education in science, political philosophy and religiosity.

Some participants were clearly able to recognise changes as a result of EMDR processing, which supports literature for the efficacy of EMDR therapy, in particular, a reduction in levels of distress and vividness of memories (van den Hout et al., 2001). However, it was also noted that although a participant may report a reduction in decrease (i.e., lowered SUDs reported to therapist), overall change was often not recognised. This suggests that participants may be unable to recognise broader changes when in the middle of a challenging therapy. As they are continuing to work on distressing material, they may not acknowledge positive changes in affect unless this is directly reflected back to them. It is possible that as participants process through the target memory and follow processing through different channels (Shapiro, 2001), which are also very challenging, they remain in a high level of arousal during the session time. As such, this may not reflect the overall reduction in levels of distress. It does not appear that this has been observed in research to date, but it is important to note in terms of ongoing motivation. This also highlights the importance of basic therapist skills to identify and reflect change back to a service user (Miller & Rollnick, 2002).

Basic reflection by the therapist can be viewed as a central point of many therapeutic approaches. Rogers argued that reflection aims to try to determine understanding of the client's inner word and whether the therapist is seeing it as the client is experiencing it at that time (Rogers, n.d.). Any discrepancy can then be explored.

Rogers also acknowledged this process can be similar to holding a mirror up in front of the client's experiences and they are able to see their experiences through the eyes of another. Within the EMDR process, this could serve to test the understanding of the therapist, in terms of assessing if the overall distress levels are reducing or enable the client to check their own perceptions and possible distortions.

As recognised by Shapiro (2001), processing in EMDR therapy is not fluid and clients may jump from one key element of an event to another. The quick pace of jumping through memories was observed by Aljazeera and was also one of the reasons that he had chosen EMDR therapy. It is suggested that this fleeting but intense awareness of related memories may be sufficient time to gain what is needed to heal without further long-drawn-out analysis. The brain is making the connections that it needs to before moving on. This offers an overall increased speed of recovery, without dwelling for long periods of time on distressing memories or in any detail that may not be necessary. This also means that individuals such as Aljazeera do not have to describe past events in detail to their therapist, which can be preferred. Again, although other therapies may be as effective, such as CBT for trauma, it could be argued that some individuals may have a preference for EMDR therapy, especially if they can use a blind protocol (Blore & Holmshaw, 2009). This may be more relevant if the individual is experiencing feelings of shame or guilt around events they are reluctant to discuss. In EMDR therapy, the therapist may not need explicit detail of what is being processed or for this information to be presented in a linear narrative; they are there to support and guide them in this process.

Participants suggested that the bilateral stimulation used in EMDR processing appeared to impact on memory narrative without conscious effort to change or analyse a narrative. This would suggest that the EMDR processing involves more than a conscious change in narrative as may be seen on CBT and imagery descripting, which in itself is viewed as a powerful therapeutic process (Arnoud, 2012).

Aljazeera spoke about the physical set-up and proximity of the therapist, which is particularly relevant in a forensic environment. If conducting traditional eye movements using their hands for bilateral stimulation, the therapist is required to sit

in much greater proximity to the client, which is generally discouraged in such environments. This may add further concerns to the therapeutic encounter that may not be there with more traditional therapies. Although there have been many studies on personal space, only a few have investigated body buffer zones and interpersonal distance in a counselling setting (Pressly & Heesacker, 2001). However, the spacing using traditional hand movements would not be within the comfort zone identified by clients ranging from 1.2 m to 1.5 m (Broekmann & Moeller, 1973; Dinges & Oetting, 1972; Lecomte, Bernstein, & Dumont, 1981). Cultural issues may also influence clients' preferred interpersonal distance (Remland, Jones, & Brinkman, 1995) and may require further exploration.

A somewhat related issue was also identified by Aljazeera. He spoke about how the therapist, being sat within the peripheral vision whilst processing, became "mixed in" with the processing. This does not appear to have been something that has been previously identified or explored.

#### *5.1.3.ii The Emotional Intensity, Safety and Containment*

The emotional impact experienced by participants engaging in EMDR therapy, appears to differ from other therapies. It is recognised that engaging in therapy, particularly with a trauma focus, can often be challenging (Mind, 2018). However, participant reflections suggested that there is something about engaging in EMDR that was different and somewhat of a shock. This reaction occurred in spite of prior therapy experience and being given information about what to expect.

In part, this emotional impact may be linked to the intensity and depth of the EMDR process, even for participants who had engaged in many types of talking therapies. Individuals engaging in EMDR therapy may start to see and feel things in a way they were not expecting, as EMDR therapy incorporates the body which other talking therapies often do not. Some of these experiences may be directly linked to their current difficulties, but some more indirectly. Albeit with clear processes for the therapist to follow, EMDR therapy appears to work in a less conscious and controlled manner than therapies such as CBT. EMDR therapy uses free association and observations of emerging and changing physical sensations or emotions (Shapiro,

2001). Shapiro (2001) suggests that EMDR processing may release physical sensations that are linked to emotions into the client's consciousness that were stored at the time of the traumatic event. Shapiro explains that this could include a rape victim feeling the hands of a rapist, all of which could be surprising to experience and further add to feelings of vulnerability for participants.

To engage successfully, participants need to open up and possibly move to a deeper level than they may have previously engaged with in therapy. This may help participants to access both memories and emotions that had previously been unconscious and hidden. With complex trauma, it is possible that individuals dissociate and the EMDR process can bring them into touch with memories and emotions that have remained hidden for a long time (Paulson, 2009; Treleaven, 2018). Although this is also commonly seen within talking therapies, EMDR therapy is reportedly faster at processing than other therapies (de Roos et al., 2011) and this could further add to the "shock" of this approach. With other approaches, such as in CBT, participants are likely to become increasingly aware of their own internal thoughts, behaviour and attitudes, where they are able to actively and consciously challenge these as appropriate. However, within EMDR therapy this is a leap into the unknown.

Jarrett (2008) highlighted the potential harm that psychological treatments could cause and referred to the work of Lilienfield (2007), who suggested that progress is closely tracked. Although little has been written about this phenomenon, it is widely recognised that trauma interventions are challenging, regardless of the therapeutic approach applied. Therapists are trained that this form of intervention may pose a risk of the client becoming overwhelmed or showing signs of increased distress (Rothschild, 2000). In part, these dangers appear to have been attributed to the potential for re-traumatisation of the individual. However, it is also noted that in this study, many of the participants chose to continue, even when they realised how challenging the therapy was. This suggests an ability for participants to understand and weigh short-term distress against longer-term gains, in terms of consent.

One participant (Joseph) had a significant history of suicidal ideation and experienced being acutely distressed during the EMDR therapy processing, to the extent that he

had thoughts of ending his life. When working with trauma, Shapiro suggests that care is taken, as the potential for abreaction is high, but that therapy can continue as long as the material is shifting, and this is seen as part of the process. This was supported by the study by Proudlock and Peris (2020), who found EMDR therapy to be effective when working with patients in acute mental health crisis, including suicidal ideation. This is important as many clinicians may be reluctant to work with individuals who are in crisis. Shapiro (2001) also highlights that clients are at greater risk of suicidal ideation and attempts when they feel greatly disturbed and do not report this information to their therapist when working within a protected environment. This refers back to the importance of the therapeutic relationship and clinical skill in EMDR therapy.

In general, participants appeared to appreciate the use of resources within the EMDR process, which offset the more challenging aspects. According to the EMDR protocol, the use of a safe place exercise is an important exercise, increasing the likelihood of successful processing. Primarily, it ensures that participants are able to quickly recover emotional stability during any disturbance, and it can be used to act as a temporary rest point during processing or closing down at the end of a session (Shapiro, 2001). In addition to the use of safe place exercise, individuals can be supported with the use of attachment-focused EMDR. These resources are often used for complex difficulties and can be central, particularly with those who have difficulties related to attachment (Parnell, 2013). There appears to have been limited research into the use of resources within EMDR therapy.

### 5.1.4 Identifying Personal Change

Albeit to differing degrees and in different ways, all participants observed personal change following their engagement in EMDR therapy and the subthemes reflect these. More specifically, the subtheme 'Changes in Mental Health' could reflect subtle changes such as feeling more in control or clear changes in their symptoms (i.e., reduction in self-harm, suicide, voices, nightmares, reduction in feelings of anger, increase in self-esteem), or how participants related to others (i.e., fear of rejection or ability to trust). Further changes were observed in relation to participant 'Insight

and Reflections on Offending Behaviour' and on their perceived 'Ability to Cope and Experience Hope for the Future'.

#### *5.1.4.i Rethinking Mental Health Diagnosis and Symptomology*

The application of EMDR therapy raised some issues around the understanding of participants' difficulties and symptomology. There appeared to be some crossover for some individuals in terms of diagnosis, and at times it appeared unclear whether their 'symptoms' were better understood as flashbacks related to past experiences and PTSD or as schizophrenia. For John, intervention resulted in a clear change of diagnosis. This appeared to reflect literature around trauma and psychosis and our understanding of these difficulties as medical or trauma-based in aetiology (Bentall, 2015; Miller, 2016; Read et al., 2004). It raised the question of how many service users may be misdiagnosed, or their difficulties misunderstood, even within current diagnostic criteria. In spite of the prevalence of trauma within secure services, and literature suggesting that it is closely linked with mental health difficulties and offending behaviour, trauma does not appear to be a primary diagnosis or reason for detention under the Mental Health Act (1983) within secure services (Department of Health, 1983) or a focus for intervention. On occasion, it may be secondary to one of schizophrenia, bipolar disorder or personality disorder. The reasons for this are currently unclear, yet hold great significance in terms of our understanding of mental health difficulties, the impact of trauma and of suitable intervention approaches.

It is possible that professionals may experience an expert bias (Pons, 2016). This would suggest that clinicians, as specialists, come from different theoretical understandings, which results in clinicians understanding and interpreting what they see based on this speciality. Pons (2016) argued that profound knowledge in small areas can result in an error of perspective and may easily overlook a more general perspective of what is being contemplated - the human being. It is possible that secure services are indeed a small area and that expert bias could be present. This raises the question of how good professionals are at differentiating diagnoses of trauma and psychosis, as well as complex PTSD, personality disorder and disorders relating to dissociation. This may be further impacted if clinicians do not seek to gain a full background history which includes adverse life experiences.

As with the participant experiences in the current study, many individuals currently detained with secure services may have experienced adverse childhood experiences or trauma. However, historically, services have focused on treating a diagnosis and relating symptomology. Some symptoms and problem behaviours that professionals may witness and target directly may in fact be a direct result of the individual trying to actively manage their distress resulting from early adverse experience and viewing difficulties within a broader social framework such as The Power Threat Meaning Framework (PTMF: Johnstone, Boyle, Cromby, Dillon, Harper, Kinderman, et al., 2018). The PTMF is a new way of understanding how and why people experience distress. More notably, it offers an alternative approach to traditional models based on psychiatric diagnosis that is applicable to those within and outside of services. It highlights the importance of power, how people experience this in their lives and, more specifically, the way this power can be misused and how people respond. In traditional approaches, these threat responses could be called symptoms. However, the PTMF also acknowledges, and to some extent normalises, how sense is made of these difficult experiences and the impact from wider society. The framework highlights the links between social factors such as poverty, discrimination and inequality, alongside traumas such as violence and abuse, and the resulting emotional impact or problem behaviours.

More recently, this framework has been used to explore the impact of long-term imprisonment, and was found to be effective in enabling individuals to explore their own challenging behaviour, whilst putting it into context and possibly fostering personal agency (Reis, Dinelli, & Elias, 2019). When reflecting on the framework one year on, it has been recognised that the response was not wholly positive, in particular the questioning of psychiatric diagnosis, which is a significant shift from the current reality, as well as the framework's socio-political nature (Johnstone et al., 2019).

This also questions what it would be like for a service user to experience such a change in their diagnosis, which can be closely linked with identity (Yanos, DeLuca, Roe, & Lysaker, 2020). Additionally, this may lead to a very different understanding of their difficulties and associated stigma, which in turn can impact on recovery (Bowen, 2019; Link, 1987; Link, Phelan, Bresnahan, Stueve, & Pecosolido, 1999). It may also be

possible that experiences of trauma may be acknowledged for the first time and they are offered support for this.

A further consideration is that services may only recommend what they have the capacity to treat. If they do not have the potential to address trauma-based interventions, as they do not have suitable clinicians employed, it is questionable whether any such referrals would be made. It is also unclear whether staff of various disciplines working in forensic services currently feel sufficiently competent to work with trauma. It is also of interest which services are currently offering trauma-based intervention such as EMDR therapy and the reasons they have for offering this service. For example, are these services more progressive in terms of research and training, do they receive better funding or does the size of the unit affect this?

#### *5.1.4.ii Abuse as an Underreported and Hidden Phenomenon*

Many of the participants within the current study experienced childhood trauma and abuse. However, as previously discussed, this might not always be known to services around the time of admission. In context, many victims of childhood abuse do not report their experiences (McGee, Garavan, DeBarra, Bryne, & Conroy, 2002; Truth Project, 2021) and there is possibly a higher nondisclosure rate in boys (Priebe & Svedin, 2008). Literature suggests that this may be due to limited support, fears over loss and control or other perceived negative consequences, perceived responsibility for abuse or lack of understanding of what happened, as well as feelings of self-blame, shame and guilt (Goodman-Brown, Edelsteain, & Goodman, 2003; Lemaigre, Taylor, & Gittoes, 2017; Quas et al., 2005; Schaeffer, Leventhal, & Asnes, 2011; Ungar, Tutty, McConnell, Barter, & Fairholm, 2009). As a result of disclosures to parents which were not believed or supported, some may have already come to believe that people in authority will not listen (Hanson & Wallis, 2018).

As children, service users may have attempted disclosure or, for one of many reasons, decided not to (McElvaney & Greene, Shogan, 2014). There have been many cases recently in the media where adults' disclosures have not been believed and, as such, it may be a legitimate concern that they will not be believed or that nothing can be done as a result of their disclosure, except more pain. Rees, Simpson, Mccormack,

Moussa and Amanatidis (2019) highlight the need for societal and institutional changes to overcome denial and silence as a response to sexual abuse which can occur within the family. In addition to previous studies, they found that self-blame and, at times, guilt were closely linked with being ignored or blamed after a disclosure. In turn, the negative reaction of a primary care giver or relative resulted in feelings of betrayal and this is psychologically harmful. It is suggested that asking about abuse in an appropriate manner may facilitate disclosure and that this should be encouraged, in addition to the importance of responding supportively if disclosures occur (Lemaigre et al., 2017).

The Independent Inquiry into Child Sexual Abuse was set up following a number of serious and high-profile cases of child sexual abuse (Independent Inquiry into Child Sexual Abuse, 2021). These incidents were not recent but showed that some organisations had failed to protect children from sexual abuse and that this was an ongoing concern. It is possible that secure services may come into contact with some of these individuals as adults. If so, issues around trust, power and previous experiences of disclosure should be considered. In addition, some service users, as part of their mental health difficulties, may have experienced delusions whereby professionals have historically not believed them. It could be argued that this may further impact on the potential for disclosure and for professionals to act on this. This is particularly notable when disclosing abuse that has occurred within healthcare settings (Zammit, Brown, Mooney, & King, 2020).

#### *5.1.4.iii Formulation and Treatment Planning*

As seen in the current study, it possible that many of the problem behaviours seen within secure services can stem from traumatic experiences or trauma re-enactment. For example, within the current study, trauma responses caused psychological distress, had a negative impact on participants' abilities to use coping strategies and hindered their ability to form and maintain relationships. For many, the pain and distress they experienced had been with them for so long that it had become a normal part of their life. Once the pain from past trauma was addressed, participants no longer found themselves struggling with overwhelming emotions which needed to be numbed through substance use or caused problems in their interactions with others.

Participants were less distressed and more able to trust which, in turn, impacted on their ability to engage with services and seek support. This questions the need for trauma interventions, such as EMDR therapy with treatment planning, and when it should occur. Should it be a primary intervention due to the impact on a wide range of issues or, as viewed by some participants, is it an indulgent extra at the end of the treatment pathway?

When attempting to understand someone's presenting difficulties, and inform treatment planning, there are many different theoretical approaches to formulation. This can include:

> Inferences about predisposing vulnerabilities, a parthenogenic learning history, biological or genetic factors, sociocultural influences, currently operating contingencies or reinforcement, conditioned stimulus response relationships, schemas, working models, beliefs about the self, others the future and the world. (Sturmey and McMurran, 2011, p.3)

The use of psychological formulation within mental health and forensic services is not a new phenomenon (British Psychological Society (BPS), 2011; Kennedy, Smalley, & Harris, 2003; Logan, 2015; Sturmey, 1996; Ward, Vertue, & Haig, 1999). Good practice suggests that all formulations should be collaborative, trauma-informed (British Psychological Society (BPS), 2011), and that formulation can be a useful way of adapting more of a trauma perspective in general (Johnstone et al., 2015). This approach is particularly effective when key MDT members are involved (Johnstone, 2013; Lake, 2008). When attempting to understand offending behaviours in highly demanding environments, best practice suggests that formulations are trauma-informed to reduce restrictive practice and prevent unintentional re-traumatisation by services (Johnstone, 2019). It is further argued that cultural change can be achieved by creating an environment which is more psychologically informed and where the feelings of staff and any associated countertransference can be understood and processed.

A further area in which understanding the impact of trauma on current behavioural difficulties and EMDR demonstrates some early promise is with addictions (Marich, 2010), moving on from the commonly held view of addiction as a disease in rehabilitation services (Partnership to end addiction, n.d.; Rehab4addiction, n.d.). An important aspect of this was the willingness to engage in EMDR therapy and how important this is to treatment outcome (Kalichman, Henderson, Shealy, & Dwyer, 1992; Ricci, 2006). Three of the participants had experienced issues with substance use in the past. It was unclear if therapists used a more general approach to treating trauma in addictions or one of the more specific protocols such as the DeTUR urge reduction protocol (Popkey, 2005) or the Feeling-State addiction theory (Miller, 2013), which focuses on understanding the psychological dynamics of behavioural addictions including substance addictions, co-dependence, anger, paraphilias and Paranoia.

#### *5.1.4.iv Increasing Hope and Resilience through Trauma Resolution*

After engaging in EMDR therapy, participants experienced increased feelings of strength, ability to cope and hope for the future. They felt more able to use the skills that they had previously, which suggests that, for some, being given coping skills was not enough. It is possible that their distress was so great before EMDR therapy desensitised their distress that the impact of these skills was not sufficient. Additionally, participants appeared to have been impacted in how they viewed their difficulties and allowed themselves to consider the possibility that they can cope rather than feeling defeated and hopeless. Prior to engaging in EMDR therapy, some participants were unable to see the possibility of change and that a different future was possible. As such, goal setting appeared futile. This reflects literature around temporal orientation and feeling stuck in the past (Holman & Silber, 1998) and that the ability to integrate past and present experiences with future expectations can impact on personal morale, sense of self, and ability to cope effectively with adversity.

After completing EMDR therapy, participants also appeared to reflect changes relevant to posttraumatic growth (Blackie et al., 2017; Tedeschi & Calhoun, 2004) or, more specifically, the changes that someone may undergo following significant adversity (Jayawickreme & Blackie, 2014). Current literature outlines that these changes can occur in a number of areas. For example, people may notice personality changes, an

improvement in their relationships with others, feeling stronger within themselves or being better able to identify new possibilities in life and experience a greater appreciation of life (Tedeschi & Calhoun, 1996). It is noted that a number of these domains were experienced by participants. This also questions the impact of personality changes and the interaction of trauma on personality development, particularly for those who have a diagnosis of personality disorder for which they may be being detained and have a trauma history.

## 5.2 Clinical implications

This section will outline the clinical implications and reflect study aims around the utility and clinical application of EMDR therapy within secure services, outlining resource needs. Further, support is given to the need for child protection measures and safeguarding measures, as well as addressing the possible political and practical implications that may accompany research within a secure service.

### 5.2.1 Therapeutic Considerations

Secure services will benefit from continuing to raise awareness of the benefits of trauma-informed services. This will include the importance of gaining a trauma history and completing comprehensive psychological formulations to understand treatment need. This will assist clinical teams in fully understanding the impact of past experiences on mental health difficulties and offending behaviours, alongside the impact of the current environment. Further, it may help to view individual difficulties within a broader framework, such as the PTMF (Johnstone, Boyle, Cromby, Dillon, Harper, Kinderman, et al., 2018) and provide staff training on this where necessary. Services should also acknowledge the potential for expert bias and understanding of diagnosis when exploring treatment options.

When taking a trauma history, consideration should be given to the detrimental impact of historical or current disclosures not being believed. In particular, the impact on therapeutic relationships and how disbelief can further erode trust. Safeguarding measures should be implemented as appropriate for the protection of the individual within the service, as well as relevant others, and appropriate guidance should be followed (British Psychological Society (BPS), 2017). There may also be some benefit

in individuals being directed to those services set up within society to support victims of child sexual abuse and to share their experiences. It will be important that this access is not prohibited by institutions, even when well-intentioned (Truth Project, n.d.).

Service users should be offered information about trauma-informed services, including the impact of trauma and of the interventions on offer within a service. Where services currently offer EMDR therapy, there may be a need for increased advertising of this approach. This should offer transparent and clearly presented information about the costs and benefits of engaging, as well as offering personal accounts and success stories. This information should also aim to normalise the experiential impact of EMDR therapy and introduce ways to manage these. Involving and engaging service users within the decision-making process could be further enhanced when the disempowering elements of their experience are considered by clinicians (Stovell, Weadren, Morrison, & Hutton, 2016).

Trauma-informed interventions, such as EMDR therapy, should be considered alongside more traditional, offence-focused interventions. As well as which interventions may be beneficial, attention should be given to when they might have the greatest impact in terms of someone's treatment pathway. In particular, this should be noted when screening for offence groups. Group facilitators may require further training for them to be able to recognise trauma impact and possible abreactions and to prevent individuals being retraumatised.

The therapeutic relationship is important in EMDR therapy and it is suggested that relationships are developed as early as possible. Service users may be required to open themselves up to the possibility of emotional and physical pain, some of which may not have been fully recollected or anticipated. The therapist should ensure a good level of trust had been developed prior to attempting processing and it is suggested that a therapist is vigilant for the different types of bilateral stimulation offered and for the comfort of the service user. When attempting to engage service users in trauma interventions such as EMDR therapy, clinicians should be mindful of the ability to offer a safe, private therapy space. Further to this, if therapy is offered, then all

clinical staff need to be aware of the negative impact if an institution and the environment are not supportive.

A further element that should be considered is the impact that the feelings of guilt and shame which someone may experience in relation to their offending history, more specifically, the effect this may have on their motivation and ability to engage meaningfully in therapy. Although guilt may be a driving force for engagement, additional feelings of shame and a need for self-punishment may have a negative impact and prove to be a significant barrier to engaging in therapy.

For those services which currently do not adhere to, or acknowledge, the benefits of implementing a trauma-informed service or have limited knowledge of alternative frameworks (Johnstone, Boyle, Cromby, Dillon, Harper, Kinderman, et al., 2018), the reasons and barriers for this should be explored. For example, is this a lack of knowledge or funding? Either way, this could negatively impact on the progress of individuals who reside in such services and may create a disunity between clinical teams where professionals may have differing understandings of an individual's difficulties and needs. Ultimately, if this is occurring, it will impact on the support and interventions available and will need to be addressed.

In recent years, services have attempted to address the stigma around mental health (Mannarini & Rossi, 2019), increase service user involvement and work more collaboratively (Jacob, 2015). However, Wagstaff, Graham, Farrell, Larkin and Nettle (2018) suggest that this remains an area of concern and for those who are traditionally viewed as challenging to engage in mental health services, many of these issues remain and may directly contribute to difficulties. For example, individuals can experience limited control over their care, particularly around medication, and services were seen as coercive which led to many participants feeling "hounded" and "persecuted" by services which did not listen to them (Wagstaff et al., 2018, p.18). The current research has demonstrated how a trauma-informed approach may be effective when working with individuals who have previously been viewed as difficult to treat, such as those with an emotionally unstable personality disorder, albeit with a known trauma link in aetiology (Susan Brown & Shapiro, 2006), but also for those

whose offending is inextricably linked to this and for which this link may have been overlooked, i.e., psychopathic traits (Baglivio et al., 2020). If services are to be more effective, they need to work hard to reduce the disparity in perceptions around treatment needs. To some extent this could be addressed through collaborative formulation and acknowledgement of trauma history and may open up avenues to engage those that have historically proved challenging.

A key component of EMDR therapy is that it is not a typical talking therapy and, as such, is arguably not limited by the same issues present when dealing with individuals who may live with developmental, cognitive or neurological issues. Seubert (2005) outlines protocols for use with various levels of developmental difficulties and outlines the challenges that may come with working with this group. This was explored further by Mevissen, Lievegoed and de Jong (2011), who argued that people with intellectual difficulties were more likely to develop PTSD than those in the general population. They also found that those who work with this population were often unlikely to recognise this. Their study further demonstrated that PTSD symptoms reduced in all of the cases and that gains persisted over a significant time period. It was further noted that physical symptoms and depression subsided, whilst social and adaptive skills improved. Although research in this area remains sparse, this may open up intervention opportunities for individuals who may previously have had more limited options.

Caution has been advised when using EMDR therapy with individuals who have autism, due to complex neurological differences, which may impact on safe and effective trauma processing. However, with a modified protocol, EMDR therapy has been used to good effect with people across the autistic spectrum (Paulson, 2014), including developmentally disabled children and adults with severe cognitive and verbal impairments. EMDR therapy has been found to reduce symptoms of PTSD and to increase verbal ability, improve social interaction, improve self-regulation, and general functioning. Additionally, Amano and Toichi (2014) argued that some patients with later-stage, severe dementia can display behavioural and psychological characteristics similar to traumatic symptoms which were related to the recollection of past events and related emotional reactions. The EMDR protocol was adapted to an "on the spot

method" which was found to have clear therapeutic effect with the small number of participants recruited with lasting benefits. If EMDR therapy were a successful intervention with these populations, this may open up intervention options greatly within secure services. This is notable considering an increasing aging population who may be in continued distress and the increase in services for those on the autistic spectrum and the impact that significant mental health difficulties may have on cognitive functioning (Fitzgerald et al., 2004), as well as prescribed medication (Nevado-Holgado, Kim, Winchester, Gallacher, & Lovestone, 2016).

### 5.2.2 Child Protection

If we are to reduce offending behaviours and mental health difficulties that have been experienced by participants within the current study, it can be argued that we need to reduce children's exposure to adverse childhood experiences, in its many forms. This is a time of increased social awareness of the impact that trauma and adverse experiences have on children. Brought into the foreground by high-profile cases, the subsequent Inquiry into Child Sexual Abuse (IICSA) and the Truth Project have allowed survivors to share their experience and be respectfully heard (Independent Inquiry into Child Sexual Abuse (IICSA), 2020; Truth Project, n.d.). Increasingly, victims are being heard in many areas where abuse has occurred. Sometimes victims are speaking out for the first time; in other cases they are being heard for the first time and society is no longer turning away. Increasingly, safeguarding is being discussed, as is the importance of prioritising the safety of children and vulnerable adults, making this everybody's responsibility (Department of Education, 2015).

### 5.2.3 Research in Forensic Settings

By their nature, secure services are cut off from the normal world and those detained within the walls are viewed as vulnerable in terms of research recruitment. As such, policies and procedures are in place to offer protection and ensure participants are able to make a voluntary decision and provide informed consent. In addition to a rigorous ethics process and increased scrutiny from ethical boards, the process also involved meeting the requirements of each individual NHS trust. More so than adhering to written policy, this process involves navigating personal concerns and views of individuals with each trust who have gatekeeping responsibilities, as well as

local staffing issues around escorting. This also includes liaising with frontline staff to gain access to participants in terms of day-to-day mental health issues, and addressing staff concerns and events on the day.

The issues around power relations and vulnerability, as well as the practical difficulties when conducting research in a forensic setting (Völlm et al., 2017), were acknowledged and considered in the research design. As a clinician, I was familiar with working within these environments and witnessed some of the difficulties. However, in reality, these were more challenging than anticipated and this study highlighted the significant practical challenges of an external researcher attempting to access this hard-to-reach population. It is possible that these difficulties were amplified as an external researcher and it is noted that research is often undertaken by the local trust, which could raise questions regarding impartiality and unbiased research.

During the current study, all hospitals and broader NHS trusts were involved from an early stage and provided with detailed research procedures and documents. After receiving ethical approval, it was expected that the focus would then be on the more mundane practicalities of gaining access and recruiting consenting participants. However, at this point, different trusts raised further concerns and requested changes or identified additional requirements. On occasion, this occurred days before the interviews were arranged to take place. Examples included denying access of the previously agreed model of an encrypted recorder device and wanting to review transcripts prior to being taken out of the hospital. Some requests at these later stages were not possible. This included the request to attend one-to-two-week training courses (equivalent to induction training required for new staff) to gain access to more than one hospital. Although feasible for longer-term studies taking place in one hospital, the current project was across differing hospitals and would have required the researcher to attend weeks, if not months, of training to conduct 10 interviews. As a result, additional alterations were made to the original protocol. This was often complicated further, as different hospitals offered different solutions, based on their available resources and specific concerns. Separate amendments were made to the Research Ethics Committee, which incurred time delays.

These amendments also raised issues around confidentiality and impartiality, in particular, the concern that specific individuals within the hospital may have access to the data for both service users and the treating therapists. The researcher was reliant that this would be managed professionally by those reviewing the data. The amendment which caused the most concern was when the researcher was denied direct access to one of the hospitals and the interviews were conducted by a student researcher employed by the NHS trust for that unit. The transcripts were then reviewed by the lead researcher, who was also a clinician within the hospital prior to being realised. This meant that the researcher never had access to the original data. Efforts were made to overcome potential issues, such as the interviewer being trained by the researcher.

#### *5.2.3.i An Organisational Threat?*

When considering the underlying reasons for the challenges of conducting research within secure services, Mason (2003) argues that research may be considered threatening to the individual, the organisation or institution as a whole and questions what happens if practice is seen as ineffective or if unethical practice is uncovered. Abuses have historically occurred in forensic cultures and Mason (2003) argues that the closed nature of such institutions may be linked to fears that research outcomes could be used against them. The many ways that the research may be obstructed at various stages in the process are listed, including how a psychiatrist may refuse access based on clinical grounds, a therapist may not approach someone receiving therapy, or security personal or hospital managers may refuse access in spite of hospital procedures indicating otherwise, or hospital-based researchers may wish to conduct similar research. As in the current study, Mason (2003) experienced these to some degree, as well as having to navigate the usual numerous layers of policies, procedures and individuals concerns.

At the time of writing, Mason (2003) highlighted that not all forensic areas came under Local Research Ethics Committees and suggested that, out of fear, some individuals may prevent research from occurring. It was argued that this may be due to a lack of understanding of medical ethics and philosophies of science or a misplaced desire to protect service users and the organisation. Some high-security services may also

consider political and media threat, and fear how some information published may present a clear political threat and, as such, be open to censorship. However, Mason (2003) argues that perceptions of threat are not often a reality and questions at what point the secrecy and closed nature of these environments reflect the mistrust and paranoia of the service users which these services are protecting.

These issues and concerns were seen to some extent in the current study. Two of the hospitals adhered to the initial procedures, for which ethical approval was granted, and devices were acquired to meet specified security requirements of the higher secure establishments. These services trusted the researcher's capacity to behave ethically and adhere to restrictions. However, one hospital refused access for the recording device, at short notice, in spite of their own policies. When this decision was questioned, policy was stated as a reason. However, the identified policy did not actually prevent access of devices completely within the unit and specific access could be granted for the purpose of research. In spite of this challenge, access was still denied and the decision, in effect, went against the organisation policy. Another hospital did not support the researcher being on site.

Accommodations and changes were made in the current study, without which the research could not have gone ahead. On balance, the decision was made to proceed, as otherwise this population would remain without a voice, which in effect may continue their experiences of not being heard. This was interesting, as not only did this provide a comparison in terms of interview content, but also in terms of organisation practice and approaches to research and control of this. This was especially noticeable when hospitals were of equivalent levels of security.

The notion that research can move beyond academic discussion and clinical implications can be seen following the results of the Core SOTP programme was published, which suggested little or no changes were observed in re-offending rates following engagement in a high profile intervention (Mews et al., 2017). The British media reported on this and blamed the Ministry of Justice for wasting large sums of money on an intervention which didn't work and may even have increased offending. Lösel et al. (2020) described how a single study had led to a "seismic event" (p.465)

which had far-reaching political, financial and practical implications and resulted in the intervention being stopped. It is argued that many institutions could be understandably cautious of coming under similar scrutiny in the future. However, this must be balanced with the need to empower and give voice to vulnerable groups and prevent the potential for ineffective and unethical practice continuing.

#### *5.2.3.ii Gatekeeping, Consent and Navigating Power*

Elements of coercion likely exist where any constraints on freedom are present and issues relating to gatekeeping could increase in relation to accessing vulnerable populations (Adshed & Brown, 2003). Bartlett and Canvin (2003) observed the power that key workers hold when attempts were made to access those with mental health difficulties, and how access could be denied even when granted by the psychiatrist and relevant ethics committee. These frontline workers hold a lot of responsibility for those in their care and this gatekeeping was viewed as "paternalistic and protective, revealing concerns that approaching service users could cause too much distress" (p.59). However, Bartlett and Canvin (2003) also recognised how this may also lead to "silencing the people they were trying to protect" (p.61), by effectively taking away their choice and their voice, resulting in a further lack of understanding about this group's needs. Further difficulties were observed within a prison environment even when significant effort was made to reduce the role of staff when recruiting participants.

In a guide for conducting research in a prison environment, Hayes, Senior, Buchanan, and Hogg (2007) described the importance of "outsiders" (p.66) understanding prison processes and the need to fit within the prison routine. It was highlighted that any difficulties would be remembered by the staff, which could then make it more difficult for projects to be carried out in the future. Although understandable to some extent, the ethical implications of this are questionable, especially when it is the staff and not the participant that makes this choice. Again, this highlights how research may not take place in spite of REC clearance or the importance of the project and highlights the power of those within the system who hold the keys. Further consideration needs to be given around how to overcome such practical obstacles to accessing hard-to-

reach populations, whilst recognising that with this may come career dangers, as seen in the cases of whistle-blowers and the need for protection (Mason, 2003).

#### *5.2.3.iii A Credible Source*

The credibility of those within the secure services has also been brought into question (Bartlett & Canvin, 2003), in particular, how staff may doubt the ability of such individuals to offer meaningful responses, whether this is due to mental health difficulties or because of the nature of being detained. To some extent, this was explored during the Ashworth Enquiry, particularly in terms of individuals' ability to give evidence and the possibility that individuals may be "hostile to the institution controlling them" (p.63). When conducting research in secure services, the expertise of the researcher needs to be upheld. It is for staff to trust that a researcher will be aware of the potential issues and limitations of some individuals, both in terms of mental health difficulties and their potential to withhold information and only tell the researcher what they think they want to hear. It is the role of the researcher to elicit meaning and interpret data from the participant responses and not for the gatekeepers to control and manage. It could be argued that it is only through this that we may be able to find ways to empower and "gain access to and give voice to groups who might ordinarily be ignored on the grounds of being too difficult or incoherent" (Bartlett & Canvin, 2003, p.69), whilst ensuring consent and anonymity.

#### *5.2.3.iv Impact on Research Design*

The challenges associated with accessing such environments and on maintaining a rigorous research design was highlighted by Bulman, Garcia and Hernon (2012). In the current study, these difficulties were reflected in the time taken to conduct the study and the ability to access a sufficient number of participants. However, these difficulties should not prevent such research taking place and Gannon and Ward (2014) highlight that research is fundamental to guiding good practice. Additionally, they acknowledge that certain key research areas have been ignored within forensic services and caution that clinicians do not overly focus on one strand of research. A continuum is needed that includes clinical experience and bridges the gap between research evidence base and practice. This is particularly relevant in clinical situations where research approaches may be difficult or unavailable.

## 5.3 Limitations

Although it was not the original remit of this study, participants were mainly recruited from high security and all participants were male. This was primarily due to recruitment issues and the use of EMDR therapy within secure services. When considering reasons for this, it is possible that such services may have access to resources, related funding and possibilities for innovation, which other services do not. It is also possible that these services had trained clinicians who were open to using EMDR therapy with this client group. This would suggest a clinician tendency towards innovation and confidence in their capabilities, which the service supported. It is possible that as EMDR therapy gains further recognition more services will be willing to use it and this in turn will allow for broader research. However, this remains a difficult situation as, if services are unwilling to fund further EMDR trained therapists as there is no clinical evidence, then further research will be unlikely to be conducted. Even within these services, some participants had not yet completed EMDR to meet the criteria for this study.

Many of the participants within the study could be defined as complex cases and only one appeared to have EMDR therapy for a single event trauma. This created some difficulty in terms of conducting analysis related to specific therapy need or length of therapy. It may be that this reflects the more complex nature of this population and this will remain an issue. However, it is also possible that if EMDR therapy is increasingly offered that recruitment to more specific analysis may become possible.

## 5.4 Directions for Further Research

As EMDR therapy is increasingly used within secure services, research could investigate its application to a broader population, including females, and to those with neuropsychological and developmental difficulties, including dementia, and different levels of security. There may also be some benefit in conducting longitudinal studies of the long-term impact of EMDR therapy on individuals, which explores further offending behaviours and/or assessment of future risk.

Trauma-informed care is becoming increasingly more known within secure services, which allows the opportunity to explore the impact this has on treatments offered. This could explore the potential for service users to be re-traumatised by their

environment and previous therapies. The service provisions for trauma-based intervention are unclear within forensic services (hospitals and prisons) and it is unknown which services offer EMDR therapy or alternative trauma therapies. For those that do, it is unclear whether this is because they have more funding opportunities and continuing professional development opportunities, or due to individual clinician interest or expertise. Alternatively, it may be such services ensure that staff are generally working more holistically and stepping out of the Risk Needs Responsivity domain and keeping up to date with broader evidence-based literature that may ensure more effective practice within secure environments (Gannon & Ward, 2014).

There will also be some benefit in exploring EMDR therapists' experiences of conducting EMDR therapy within secure services, including investigating the referrals process, the impact of timing on the treatment pathway, as well as the control of external bodies such as a tribunal hearing.

The broader attitudes of the public, service users and criminal justice related organisations to trauma-informed interventions such as EMDR therapy could also be beneficial. These attitudes will likely impact on the identified need and support for such interventions in the future.

As clinical staff become trained in trauma-informed approaches, it will need to be explored whether staff feel sufficiently trained to deal with trauma. This is particularly relevant when the importance of relationships with staff is considered alongside the potential for harm if disclosures are inappropriately managed. This also raises issues around diagnostic issues and the potential for expert bias within services and how this can be reviewed and monitored. For example, how do various clinicians understand presenting difficulties and what are their beliefs about a range of diagnoses (including PTSD, complex trauma, dissociative disorders, personality disorder and psychosis) with secure services? Ultimately, why is trauma not seen as a primary diagnosis within these services?

A further area of limited research is around exploring the proximity and comfort of the EMDR therapist to the client within secure services and, more specifically, whether

comfort impacts on efficacy. With recent changes in terms of service provision due to Coronavirus and the increased use of online therapy within general services (British Psychological Society (BPS), 2020), the application of online EMDR therapy with individuals residing in secure services could be further explored.

## 5.5 Conclusion

Historically, the expression of trauma symptomology has been misunderstood and the treatment of individuals with these experiences has been concerning. However, the link between trauma, mental health difficulties and criminal behaviours is becoming more widely acknowledged. Trauma-informed formulations better observe the impact that trauma and adverse childhood experiences can have on individual functioning. In turn, this offers a more comprehensive and collaborative understanding of presenting difficulties and of offending behaviours.

Although trauma-informed care has gained momentum in recent years, secure services primarily offer offence-focused interventions. The use of EMDR therapy has been slowly growing within secure services, although it was neither offence-focused nor mandated. Little was known about service user experiences of why they might engage in this therapy or how it may be beneficial in terms of recovery or risk reduction. As such, this study aimed to provide the opportunity for participants detained within secure services to communicate their understanding of their current situation and personal experiences of EMDR therapy, whilst residing within a secure service.

The analysis revealed how EMDR therapy was life changing for all of the participants involved. It provided a detailed exploration of their experiences and identified four main themes that were central to participant engagement in EMDR therapy within a secure service. The first theme was the 'Decision to Engage in EMDR Therapy' including 'Accessing Information and the Unknown', along with 'Making a Personal Commitment to Engage in the Therapy'. The second was the 'Essential Support Structures' that were in place and identified the 'Challenges of a Secure Environment' and the 'Necessity of the Therapeutic Relationship'. The third theme was the 'EMDR Therapy Process', which involved the 'Functional Aspects of the Use of Bilateral

Stimulation' and the Visceral Impact of Engagement'. The final theme was around 'Identifying Personal Change' that participants observed in relation to 'Changes in Mental Health and Diagnosis', 'Insights and Reflections on Offending Behaviour' and 'Ability to Cope and Experience Hope for the Future'. In spite of the many positive elements that participants experienced as a result of engaging in EMDR therapy, it was not an easy therapy to engage in and was emotionally challenging for many. However, participants appeared to accept this emotional challenge as part of the process that they needed to go through. In part, participants were motivated by the perceived personal benefits. However, they were also encouraged and supported by the relationship with their therapist.

Overall, it would seem that when services acknowledge the impact of trauma in all of its forms, EMDR therapy offers a real way of engaging and accessing a vulnerable and difficult-to-reach group residing within secure services. As well as reducing personal distress and related mental health difficulties, which appeared to be long-lasting, this therapy has the potential to have a broader impact on problematic behaviours.

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# Appendices

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# Appendix 1: Semi Structured Interview Guide

## Semi-Structured Interview Guide

*"Thank you for meeting with me today and agreeing to talk to me about your experiences of EMDR therapy. I am Marnie and I am conducting this research. I hope you have had an opportunity to look at the information sheet before today.* [Go through information sheet, consent form and answer any questions. Sign as appropriate].

*We have up to an hour to discuss your experiences. In your own words, here are some of the things that I would like to hear about:*

- *A brief overview of your difficulties and what you think has stopped you moving forwards (this only needs to be brief and relevant to your EMDR therapy referral).*
- *How you were referred for EMDR therapy and what you wanted to gain.*
- *What EMDR therapy was like for you.*
- *What changes (if any) you have noticed since engaging in EMDR therapy.*

*I would like you to be able to talk openly about your personal experiences. Please feel free to tell me anything else that you think is relevant that I might have missed. However, due to the time limit, sometimes I may ask if we can move onto the next topic if I think we might run out of time. If you feel you need to talk about this further, then it might be useful to speak with your key worker or named nurse. Remember that you do not have to talk about a topic if you don't want to.*

*What would you like your Pseudonym to be? This will be the name included in any published work and also be the name to identify your interview tapes if you wish to withdraw from the study.* [Record name and start the semi-structured interview].

**A. Background to EMDR Referral**

1. To start with I'd like to have a brief overview of why you believe that you are in hospital and what you think has stopped you moving forwards.
    - What difficulties have you experienced?
    - What caused these difficulties?
    - How long have you had these difficulties?
    - Do you know why your difficulties persist? If yes, tell me about this.
    - Do you think your difficulties are linked with why you are still detained in hospital? If yes, tell me about this.

2. Describe to me in as much detail as possible, and in your own words, what are your previous therapy experiences?
    - Do you know what type of therapy you have had in the past? If yes, tell me about this.
    - Were you aware of any benefits or downsides to these therapies? If yes, tell me about these.

3. How did you come to engage in EMDR therapy?
    - How did you find out about EMDR therapy?
    - How was the referral made? Who made it?
    - What were your initial thoughts?
    - Did you feel that you had a choice? Tell me about that.

4. What did you want to gain from EMDR therapy? Was this the same or different to your team?

**B. EMDR Process & Therapeutic Relationship**

5. Describe to me in as much detail as possible and in your own words…
6. What EMDR was like for you?
    - Tappers? Eye movements? Mixture?
    - Format?
    - Language?
    - What stood out for you? Good bits/ bad bits?
7. What was the therapeutic relationship like? How did you get on with your therapist?

**Outcomes, Impact and Understanding of EMDR**

8. Describe to me in as much detail as possible and in your own words…
9. What changes you have noticed since completing EMDR therapy?
    - Did EMDR therapy work?
    - Is anything else different/ new? Feelings, beliefs, behaviours
    - Do your difficulties feel different now? Do you feel different?
    - How do you think EMDR helped? What made it work?
    - Why don't you think EMDR helped? If everything is the same, why do you think it didn't change? Could anything have been done differently?
10. What do you think caused the changes (if any)?

11. Is there anything else you would like to add? Ask me?

# Appendix 2: Clinical Team Letter & Information Sheet

Version 2 – 03.04.18

Marnie Allen
Llandaff Campus
Cardiff Metropolitan University
Cardiff, CF5 2BY
Tel: [redacted]
Email: M.Allen14@outlook.cardiffmet.ac.uk

(*Date*)

Dear _____,

**Study Title: "Exploring personal experiences of EMDR therapy within a secure service"**

We are conducting interviews as part of a research study to increase our understanding of people's experiences of EMDR therapy. As some of the patients that you work with have engaged in EMDR therapy, in the past, we would like them to take part. The project will require participants to engage in an informal discussion, which will last about an hour and take place within the hospital. The aim of the discussion will be to capture the participants thoughts and perspectives on their personal experiences of EMDR. All responses will be confidential. I have attached further information sheets about the project and consent forms.

I will be using an opportunity sample. To identify participants who may be suitable for this study, I am primarily liaising with treating EMDR therapists and Responsible Clinician's. However, I also understand that this will be discussed with the participants treating clinical team. In terms of suitability for the study, please see the following inclusion criteria:

- Have engaged in, and completed, EMDR therapy
- Males or females
- Have experienced complex mental health disorders
- Have been detained under MHA (1983)
- Have the capacity to consent to engage in the project

I will only approach suitable participants after it has been agreed by their treating clinical team. I will not need any personal information prior to this. The only information used in the study will be gained during interview. Please do not hesitate to contact me if you have any questions.

Thank You,

**Marnie Allen**
HCPC Registered & Chartered Forensic Psychologist

Version.1. 07.04.17

**Research Information Sheet**

Cardiff Metropolitan University | Prifysgol Metropolitan Caerdydd

# Exploring Personal Experiences of EMDR Therapy within a Secure Service

## What is the research about?

The aim of the study will be to develop an understanding of personal experiences of EMDR therapy within secure services. This will provide further information about the application of trauma based therapy within these settings and as such inform resource needs.

The project will form part of the researcher's Doctorate degree at Cardiff Metropolitan University.

## Background Information

Trauma has consistently been a connecting factor for varying acts of violence, with offenders presenting with a higher prevalence of Post-traumatic stress disorder (PTSD) and associated symptoms when compared with the general population (American Psychiatric Association (APA), 1994). More recent research demonstrates that traumatic experiences and criminal behaviours are fundamentally interlinked (Ardino, 2012).

Eye Movement Desensitization and reprocessing (EMDR) therapy is a psychotherapeutic approach developed by Francine Shapiro in 1987. In recent years, EMDR therapy has become widely recognised as an effective approach for treating trauma outside of secure environments. EMDR therapy's application to mental health difficulties including anxiety, phobias, excessive grief somatic disorders and borderline personality disorder is being explored with positive results. Additionally, EMDR therapy is being used to address anger, substance use problems and trauma in psychosis.

Currently, EMDR therapy is not seen as an offence focused intervention and therefore a service user may not be directed to engage in it. As such, service user' motivation for engaging within EMDR may be different to other offence focused interventions. Little is known about service user experiences of why they might engage in EMDR therapy and how it may be beneficial to them in terms of their recovery and/ or risk reduction.

## Who will the Research Involve?

Participants will be males and females with complex mental health disorders. Participants will be currently detained under the Mental Health Act (1983) and residing within a secure service. Participants will be invited from different secure services offering different levels of security.

All participants will have a forensic history.

The sample will include the last 10-12 suitable service users who completed EMDR therapy. EMDR therapy may have lasted as little as 4 sessions or over 2 years. Completion (i.e., they have met the therapy goals and not disengaged) will prompt an invitation to engage in a semi structured interview. Suitable participants will be identified via the practicing EMDR therapist within the unit.

## What will the Research Involve?

Participants will be invited to engage in a semi-structured interview lasting approximately 60-90 minutes. The interview will provide the opportunity for participants to communicate their understanding of their current situation and experiences of EMDR therapy. Participants will be asked to talk as widely as possible about what EMDR therapy was like for them, how they made sense of it, and the different ways engaging in EMDR therapy may have influenced their feelings, attitudes, beliefs or behaviours. This will also explore the collaborative process of the therapy referral and how this may have differed from previous interventions offered.

Thematic Analysis (TA) will be used as a means to explore personal experiences of the EMDR process within a secure service.

## How to contact me

For further information, please contact:

**Marnie Allen**

Chartered & HCPC Registered Forensic Psychologist & EMDR Therapist

M.Allen14@outlook.cardiffmet.ac.uk

# Appendix 3: Participant Letter & Information Sheet

Version 2 – 03.04.18

Cardiff Metropolitan University

**Study Title: "Exploring personal experiences of EMDR therapy within a secure service"**

We are conducting interviews as part of a research study to increase our understanding of people's experiences of EMDR therapy. As you have engaged in EMDR therapy, in the past, we would like you to take part. You do not have to take part but if you want to then the discussion will take place at your hospital in a room you are happy with. It will take about 1 hour but you can stop whenever you want to.

It will be a very informal discussion and you don't have to say anything that you don't want to. We are simply trying to capture your thoughts and perspectives on your personal experiences. Your responses to the questions will be kept confidential. After each interview, you can pick a name of your choice to ensure that you cannot be recognised during the write up of findings.

There is no compensation for participating in this study. However, your participation will be a valuable addition to our research and findings could lead to greater public understanding of individual experiences of EMDR therapy. The attached information sheets will give you some additional information about the study.

If you are willing to participate, I will arrange a time and date to meet with you through your clinical team. Where possible, I can be flexible in terms of considering times that better suit you. For example, if you prefer mornings or afternoons.

If you have any questions, please do not hesitate to ask. Your clinical team will be able to contact me, but please feel free to talk to them about the project if you wish. The contact person at your hospital for this project is ..... (*person identified within each trust*)

Thank You,

**Mamie Allen**
Chartered Forensic Psychologist

Version.3. 06.06.18
IRAS 210766

**Participant Information Sheet**

Cardiff Metropolitan University | Prifysgol Metropolitan Caerdydd

# Exploring Personal Experiences of EMDR Therapy within a Secure Service

## You are invited to take part in a research study.

This information sheet will help you to understand why the research is being done and to help you decide whether you want to take part.

Please ask questions if you don't understand something or want some more information. Talk to others about the study if you want to.

Take your time to decide if you want to take part.

## What is the research about?

To learn what it is like for people to have EMDR therapy in a secure hospital.

## What is the purpose of the research?

The project will be part of the researcher's professional development as a forensic psychologist. It will form part of her Doctorate degree at Cardiff Metropolitan University.

It will also allow us to gain a better understanding of people's experiences of EMDR and any impact it may have had.

## Why you?

You are being asked because you recently engaged in EMDR therapy and we think that we could learn a lot from your experiences.

## Do I have to do it?

**No.** It is your choice. You don't have to do it if you don't want to. It will not impact on your care, treatment or progress.

## What will I have to do?

You will be asked to sign a consent form to say you agree to take part. The form will ask you if you understand what the study is about and what you have to do. You can ask as many questions as you like and you don't have to sign if you don't want to take part.

Your clinical team are aware that you have been approached to participate in the study, so that they can support you, whether you decide to take part, or not.

We'd like to talk to you about your experiences of EMDR therapy and the reasons for doing it. This discussion will take place at your hospital in a room you are happy with. It will take about 1 hour but you can stop whenever you want to. You can choose when you want this to happen.

The discussion will be recorded and later typed up.

You will not have to do anything after we have talked.

## What if I change my mind?


If you start the interview and then decide you don't want to carry on, that's OK, we can stop immediately. You can decide if you want any information used in the study.

If you decide after the interview has finished that you don't want some, or all, of the information used in the study, there is no problem, just let me know. Any information you don't want to be included will be destroyed.

You can change your mind at any point up to 2 weeks after the interview.

Changing your mind will <u>not</u> impact on your treatment.

You do <u>not</u> have to give a reason.

## What happens to the information about me?

All of the information that you will provide will be kept strictly confidential and in a locked cabinet.

A code number/ name will be used to identify your information. Basic information such as your age and gender will be included, but any identifying information will not be.

All information will be stored safely and destroyed after 5 years.

## How to contact me

If you have any questions just ask. If you have any concerns just ask.

You can ask yourself, or you can get a member of your clinical team, or someone else you trust, to ask.

**Researcher: Marnie Allen**

MAllen4@outlook.cardiffmet.ac.uk

## How can I complain?

If you wish to make a complaint about the research, please speak with a member of your clinical team and/ or contact my supervisor Daniel Heggs (Cardiff Metropolitan University) DHeggs@cardiffmet.ac.uk

# Appendix 4: Consent Form

Version.3. 06.06.18
IRAS 210766

Cardiff Metropolitan University | Prifysgol Metropolitan Caerdydd

**Consent Form**

## Exploring Personal Experiences of EMDR Therapy within a Secure Service

**Name of researcher:** Marnie Allen

**Participant Name:**

**Code Name/ Number:**

**Please tick ☑ each box**

| | |
|---|---|
| 1. I confirm that I have read and understood the information sheet for the above study | ☐ |
| 2. I have had the opportunity to consider the information and ask questions | ☐ |
| 3. I understand that I don't have to participate and that it is my choice | ☐ |
| 4. I understand that I can withdraw up to 2 weeks after the interview. My care will not be effected and I do not have to give a reason | ☐ |
| 5. I agreed to take part in the study | ☐ |
| 6. I agree to the discussion being recorded | ☐ |
| 7. I understand that there are limit to confidentiality | ☐ |
| 8. I agree to the use of anonymised quotes in publications | ☐ |
| 9. I agree that my Clinical Team will be informed of my participation on the study | ☐ |

| | | |
|---|---|---|
| Participant Name | Signature | Date |
| Researcher Name | Signature | Date |

# Appendix 5: Transparency and your Data

Cardiff Metropolitan University | Prifysgol Metropolitan Caerdydd

## Transparency and Your data

Research organisations must be transparent about the personal data they process for research. Transparency is a fundamental principle of existing data protection law. The new law increases the amount of information that must be provided to research participants.

### What does this mean for you?

Cardiff Metropolitan University is the sponsor for this study based in the United Kingdom. We will be using information from you (i.e., recordings from interviews) in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. Cardiff Metropolitan University will keep identifiable information about you for 5 years after the study has finished.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. As outlined in the patient information sheet, you can withdraw up to 2 weeks after the interview. If you withdraw from the study, we will destroy the information you have given us. To safeguard your rights, we will use the minimum personally-identifiable information possible.

You can find out more about how we use your information by contacting Marnie Allen (Researcher). Any objections should be made in writing to: -

**University's Information and Data Compliance Officer**
Sean Weaver
Cardiff Metropolitan University Western Avenue
Llandaff
Cardiff
CF5 2YB

### Your data and confidentiality

Cardiff Metropolitan University will keep your name and contact details confidential and will not pass this information. Cardiff Metropolitan University will use this information as needed, to contact you about the research study, and make sure that relevant information about the study is recorded for your care, and to oversee the

quality of the study. Certain individuals from Cardiff Metropolitan University and regulatory organisations may look at the interview transcripts to check the accuracy of the research study. However, they will only receive information without any identifying information. The people who analyse the information, apart from the main researcher (Marnie Allen) with whom you will conduct the interviews with, will not be able to identify you and will not be able to find out your name or contact details.

Cardiff Metropolitan university will keep identifiable information about you from this study for 5 years after the study has finished.

## Personal data and publication

When you agree to take part in a research study, the information about your health and care may be provided to researchers running other research studies in this organisation and in other organisations. These organisations may be universities, NHS organisations or companies involved in health and care research in this country or abroad. Your information will only be used by organisations and researchers to conduct research in accordance with the UK Policy Framework for Health and Social Care Research.

This information will not identify you and will not be combined with other information in a way that could identify you. The information will only be used for the purpose of health and care research and cannot be used to contact you or to affect your care. It will not be used to make decisions about future services available to you, such as insurance.

## Further Information

If you wish to make a complaint you have the right to contact the Information Commissioner. The contact details are:

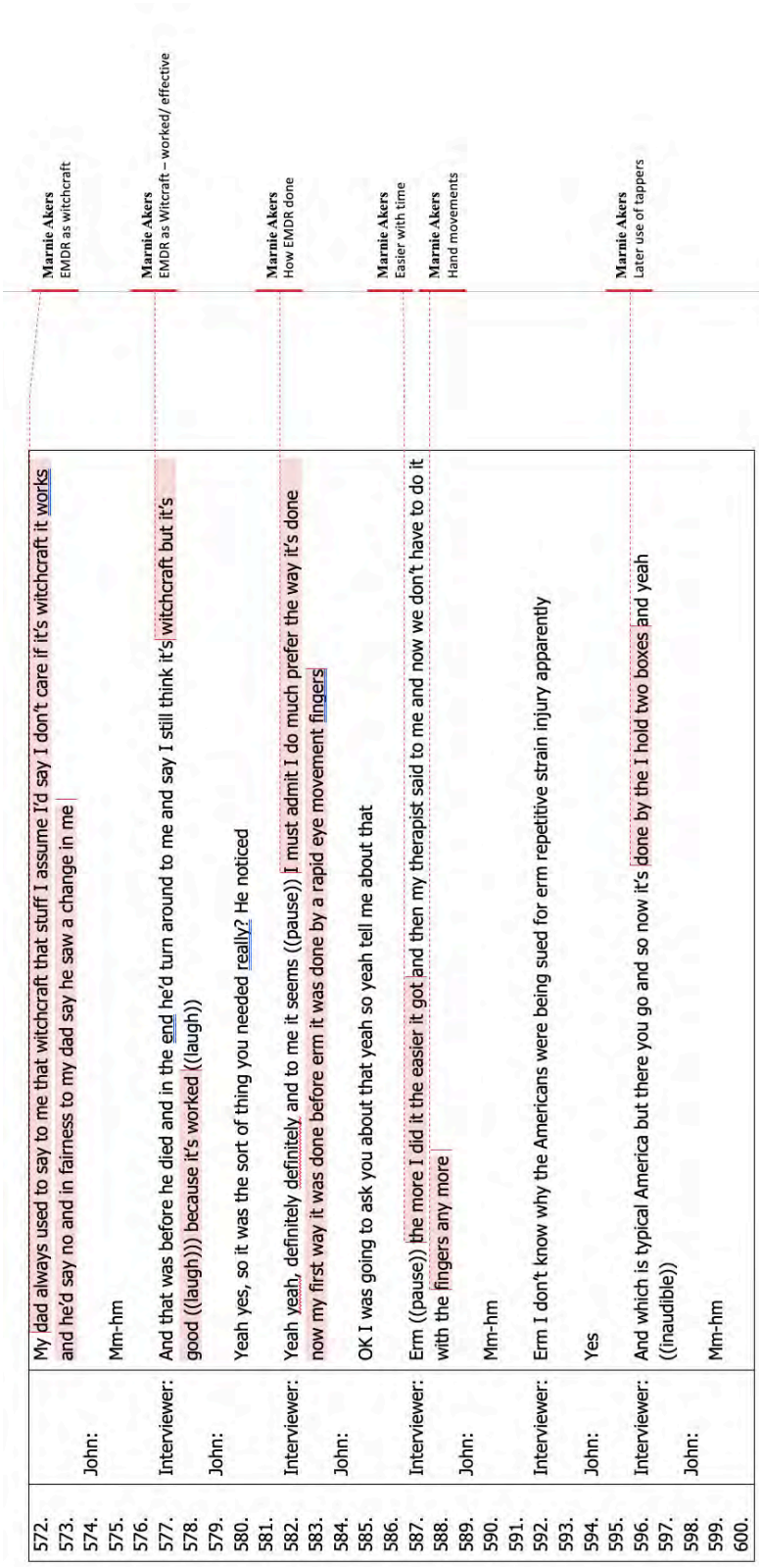
**Information Commissioner's Office**
Wycliffe House
Water Lane
Wilmslow
Cheshire
SK9 5AF
www.ico.org

# Appendix 6: Transcription Method

Transcription Notation includes the following symbols (adapted from and Braun & Clarke, 2013)

| Feature | Notation | Explanation of Use |
|---|---|---|
| The identity of the speaker | Interviewer: | The speakers name followed by a colon indicates the identity of the speaker. Interviewer: for when the interviewer is speaking. Pseudonym: for when the participant is speaking. A new line will be used every time a new speaker enters the conversation. A capital letter will be used at the start of the first word. |
| A significant pause | ((pause)) | ((pause)) indicates a significant pause of a second or less. ((long pause)) to signal a much longer pause of a few seconds. |
| Laughing, coughing etc. | ((laughs))<br>((coughs)) | Signals a speaker laughing or coughing during their turning of speaking.<br>A new line will signal someone else owning the laughter. ((general laughter)) will be used to indicate multiple ownership. |
| Spoken abbreviations | | Abbreviations such as TV, will only be used if the speaker uses them. Otherwise this will be written in full to represent the spoken word. |
| Hyhen | - | Indicates an abrupt halt or interruption in utterance. |
| Inaudible speech | ((inaudible)) | For speech and sounds that are inaudible |
| Uncertainty | (text) | To signal the best guess about what was said, but if not sure this is correct. |
| Non-verbal utterances | Erm, er, mm, mm-hm | Phonetically consistent commonly used non-verbal sounds uttered during discussion. |
| Spoken numbers | | All numbers will be spelled out. Attention given to exactly how they were uttered. For example, "a hundred" or "one hundred". |
| Use of punctuation | | Although punctuation is commonly used to highlight specific features of spoken language. However, this can change the meaning of data. As such no punctuation was used. |
| Annonymising | [text] | Where information needs to be anonymised |

# Appendix 7: Example of Coding and Transcript – "John"




| | | |
|---|---|---|
| 572. | | My dad always used to say to me that witchcraft that stuff I assume I'd say I don't care if it's witchcraft it works |
| 573. | | and he'd say no and in fairness to my dad say he saw a change in me |
| 574. | John: | |
| 575. | | Mm-hm |
| 576. | | |
| 577. | Interviewer: | And that was before he died and in the end he'd turn around to me and say I still think it's witchcraft but it's |
| 578. | | good ((laugh))) because it's worked ((laugh)) |
| 579. | John: | |
| 580. | | Yeah yes, so it was the sort of thing you needed really? He noticed |
| 581. | | |
| 582. | Interviewer: | Yeah yeah, definitely definitely and to me it seems ((pause)) I must admit I do much prefer the way it's done |
| 583. | | now my first way it was done before erm it was done by a rapid eye movement fingers |
| 584. | John: | |
| 585. | | OK I was going to ask you about that yeah so yeah tell me about that |
| 586. | | |
| 587. | Interviewer: | Erm ((pause)) the more I did it the easier it got and then my therapist said to me and now we don't have to do it |
| 588. | | with the fingers any more |
| 589. | John: | |
| 590. | | Mm-hm |
| 591. | | |
| 592. | Interviewer: | Erm I don't know why the Americans were being sued for erm repetitive strain injury apparently |
| 593. | | |
| 594. | John: | Yes |
| 595. | | |
| 596. | Interviewer: | And which is typical America but there you go and so now it's done by the I hold two boxes and yeah |
| 597. | | ((inaudible)) |
| 598. | John: | |
| 599. | | Mm-hm |
| 600. | | |

# Appendix 8: Example of Practice Diary Entry

28.11.18

*Transcription of First Interview with "XXX" (conducted on 04.09.18)*

I looked for the most appropriate transcription method for my research and after some discussion with my supervisors, I decided that it did not need a complex version. As I was planning to do thematic analysis, I am primarily concerned with what is being said and not how. However, this still took much longer than I had anticipated (9 hours). As such I will need to factor this into my timescales and planning.

I am pleased that I have chosen to transcribe all of the interviews myself. In part this decision was to reduce complexity of issues around data protection and confidentiality and ethics. However, I feel that I am already very familiar with the data.

I had found that much of the content had been what I had been expecting and hoping for. However, I need to be mindful of this and to remain impartial when looking for codes and themes later on. I need to be aware of leading the content in future interviews unconscious through verbal language or body language and focus on the questions and remain curious to what the future participants have to say.

I was pleased that there was little content that needed to be anonymised. I believe that I have sufficient information from this interview. I did not necessarily want a detailed background/offence detail. However, I am wondering if this will be questioned later on and if I need to be able to defend my reasons for this choice.

This has led me to consider the benefits of accessing this information from the hospital records (diagnosis and offence history) but this also raises further ethical issues, especially in secure services. At this point I think that this was the correct decision, but I will need to revisit this on completion.

I also reflected on not having an escort other than to take me to the interview room. The patient is now in the community but completed EMDR therapy whilst under section at the hospital. I was able to contact staff by phone if needed and was given an alarm. I think the hospital made this decision in light of my clinical experience but highlights this and that I was pleased that I had this experience. Although I wonder what it would have been like as a researcher entering this low secure environment for the first time. I wondered how the interview may have been different if there was an escort present in the room, outside of the room or if the interview was conducted by someone from the hospital. Would it have helped or hindered? Does that depend on the participant?

07.01.19 & 08.01.19

*XXXXXX Hospital*

I had initially planned to conduct the interviews at XXXXX High Secure Hospital in December but once again this had been delayed. The general delays during the research process have been frustrating and I was aware that after travelling a considerable distance to the hospital that another problem may arise. This seems in part that there are differences between general agreements/ polices through to trust policies, to more local (individual hospital and department) agreements and even to the view of specific individuals involved.

Prior to leaving yesterday, I had again checked confirmed with the hospital that I had all of the necessary agreements to enter the building for the purpose of conducting the interviews and to bring a Dictaphone. On the advice of the local researcher for the trust, I arranged to be available for 2 days to increase the possibility of interviewing participants. For example, a participant may have difficulties one day and refuse to engage but may be happy to the next day. This allowed for some flexibility. I was aware that I was potentially conducting three interviews and thought that 2 days would offer sufficient opportunity.

On entering the building, I was glad that I had experience of working within high secure services and aware of general protocols in terms of checking into reception, going through security and ensuring my overnight bag fit into one of the lockers. I was relieved that my entry ran smoothly.

Again, I think that it helped that I was familiar with these environments. XXX is a large hospital but the reception area is similar to airport security in terms of going through scanners, having your possessions searched and having to wait in locked areas whilst staff are ready for you. To some degree this may reflect what it is like to be powerless within these institutions and the feeling of being watched and controlled. It often feels different when in these situations and with no keys as a staff member and no freedom to move around freely. This included asking permissions to be escorted to toilets, being escorted to lunch in the dining hall. Anywhere I wanted to go or anything I needed, I had to ask and be accompanied.

I had been in email contact with one of the researchers within the trust who had agreed prior to my arrival, to act as my escort. This meant that I would not have to complete a week long induction training to conduct the 3 interviews. My escort was indelibly helpful and friendly whilst I was there and escorted me around the hospital. The escort had contacted all of the wards on arrival to confirm the meeting times and participant willingness to engage. Unlike the previous interview which took place within the hospital (an interview room just into the hospital but off the reception), these all took place in an interview room on the participants ward.

Interview 1

The first interview in this hospital was with “XXXX” on the XXX Unit. He presented as XXXXXXXXXXXXXX and a “XXXX vibe”. He was articulate and confident. The interview progressed well and was similar in content to the first interview. I noted an initial reluctance to my early questions around what had bought him to hospital, and he questioned how this was related to his engagement with EMDR. I had to rephrase this to discussing what if anything he felt was relevant. This highlighted my initial concerns about engagement and the interview being shut down if I pressed the focus on offending history too much early on. The interview recorded content lasted 35 min. However, this was around an hour with the participant altogether with introductions, questions, and consent, which was the time that I was aiming for.

Interview 2

This interview was with “XXXX”, which was on another ward within the XXX Unit. This interview also seemed to go well. I realised that all the interviews so far were of a similar length and although I was aware of the time, I do not think that I finished early or rushed sections or drew them out artificially. Again, I think an hour limit for total contact is sufficient within this service.

Interview 3

This interview was planned for the previous day (07.01.19). However, “XXXX” had been in bed at the time and had not felt up to seeing me. However, he had informed staff that he would see me the following day.

When I returned the following morning, the ward was contacted and he again said that he was happy to see me. XXXX was on the unit for patients with a XXX diagnosis. He engaged well and was pleasant. However, the interview lasted about 20-30 minutes in total. This included about 10 minutes of introductions and 10 minutes of interview content. I used my judgement in terms of not pushing Lee to elaborate on further points. I did prompt in each area at least once but did not think it would be good to follow this further in terms of overall engagement. I generally felt that although he was pleasant that he was not a ‘talkative person’ and would likely find this situation quite taxing. He answered questions in all of the topic areas, albeit in somewhat less depth.

During the interviews I was able on occasion to experience what it was like to possible engage in therapy with an escort close by and to hear the noises of a ward in the background.

Action:

- Email Thanks to XXXX (local trust researcher), XXXX (research department) and XXXX (Psychology Dept)
- Email XXXX (Psychology research contact) at XXXX Hospital to set dates for next interviews

- Transcribe interviews
- Finish writing introduction section
- Check next supervision date

# Appendix 9: Final Draft of IRAS Form (06.02.18)

IRAS Form | Reference: 18\sc\0034 | IRAS Version 5.7.0

**Welcome to the Integrated Research Application System**

**IRAS Project Filter**

The integrated dataset required for your project will be created from the answers you give to the following questions. The system will generate only those questions and sections which (a) apply to your study type and (b) are required by the bodies reviewing your study. Please ensure you answer all the questions before proceeding with your applications.

Please complete the questions in order. If you change the response to a question, please select 'Save' and review all the questions as your change may have affected subsequent questions.

**Please enter a short title for this project** (maximum 70 characters)
Exploring personal experiences of EMDR therapy within secure services.

**1. Is your project research?**

(●) Yes ( ) No

**2. Select one category from the list below:**

( ) Clinical trial of an investigational medicinal product
( ) Clinical investigation or other study of a medical device
( ) Combined trial of an investigational medicinal product and an investigational medical device
( ) Other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice
( ) Basic science study involving procedures with human participants
( ) Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology
(●) Study involving qualitative methods only
( ) Study limited to working with human tissue samples (or other human biological samples) and data (specific project only)
( ) Study limited to working with data (specific project only)
( ) Research tissue bank
( ) Research database

**If your work does not fit any of these categories, select the option below:**

( ) Other study

**2a. Please answer the following question(s):**

| | | |
|---|---|---|
| a) Does the study involve the use of any ionising radiation? | ( ) Yes | (●) No |
| b) Will you be taking new human tissue samples (or other human biological samples)? | ( ) Yes | (●) No |
| c) Will you be using existing human tissue samples (or other human biological samples)? | ( ) Yes | (●) No |

**3. In which countries of the UK will the research sites be located?** *(Tick all that apply)*

[x] England
[ ] Scotland

☐ Wales
☐ Northern Ireland

**3a. In which country of the UK will the lead NHS R&D office be located:**

◉ England
◯ Scotland
◯ Wales
◯ Northern Ireland
◯ This study does not involve the NHS

**4. Which applications do you require?**

*IMPORTANT: If your project is taking place in the NHS and is led from England select 'IRAS Form'. If your project is led from Northern Ireland, Scotland or Wales select 'NHS/HSC Research and Development Offices' and/or relevant Research Ethics Committee applications, as appropriate.*

☑ IRAS Form
☐ Confidentiality Advisory Group (CAG)
☐ Her Majesty's Prison and Probation Service (HMPPS)

*For NHS/HSC R&D Offices in Northern Ireland, Scotland and Wales the CI must create NHS/HSC Site Specific Information forms, for each site, in addition to the study wide forms, and transfer them to the PIs or local collaborators.*

*For participating NHS organisations in England different arrangements apply for the provision of site specific information. Refer to IRAS Help for more information.*

**Most research projects require review by a REC within the UK Health Departments' Research Ethics Service. Is your study exempt from REC review?**

◯ Yes ◉ No

**5. Will any research sites in this study be NHS organisations?**

◉ Yes ◯ No

**5a. Are all the research costs and infrastructure costs (funding for the support and facilities needed to carry out research e.g. NHS Support costs) for this study provided by a NIHR Biomedical Research Centre, NIHR Biomedical Research Unit, NIHR Collaboration for Leadership in Health Research and Care (CLAHRC), NIHR Patient Safety Translational Research Centre or a Diagnostic Evidence Co-operative in all study sites?**

**Please see information button for further details.**

◯ Yes ◉ No

***Please see information button for further details.***

**5b. Do you wish to make an application for the study to be considered for NIHR Clinical Research Network (CRN) Support and inclusion in the NIHR Clinical Research Network Portfolio?**

**Please see information button for further details.**

◯ Yes ◉ No

*The NIHR Clinical Research Network provides researchers with the practical support they need to make clinical studies happen in the NHS e.g. by providing access to the people and facilities needed to carry out research "on the ground".*

*If you select yes to this question, you must complete a NIHR Clinical Research Network (CRN) Portfolio Application Form (PAF) immediately after completing this project filter question and before submitting other applications. Failing to complete the PAF ahead of other applications e.g. HRA Approval, may mean that you will be unable to access NIHR CRN Support for your study.*

**6. Do you plan to include any participants who are children?**

○ Yes ◉ No

**7. Do you plan at any stage of the project to undertake intrusive research involving adults lacking capacity to consent for themselves?**

○ Yes ◉ No

*Answer Yes if you plan to recruit living participants aged 16 or over who lack capacity, or to retain them in the study following loss of capacity. Intrusive research means any research with the living requiring consent in law. This includes use of identifiable tissue samples or personal information, except where application is being made to the Confidentiality Advisory Group to set aside the common law duty of confidentiality in England and Wales. Please consult the guidance notes for further information on the legal frameworks for research involving adults lacking capacity in the UK.*

**8. Do you plan to include any participants who are prisoners or young offenders in the custody of HM Prison Service or who are offenders supervised by the probation service in England or Wales?**

○ Yes ◉ No

**9. Is the study or any part of it being undertaken as an educational project?**

◉ Yes ○ No

Please describe briefly the involvement of the student(s):
Doctoral research

**9a. Is the project being undertaken in part fulfilment of a PhD or other doctorate?**

◉ Yes ○ No

**10. Will this research be financially supported by the United States Department of Health and Human Services or any of its divisions, agencies or programs?**

○ Yes ◉ No

**11. Will identifiable patient data be accessed outside the care team without prior consent at any stage of the project (including identification of potential participants)?**

○ Yes ◉ No

**Integrated Research Application System**
**Application Form for Research involving qualitative methods only**

## IRAS Form (project information)

*Please refer to the E-Submission and Checklist tabs for instructions on submitting this application.*

The Chief Investigator should complete this form. Guidance on the questions is available wherever you see this symbol displayed. We recommend reading the guidance first. The complete guidance and a glossary are available by selecting Help.

Please define any terms or acronyms that might not be familiar to lay reviewers of the application.

**Short title and version number:** (maximum 70 characters - this will be inserted as header on all forms)
Exploring personal experiences of EMDR therapy within secure services.

*Please complete these details after you have booked the REC application for review.*

**REC Name:**
South Central - Berkshire

**REC Reference Number:**
18\sc\0034

**Submission date:**
02/01/2018

## PART A: Core study information

### 1. ADMINISTRATIVE DETAILS

**A1. Full title of the research:**

Exploring personal experiences of EMDR therapy within secure services.

**A2-1. Educational projects**

Name and contact details of student(s):

**Student 1**

| | Title | Forename/Initials | Surname |
|---|---|---|---|
| | Ms | Marnie E | Allen |
| Address | Llandaff Campus | | |
| | Western Avenue | | |
| | Cardiff | | |
| Post Code | CF5 2YB | | |
| E-mail | M.Allen14@outlook.cardiffmet.ac.uk | | |
| Telephone | [redacted] | | |
| Fax | | | |

Give details of the educational course or degree for which this research is being undertaken:

Name and level of course/ degree:
"Top up" Doctorate in Forensic Psychology

Name of educational establishment:
Cardiff Metropolitan University

Name and contact details of academic supervisor(s):

**Academic supervisor 1**

| | Title | Forename/Initials | Surname |
|---|---|---|---|
| | Dr | Karen | De Claire |
| Address | Llandaff Campus | | |
| | Western Avenue | | |
| | Cardiff | | |
| Post Code | CF5 2YB | | |
| E-mail | [redacted] | | |
| Telephone | | | |
| Fax | | | |

**Academic supervisor 2**

| | Title | Forename/Initials | Surname |
|---|---|---|---|
| | Dr | Leanne | Freeman |
| Address | Llandaff Campus | | |
| | Western Avenue | | |
| | Cardiff | | |
| Post Code | CF5 2YB | | |
| E-mail | [redacted] | | |
| Telephone | | | |
| Fax | | | |

**Academic supervisor 3**

| | Title | Forename/Initials | Surname |
|---|---|---|---|
| | Dr | Daniel | Hegg |
| Address | Llandaff Campus | | |
| | Western Avenue | | |
| | Cardiff | | |
| Post Code | CF5 2YB | | |
| E-mail | [redacted] | | |
| Telephone | | | |
| Fax | | | |

Please state which academic supervisor(s) has responsibility for which student(s):
*Please click "Save now" before completing this table. This will ensure that all of the student and academic supervisor details are shown correctly.*

| Student(s) | Academic supervisor(s) |
|---|---|
| **Student 1** Ms Marnie E Allen | ☑ Dr Leanne Freeman<br>☑ Dr Karen De Claire<br>☑ Dr Daniel Hegg |

*A copy of a current CV for the student and the academic supervisor (maximum 2 pages of A4) must be submitted with the application.*

**A2-2. Who will act as Chief Investigator for this study?**

- (•) Student
- ( ) Academic supervisor
- ( ) Other

**A3-1. Chief Investigator:**

| | Title | Forename/Initials | Surname |
|---|---|---|---|
| | Ms | Marnie E | Allen |

| | |
|---|---|
| Post | Forensic Psychologist |
| Qualifications | 'Top Up' Forensic Doctorate (D. Foren.Psy.), Cardiff Metropolitan University. ONGOING.<br>Qualification in Forensic Psychology: Stage 2. The British Psychological Society.<br>MSc in Forensic Psychology. University of Portsmouth.<br>Diploma in Psychology (Conversion for Postgraduates), The Open University.<br>BSc (honours) Psychology with English, King Alfred's College, Winchester |
| ORCID ID | |
| Employer | Cardiff Metropolitan University |
| Work Address | Llandaff Campus<br>Western Avenue<br>Cardiff |
| Post Code | CF5 2YB |
| Work E-mail | M.Allen14@outlook.cardiffmet.ac.uk |
| * Personal E-mail | M.Allen14@outlook.cardiffmet.ac.uk |
| Work Telephone | |
| * Personal Telephone/Mobile | [redacted] |
| Fax | |

** This information is optional. It will not be placed in the public domain or disclosed to any other third party without prior consent.*
*A copy of a current CV (maximum 2 pages of A4) for the Chief Investigator must be submitted with the application.*

**A4. Who is the contact on behalf of the sponsor for all correspondence relating to applications for this project?**
*This contact will receive copies of all correspondence from REC and HRA/R&D reviewers that is sent to the CI.*

| | Title | Forename/Initials | Surname |
|---|---|---|---|
| | | Ian | IMathieson |

| | |
|---|---|
| Address | |
| Post Code | |
| E-mail | IMathieson@cardiffmet.ac.uk |
| Telephone | |

Fax

**A5-1. Research reference numbers.** *Please give any relevant references for your study:*

| | |
|---|---|
| Applicant's/organisation's own reference number, e.g. R & D (if available): | |
| Sponsor's/protocol number: | NA |
| Protocol Version: | NA |
| Protocol Date: | |
| Funder's reference number: | NA |
| Project website: | NA |

**Additional reference number(s):**

| Ref.Number Description | Reference Number |
|---|---|

*Registration of research studies is encouraged wherever possible. You may be able to register your study through your NHS organisation or a register run by a medical research charity, or publish your protocol through an open access publisher. If you have registered your study please give details in the "Additional reference number(s)" section.*

**A5-2. Is this application linked to a previous study or another current application?**

○ Yes ◉ No

*Please give brief details and reference numbers.*

## 2. OVERVIEW OF THE RESEARCH

*To provide all the information required by review bodies and research information systems, we ask a number of specific questions. This section invites you to give an overview using language comprehensible to lay reviewers and members of the public. Please read the guidance notes for advice on this section.*

**A6-1. Summary of the study.** *Please provide a brief summary of the research (maximum 300 words) using language easily understood by lay reviewers and members of the public. Where the research is reviewed by a REC within the UK Health Departments' Research Ethics Service, this summary will be published on the Health Research Authority (HRA) website following the ethical review. Please refer to the question specific guidance for this question.*

Trauma has consistently been a connecting factor for varying acts of violence, with offenders presenting with a higher prevalence of Post-traumatic stress disorder (PTSD) and associated symptoms when compared with the general population (American Psychiatric Association (APA), 1994). More recent research demonstrates that traumatic experiences and criminal behaviours are fundamentally interlinked (Ardino, 2012).

Eye Movement Desensitization and Reprocessing (EMDR) therapy is a psychotherapeutic approach developed by Francine Shapiro in 1987. With an initial focus on trauma and encompassing cognitions, imagery and bodily sensations, EMDR therapy offers a different type of therapy compared to the talking therapies commonly used within secure services (Shapiro, 1998).

EMDR has become widely recognised as an effective approach for treating trauma outside of secure environments (Dutch National Steering Committee, 2003; UK Department of Health, 2001; World Health Organisation (WHO), 2013).Alongside CBT, EMDR therapy is becoming more often viewed as a treatment of choice and being applied to a growing number of mental health difficulties including phobias, anxiety, personality disorder and voices (Luber, 2009).

In recent years, therapists have started using EMDR therapy within secure services. Known for its trauma roots, EMDR therapy's use may have started in this area but appears to have further broadened, for example, being used alongside offence focused intervention (Ricci & Clayton, 2009). Currently little is known about service user experiences of why they engage in EMDR therapy or how it may be beneficial to them in terms of their recovery and/ or risk reduction.

Service users who are currently residing within a secure hospital, and have completed EMDR therapy, will be invited to engage in an interview to discuss their experiences about this. Interviews will typically last about an hour.

Thematic Analysis (TA) will be used as a means to explore personal experiences of the EMDR process within a secure service.

**A6-2. Summary of main issues.** *Please summarise the main ethical, legal, or management issues arising from your study and say how you have addressed them.*

*Not all studies raise significant issues. Some studies may have straightforward ethical or other issues that can be identified and managed routinely. Others may present significant issues requiring further consideration by a REC, HRA, or other review body (as appropriate to the issue). Studies that present a minimal risk to participants may raise complex organisational or legal issues. You should try to consider all the types of issues that the different reviewers may need to consider.*

The research will form part of my "top up" doctorate at Cardiff Metropolitan University. As such my supervisors will support me in the research proposal, including design. I work within a secure hospital and initially considered conducting the research where I work. However, this could have created problems with a dual role in terms of therapist and researcher. As such I liaised with other hospitals using EMDR therapy in a similar manner. This would allow me to conduct the research independently of my role as a therapist.

The aim of the research is to develop an understanding of personal experiences of EMDR therapy within secure services.

The research objectives are based around exploring people's experiences and how the world is seen and understood from their perspective. As such this lends itself to more qualitative, and in particular, experiential research. Suitable analytical methods include Interpretative Phenomenological Analysis (IPA) (Smith, Flowers, & Larkin, 2009) and experiential Thematic Analysis (Braun & Clarke, 2013). Both of these approaches focus on the individual and their framing. However, TA explores the data as a whole and explore overall patterns. It is argued that such this approach may offer greater flexibility. That is, being able to explore lived experiences (e.g., "What EMDR feels like") but also allowing the option to evaluate and compare EMDR with other therapies. It is for this reason that TA will be used to explore personal experiences of the EMDR process within a secure service.

When considering the research question around people's experiences, interviews are arguably a suitable data source. Other forms e.g., focus groups, personal blogs, may not be accessible for this group and surveys may not provide the richness of data sought. As the interventions will already have been completed researcher directed diaries would not be suitable. Semi-structured interviews also allow for participants to be able to raise issues not previously anticipated.

The study will take place within secure hospitals that use EMDR therapy within the service. The researcher will identify suitable participants via the psychologist employed at the unit. Participants will be males and/ or females with complex mental health disorders. They will be currently detained under the Mental Health Act (1983) and residing within medium or low secure services. The sample will include the last 10-12 suitable service users to have completed EMDR therapy.

Participants will be invited to engage in a semi-structured interview. The researcher will be informed by a schedule, but participants will be encouraged to talk in detail about their particular concerns and asked about important individual topics which may arise. This will provide participants with the opportunity to communicate their understanding of their current situation and experiences of EMDR therapy. Questions will include exploration of the referral process, what it is like to engage in EMDR, how service users makes sense of EMDR and how service users describe the impact of EMDR and how they feel EMDR therapy may have influenced their feelings attitudes, beliefs or behaviours.

The nature of the research, and a participant's contribution, will be made clear from the outset. Standard ethical procedures will be used in terms of the participants being given written and verbal information about the study, of their right to withdraw and ways to contact the researcher. Giving potential participants sufficient information about the research in an understandable format will require careful drafting of the information sheet, particularly as some participants are likely to have literacy difficulties. At least one pilot test of the process for informing and debriefing will be carried out.

Service users within secure hospitals are often some of the most vulnerable in society. Within a forensic environment individuals are placed under greater restrictions when compared with the general population and their choices limited. Great care will be taken to ensure that truly informed consent is obtained before involving them in research. That is they are fully aware that they have a choice to refuse to engage in the research and that their engagement, or refusal, will have no impact on their current / future care or ability to progress.

There will be no direct benefit to the participant, but their contribution will help further understanding about service user experiences of EMDR and may inform thinking about what treatment options are considered in the future and how they are offered. Additionally, it may offer an opportunity to be able to reflect on their experiences.

Participants will be able, during the data gathering phase, to freely withdraw or modify their consent and ask for destruction of all or part of the data that they have contributed. They will be verbally informed of this process prior to signing the consent form and provided with written instructions about how to do this. This will also include a reminder that withdrawal will have no impact on their access to treatment or detention.

The privacy of participants will be respected and individuals will not be personally identifiable. Confidentiality will be respected and any information and data collected will be appropriately anonymised and other parties will be unable to trace this information back to them.

Consent to research protocol will be critical to the ethical conduct of the research project and will be compliant with the requirements of the Mental Capacity Act (2005) and The British Psychological Society's (BPS) code of ethics (British Psychological Society, 2014). Eligibility to consent to engage in the research will be discussed, and agreed, with the service user's team, which will include the treating therapist and Responsible Clinician. Participant assent will be monitored by the researcher and the service user's clinical team who will be sensitive to any signs, verbal or non-verbal, that the participant is not wholly willing to continue with the data collection. Any changes in the participant's capacity to consent will prompt a review of their eligibility to contribute to the research.

When considering risks to participants, all participants will have had the opportunity to engage in EMDR and as such the research will not impede on their ability to access services. Participants will be asked to discuss their experiences of therapy and the reasons for having EMDR. As such procedures will be in place to support participants following interview.

Individuals approached to take part in the study will be those whose mental health was such that the treating clinician deems it safe for the clients "mental wellbeing" to participate in the study. Treating clinicians will approach all participants at the end of EMDR therapy when they are assessing their psychological response to treatment and their suitability for discharge, or for further intervention. This will inform their clinical judgement in respect to whether the client will be emotionally and psychologically stable enough to engage in the study. Following the study they will also be given the name of a psychologist with whom they can discuss any concerns.

## 3. PURPOSE AND DESIGN OF THE RESEARCH

**A7. Select the appropriate methodology description for this research.** *Please tick all that apply:*

- ☐ Case series/ case note review
- ☐ Case control
- ☐ Cohort observation
- ☐ Controlled trial without randomisation
- ☐ Cross-sectional study
- ☐ Database analysis
- ☐ Epidemiology
- ☐ Feasibility/ pilot study
- ☐ Laboratory study
- ☐ Metanalysis
- ☑ Qualitative research
- ☐ Questionnaire, interview or observation study
- ☐ Randomised controlled trial
- ☐ Other (please specify)

**A10. What is the principal research question/objective?** *Please put this in language comprehensible to a lay person.*

To develop an understanding of personal experiences of EMDR therapy within secure services.

**A11. What are the secondary research questions/objectives if applicable?** *Please put this in language comprehensible to a lay person.*

NA

**A12. What is the scientific justification for the research?** *Please put this in language comprehensible to a lay person.*

Trauma has consistently been a connecting factor for varying acts of violence, with offenders presenting with a higher prevalence of Post-traumatic stress disorder (PTSD) and associated symptoms when compared with the general population (American Psychiatric Association (APA), 1994). More recent research demonstrates that traumatic experiences and criminal behaviours are fundamentally interlinked (Ardino, 2012) and there is a body of literature which documents the relationship between trauma, childhood abuse, and aggressive and criminal acts (Ardino, Milani, & Di Blasio, 2013; Maxfield & Widom, 1996; Turner, Finkelhor, & Ormrod, 2006).

In addition to aggression and violence, the comorbidity between PTSD and substance use indicates an increased risk of relapse (Kubiak, 2004) and the chances of becoming embedded within the criminal justice system (Ouimette, Finney, & Moos, 1999). Within clinical practice, this link has been clearly identified and acknowledged within commonly used risk assessments (Hart et al., 2003; Douglas, Hart, Webster, & Belfrage, 2013). Although, trauma and adverse life experiences may be recognised within some offence focused groups as a link to offending, the nature of the intervention is not to address this work directly and very few interventions or programs directly aim to address the trauma itself in any depth.

Eye Movement Desensitization and Reprocessing (EMDR) therapy is a psychotherapeutic approach developed by Francine Shapiro in 1987. EMDR involves a number of elements from a variety of other therapeutic approaches. The element that is unique to EMDR is the use of "bilateral stimulation". Traditionally, this has involved the therapist leading a client in a series of lateral eye movements. Other forms of bilateral stimulation include alternating bilateral sounds or touch. During the sets the client is asked notice what they are experiencing and then provide a brief description of this. This appears somewhat similar to free association but participants may report experiencing images, thoughts or bodily sensations (e.g., pain of a traumatic event).

With a focus on trauma and encompassing cognitions, imagery and also bodily sensations, EMDR therapy offers a different type of therapy compared to the talking therapies commonly used within secure services. It is also different in that it uses eye movements or other bilateral methods within the process and is seen a new therapy approach which has attracted a lot of opposition (Russell, 2008).

In recent years, EMDR has become widely recognised as an effective approach for treating trauma outside of secure environments (Dutch National Steering Committee, 2003; UK Department of Health, 2001; World Health Organisation (WHO), 2013). Alongside CBT, EMDR therapy is becoming more often viewed as a treatment of choice. Not only is the approach superior in ameliorating symptoms (Bison, Robert, Andres, Cooper, & Lewis, 2013; Clinical Resource Efficiency Support Team (CREST), 2003), it offers treatment gains in fewer sessions (de Roos et al., 2011), which are long lasting (Edmond, Rubin, & Wambach, 1999). Further EMDR therapy does not involve the need to directly challenge beliefs, extend exposure or involve homework (World Health Organisation (WHO), 2013).

EMDR therapy's application to other mental health difficulties includes anxiety, phobias, and excessive grief somatic disorders (Luber, 2009). Additionally, EMDR therapy is being used to address anger, substance use problems and trauma in psychosis (Van Den Berg & Van Der Gaag, 2012). Borderline personality disorder is being explored with positive results (Brown & Shapiro, 2006; Fernandez & Faretta, 2007).

Many of these difficulties can be seen within secure services and, in recent years, therapists have started using EMDR therapy. Known for its trauma roots, EMDR therapy's use may have started in this area but appears to have further broadened, for example, being used alongside offence focused intervention (Ricci & Clayton, 2009). However, there is currently little known about its possible use and role within secure services.

EMDR does not target a service users offending behaviour directly. However, reducing their distress may arguably impact on their problematic and/ or offence focused behaviours; thereby indirectly addressing risk reduction. Additionally, EMDR has been argued to increase insight into offending behaviours (Ricci & Clayton, 2009).

Currently, EMDR is not seen as an offence focused intervention and therefore a requirement for a service user to engage in. As such, service user' motivation for engaging within EMDR may be different to other offence focused interventions. It could be argued that a service user engages in EMDR solely for their own benefits; suggestive of a more meaningful engagement. This is of note when motivation has been a pre-requisite and essential component for treatment (McMurran, 2009), with secure services targeting resources towards programmes and clients most likely to

benefit (Williamson, Day, Howells, Bubner, & Jauncey, 2003). Currently little is known about service user experiences of why they engage in EMDR therapy and how it may be beneficial to them in terms of their recovery and/ or risk reduction.

**A13. Please summarise your design and methodology.** *It should be clear exactly what will happen to the research participant, how many times and in what order. Please complete this section in language comprehensible to the lay person. Do not simply reproduce or refer to the protocol. Further guidance is available in the guidance notes.*

The study will take place at secure hospitals within the NHS.

Participants will be males and females with complex mental health disorders. They will be currently detained under the Mental Health Act (1983) and residing within high, medium or low secure services. The sample will include the last 10-12 suitable service users to have completed EMDR therapy.

Participants will be invited to engage in a semi structured interview, conducted by the researcher. Written information about the study will be made available prior to being invited to attend the interview and any questions answered. Suitable participants will be identified by their clinical team and an interview arranging if they agree to meet with the researcher. No confidential information will be taken prior to this interview.

Verbal and written consent will be gained at the start of the interview. The interview will then provide consenting participants the opportunity to communicate their understanding of their current situation and experiences of EMDR therapy. Participants will be asked to talk as widely as possible about what EMDR therapy was like for them and the different ways engaging in EMDR therapy may have influenced their feelings attitudes, beliefs or behaviours.

The interviews will be semi-structured in that the researcher will be informed by a schedule, but participants will be encouraged to talk in detail about their particular concerns and be probed on important individual topics which may arise.

Data gained from the interviews will be transcribed (annonymised where necessary) and Thematic Analysis will be used to analyse the data.

**A14-1. In which aspects of the research process have you actively involved, or will you involve, patients, service users, and/or their carers, or members of the public?**

- [x] Design of the research
- [ ] Management of the research
- [ ] Undertaking the research
- [ ] Analysis of results
- [ ] Dissemination of findings
- [ ] None of the above

*Give details of involvement, or if none please justify the absence of involvement.*
Service users have been involved in the design of the participant information sheets and interview questions.

## 4. RISKS AND ETHICAL ISSUES

### RESEARCH PARTICIPANTS

**A15. What is the sample group or cohort to be studied in this research?**

Select all that apply:

- [ ] Blood
- [ ] Cancer
- [ ] Cardiovascular

- [ ] Congenital Disorders
- [ ] Dementias and Neurodegenerative Diseases
- [ ] Diabetes
- [ ] Ear
- [ ] Eye
- [ ] Generic Health Relevance
- [ ] Infection
- [ ] Inflammatory and Immune System
- [ ] Injuries and Accidents
- [x] Mental Health
- [ ] Metabolic and Endocrine
- [ ] Musculoskeletal
- [ ] Neurological
- [ ] Oral and Gastrointestinal
- [ ] Paediatrics
- [ ] Renal and Urogenital
- [ ] Reproductive Health and Childbirth
- [ ] Respiratory
- [ ] Skin
- [ ] Stroke

| | |
|---|---|
| Gender: | Male and female participants |
| Lower age limit: 18 | Years |
| Upper age limit: 100 | Years |

**A17-1. Please list the principal inclusion criteria (list the most important, max 5000 characters).**

Have engaged in, and completed, EMDR therapy
Males and females.
Complex mental health disorders.
Currently detained under the Mental Health Act (1983) and residing within high, medium or low secure services.

**A17-2. Please list the principal exclusion criteria (list the most important, max 5000 characters).**

Have not completed EMDR therapy.
Are not currently stable enough to engage in the interview.
Lack of capacity and/or consent to engage in the research.

## RESEARCH PROCEDURES, RISKS AND BENEFITS

**A18. Give details of all non-clinical intervention(s) or procedure(s) that will be received by participants as part of the research protocol.** *These include seeking consent, interviews, non-clinical observations and use of questionnaires.*

Please complete the columns for each intervention/procedure as follows:

1. Total number of interventions/procedures to be received by each participant as part of the research protocol.
2. If this intervention/procedure would be routinely given to participants as part of their care outside the research, how many of the total would be routine?
3. Average time taken per intervention/procedure (minutes, hours or days)

4. Details of who will conduct the intervention/procedure, and where it will take place.

| Intervention or procedure | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| Interviews | 1 | 0 | 1 hour | Marnie Allen will conduct the interviews. Interviews will take place in a suitable room within the secure hosital. Service users will have some choice in which room is used - able to express a preference. |

**A21. How long do you expect each participant to be in the study in total?**

Participants will be invited to attend the interviews by therapist within the hospital and see if they are interested in engaging. However, signed consent will occur at the time of the interview. I would expect that the interview lasts approximately 1 hour.

**A22. What are the potential risks and burdens for research participants and how will you minimise them?**

*For all studies, describe any potential adverse effects, pain, discomfort, distress, intrusion, inconvenience or changes to lifestyle. Only describe risks or burdens that could occur as a result of participation in the research. Say what steps would be taken to minimise risks and burdens as far as possible.*

When considering risks to participants, all participants will have had the opportunity to engage in EMDR therapy and as such the research will not impede on participants ability to access services. Additionally, this is not a new therapy being offered. Following successful completion of EMDR therapy, the research will involve asking participants to discuss their experiences of therapy and the reasons for having EMDR. To be included in the study participants must have successfully completed therapy. This would suggest that their distress in this area should have been reduced prior to interview. The interview will primarily be focused on the process of EMDR and not specifically on exploring their mental health difficulties. However it is acknowledged that discussion of mental health difficulties may be a relevant aspect of the interview. It will be made clear that participants only need to discuss topics which they are comfortable doing.

Individuals approached to take part in the study will be those whose mental health was such that the treating clinician deems it safe for the clients "mental wellbeing" to participate in the study. Treating clinicians will approach all participants at the end of EMDR therapy when they are assessing their psychological response to treatment and their suitability for discharge, or for further intervention. This will inform their clinical judgement in respect to whether the client will be emotionally and psychologically stable enough to engage in the study. Following the interview, procedures will be in place to support participants; they will be given the name of a psychologist with whom they can discuss any concerns.

The privacy of participants will be respected and individuals will not be personally identifiable. Confidentiality will be respected and any information and data collected will be appropriately anonymised and other parties will be unable to trace this information back to them.

**A23. Will interviews/ questionnaires or group discussions include topics that might be sensitive, embarrassing or upsetting, or is it possible that criminal or other disclosures requiring action could occur during the study?**

◉ Yes ○ No

*If Yes, please give details of procedures in place to deal with these issues:*

Participants may talk about sensitive, embarrassing or upsetting information. It is also possible that criminal or other disclosures requiring action could occur during the study. Participants will be reminded that they only have to talk about topics that they are comfortable with. They will also be offered additional support as necessary, e.g., to meet with their therapist.

Participants will be informed of basic limits to confidentiality and the need for safeguarding. For example, if they talk about information related to crimes that they have committed which no one knows about or about issues relevant to safeguarding (e.g., abuse of a child). If something is disclosed then the interview for the purpose of research will be terminated. The reasons will be discussed with the participant and subsequently raised with the relevant people within the hospital. The interviewer is a psychologist and is experienced with discussing issues around confidentiality and the need to discuss disclosures of further offences with the care team. Also the interviewer has attended safeguarding training.

**A24. What is the potential for benefit to research participants?**

There will be no direct benefit to the participant, but their contribution will help further understanding about service user experiences of EMDR and may inform thinking about what treatment options are considered in the future and how they are offered. Additionally, they will be able to reflect on their experiences.

The nature of the research, and a participant's contribution, will be made clear from the outset. Standard ethical procedures will be used in terms of the participants being given written and verbal information about the study, of their right to withdraw and ways to contact the researcher. Giving potential participants sufficient information about the research in an understandable format will require careful drafting of the information sheet, particularly as some participants are likely to have literacy difficulties. At least one pilot test of the process for informing and debriefing will be carried out.

Service users within secure hospitals are often some of the most vulnerable in society. Within a forensic environment individuals are placed under greater restrictions when compared with the general population and their choices limited. Great care will be taken to ensure that truly informed consent is obtained before involving them in research. That is they are fully aware that they have a choice to refuse to engage in the research and that their engagement, or refusal, will have no impact on their current / future care or ability to progress.

**A26. What are the potential risks for the researchers themselves?** *(if any)*

The researcher is a HCPC registered and chartered forensic psychologist currently working within a secure service. Therefore the researcher has attended breakaway training relevant to this environment. The researcher will check with the unit staff if they feel that the participant is able to engage in the interview at that time.

If dealing with an agitated or aggressive participant the researcher will use the skills and techniques learnt during her breakaway training. Further training will be undertaken as necessary at each unit and personal alarms will be provided to use as appropriate.

## RECRUITMENT AND INFORMED CONSENT

*In this section we ask you to describe the recruitment procedures for the study. Please give separate details for different study groups where appropriate.*

**A27-1. How will potential participants, records or samples be identified? Who will carry this out and what resources will be used?** *For example, identification may involve a disease register, computerised search of GP records, or review of medical records. Indicate whether this will be done by the direct healthcare team or by researchers acting under arrangements with the responsible care organisation(s).*

The researcher will identify which secure hospitals currently use EMDR therapy. The researcher will then contact the head of psychological therapy services to discuss the project. Suitable participants will be identified via the psychologist/ therapist employed at the unit in collaboration with the service users direct clincial team. This study will involve qualitative analysis and as such the use of staff to recruit participants will not negatively impact on the study in terms of methodology.

Participants will be males and females with complex mental health disorders. They will be currently detained under the Mental Health Act (1983) and residing within medium or low secure services. The sample will include the last 10-12 suitable service users to have completed EMDR therapy.

**A27-2. Will the identification of potential participants involve reviewing or screening the identifiable personal information of patients, service users or any other person?**

○ Yes ◉ No

*Please give details below:*
The EMDR therapist in the hospital will be given the inclusion/ exclusion criteria. The researcher will interview those participants deemed as suitable and will not personally screen personal information of patients.

**A28. Will any participants be recruited by publicity through posters, leaflets, adverts or websites?**

○ Yes ◉ No

**A29. How and by whom will potential participants first be approached?**

Potential participants will initially be approached by their treating EMDR therapist. This will be done verbally but also supported with the patient information sheet which has been attached. They will have finished therapy and be told that their willingness to engage in the interview will not impact on their future care or treatment.

**A30-1. Will you obtain informed consent from or on behalf of research participants?**

◉ Yes ○ No

*If you will be obtaining consent from adult participants, please give details of who will take consent and how it will be done, with details of any steps to provide information (a written information sheet, videos, or interactive material). Arrangements for adults unable to consent for themselves should be described separately in Part B Section 6, and for children in Part B Section 7.*

*If you plan to seek informed consent from vulnerable groups, say how you will ensure that consent is voluntary and fully informed.*

Service users within secure hospitals are often some of the most vulnerable in society. Within a forensic environment individuals are placed under greater restrictions when compared with the general population and their choices limited. Great care will be taken to ensure that truly informed consent is obtained before involving them in research. That is they are fully aware that they have a choice to refuse to engage in the research and that their engagement, or refusal, will have no impact on their current / future care or ability to progress.

Participants will be able, during the data gathering phase, to freely withdraw or modify their consent and ask for destruction of all or part of the data that they have contributed. They will be verbally informed of this process prior to signing the consent form and provided with written instructions about how to do this. This will also include a reminder that withdrawal will have no impact on their access to treatment or detention.

The privacy of participants will be respected and individuals will not be personally identifiable. Confidentiality will be respected and any information and data collected will be appropriately anonymised and other parties will be unable to trace this information back to them.

Consent to research protocol will be critical to the ethical conduct of the research project and will be compliant with the requirements of the Mental Capacity Act (2005) and The British Psychological Society's (BPS) code of ethics (British Psychological Society, 2014). Eligibility to consent to engage in the research will be discussed, and agreed, with the service user's team, which will include the treating therapist and Responsible Clinician. Participant assent will be monitored by the researcher and the service user's clinical team who will be sensitive to any signs, verbal or non-verbal, that the participant is not wholly willing to continue with the data collection. Any changes in the participant's capacity to consent will prompt a review of their eligibility to contribute to the research.

The particiants Responsible Clinician (RC) and care teams will be made aware of the research. They will agree, prior to the researcher meeting the particiant, that they are happy for the interview to take place and belive that the participant has the capacity to consent to engage.

*If you are not obtaining consent, please explain why not.*

*Please enclose a copy of the information sheet(s) and consent form(s).*

**A30-2. Will you record informed consent (or advice from consultees) in writing?**

◉ Yes ○ No

**A31. How long will you allow potential participants to decide whether or not to take part?**

Participants will be given 2 weeks to decide if they want to engage.

**A33-1. What arrangements have been made for persons who might not adequately understand verbal explanations or written information given in English, or who have special communication needs?** *(e.g. translation, use of interpreters)*

Consideration of literacy levels and level of cognitive functioning will be given when designing the participant consent and information sheets. Participants will be required to engage in interview and as such need to be able to communicate using English to the level that they believe that they can express their views about their engagement in herapy.

**A35. What steps would you take if a participant, who has given informed consent, loses capacity to consent during the study?** *Tick one option only.*

- ○ The participant and all identifiable data or tissue collected would be withdrawn from the study. Data or tissue which is not identifiable to the research team may be retained.
- ◉ The participant would be withdrawn from the study. Identifiable data or tissue already collected with consent would be retained and used in the study. No further data or tissue would be collected or any other research procedures carried out on or in relation to the participant.
- ○ The participant would continue to be included in the study.
- ○ Not applicable – informed consent will not be sought from any participants in this research.
- ○ Not applicable – it is not practicable for the research team to monitor capacity and continued capacity will be assumed.

*Further details:*

Any suggestion that the participant no longer consents will result in their data being withdrawn from the study. Data will also be withdrawn if the patients care team recommends/requests this.

*If you plan to retain and make further use of identifiable data/tissue following loss of capacity, you should inform participants about this when seeking their consent initially.*

## CONFIDENTIALITY

In this section, personal data means any data relating to a participant who could potentially be identified. It includes pseudonymised data capable of being linked to a participant through a unique code number.

### Storage and use of personal data during the study

**A36. Will you be undertaking any of the following activities at any stage (including in the identification of potential participants)?** *(Tick as appropriate)*

- ☐ Access to medical records by those outside the direct healthcare team
- ☐ Access to social care records by those outside the direct social care team
- ☐ Electronic transfer by magnetic or optical media, email or computer networks
- ☐ Sharing of personal data with other organisations
- ☐ Export of personal data outside the EEA
- ☐ Use of personal addresses, postcodes, faxes, emails or telephone numbers
- ☑ Publication of direct quotations from respondents
- ☐ Publication of data that might allow identification of individuals
- ☐ Use of audio/visual recording devices
- ☑ Storage of personal data on any of the following:
  - ☑ Manual files (includes paper or film)
  - ☐ NHS computers

- ☐ Social Care Service computers
- ☑ Home or other personal computers
- ☑ University computers
- ☐ Private company computers
- ☐ Laptop computers

*Further details:*
I will be reliant on the patients care team identifying appropriate participants. Any information to be used in the research will be gained during interview, including demographic information.

Data will be annonymised and then analysed on a home computer, as my university course is distance learning. No personal/ identifiable data will be held on the computer. Data will be stored via Univeristy storage and not on the computer itself.

All manual files will be stored securely in locked cabinets and/ or password protected.

Although quotes may be used in publication, consideration will be given to whether this would mean that the participant is easily identifiable by this information rather than giving an example of a theme.

**A37. Please describe the physical security arrangements for storage of personal data during the study?**

Any data in (hardcopy) will be stored in a locked filing cabinet which only Marnie Allen (main researcher) will have access to. This will include storage of recording devices/ and printed information. This data will be annonymised. The particiant will be asked to provide a pseudonym after they enage in interview. They will need to provide this pseudonym to withdraw their data as this will identify their data. The only personal data that will have participants names will be the consent forms.

**A38. How will you ensure the confidentiality of personal data?** *Please provide a general statement of the policy and procedures for ensuring confidentiality, e.g. anonymisation or pseudonymisation of data.*

I work as a psychologist privately and will treat the research data in a similar manner to that of my private clients, in terms of confidentiality. I am also on the data protection register, which I pay for as part of my private (therapy/ expert witness) business.

Each participant will provide a pseudonym which will identify their data. This is relevant if they wish to withdraw. This could be written down for them to keep if they wish.

When audio data is transcribed, any identifying information will be removed. Audio data will be stored in a locked cabinet. All information will be and destroyed after 5 years of the acceptance of my thesis.

**A40. Who will have access to participants' personal data during the study?** *Where access is by individuals outside the direct care team, please justify and say whether consent will be sought.*

As the main researcher, Marnie Allen will be the only person able to access personal data.

## Storage and use of data after the end of the study

**A41. Where will the data generated by the study be analysed and by whom?**

Data will remain in the UK.
Marnie Allen will analyse the data. All data will be stored securely (password/ locked cabinet).

**A42. Who will have control of and act as the custodian for the data generated by the study?**

| | Title Forename/Initials Surname |
|---|---|
| | Ms Marnie E Allen |
| Post | Forensic Psychologist |
| Qualifications | 'Top Up' Forensic Doctorate (D. Foren.Psy.), Cardiff Metropolitan University. ONGOING.<br><br>Qualification in Forensic Psychology: Stage 2. The British Psychological Society.<br><br>MSc in Forensic Psychology. University of Portsmouth.<br><br>Diploma in Psychology (Conversion for Postgraduates), The Open University.<br><br>BSc (honours) Psychology with English, King Alfred's College, Winchester |
| Work Address | Llandaff Campus<br>Western Avenue<br>Cardiff |
| Post Code | CF5 2YB |
| Work Email | M.Allen14@outlook.cardiffmet.ac.uk |
| Work Telephone | [redacted] |
| Fax | |

**A43. How long will personal data be stored or accessed after the study has ended?**

- (•) Less than 3 months
- ( ) 3 – 6 months
- ( ) 6 – 12 months
- ( ) 12 months – 3 years
- ( ) Over 3 years

**A44. For how long will you store research data generated by the study?**

Years: 5
Months:

**A45. Please give details of the long term arrangements for storage of research data after the study has ended.** *Say where data will be stored, who will have access and the arrangements to ensure security.*

Data will be stored in a locked cabinet (hardcopy and electronically on a USB stick which will also be password protected). This will only be accessed by Marnie Allen who will be responsible for destroying it after 5 years.

## INCENTIVES AND PAYMENTS

**A46. Will research participants receive any payments, reimbursement of expenses or any other benefits or incentives for taking part in this research?**

- ( ) Yes
- (•) No

**A47. Will individual researchers receive any personal payment over and above normal salary, or any other benefits or incentives, for taking part in this research?**

- ( ) Yes
- (•) No

**A48. Does the Chief Investigator or any other investigator/collaborator have any direct personal involvement (e.g. financial, share holding, personal relationship etc.) in the organisations sponsoring or funding the research that may give rise to a possible conflict of interest?**

○ Yes ◉ No

## NOTIFICATION OF OTHER PROFESSIONALS

**A49-1. Will you inform the participants' General Practitioners (and/or any other health or care professional responsible for their care) that they are taking part in the study?**

◉ Yes ○ No

*If Yes, please enclose a copy of the information sheet/letter for the GP/health professional with a version number and date.*

**A49-2. Will you seek permission from the research participants to inform their GP or other health/ care professional?**

◉ Yes ○ No

*It should be made clear in the participant's information sheet if the GP/health professional will be informed.*

## PUBLICATION AND DISSEMINATION

**A50. Will the research be registered on a public database?**

◉ Yes ○ No

*Please give details, or justify if not registering the research.*
EMDR Research Foundation
http://emdrresearchfoundation.org/

All studies open at [redacted]HS Foundation Trust will be included on quarterly report. Information relating to this project will be registered on the Health Research Authority website, which is publically available information.

*Registration of research studies is encouraged wherever possible.*
*You may be able to register your study through your NHS organisation or a register run by a medical research charity, or publish your protocol through an open access publisher. If you are aware of a suitable register or other method of publication, please give details. If not, you may indicate that no suitable register exists. Please ensure that you have entered registry reference number(s) in question A5-1.*

**A51. How do you intend to report and disseminate the results of the study?** *Tick as appropriate:*

- ☑ Peer reviewed scientific journals
- ☐ Internal report
- ☑ Conference presentation
- ☐ Publication on website
- ☐ Other publication
- ☐ Submission to regulatory authorities
- ☐ Access to raw data and right to publish freely by all investigators in study or by Independent Steering Committee on behalf of all investigators
- ☐ No plans to report or disseminate the results

☑ Other (please specify)

Doctoral research thesis

**A52. If you will be using identifiable personal data, how will you ensure that anonymity will be maintained when publishing the results?**

No identifiable information will be used.

**A53. Will you inform participants of the results?**

◉ Yes ○ No

*Please give details of how you will inform participants or justify if not doing so.*
They will be offered a summary version of the results on completion.

## 5. Scientific and Statistical Review

**A54. How has the scientific quality of the research been assessed?** *Tick as appropriate:*

- ☐ Independent external review
- ☐ Review within a company
- ☐ Review within a multi-centre research group
- ☐ Review within the Chief Investigator's institution or host organisation
- ☐ Review within the research team
- ☑ Review by educational supervisor
- ☐ Other

*Justify and describe the review process and outcome. If the review has been undertaken but not seen by the researcher, give details of the body which has undertaken the review:*
Doctoral Researchers at Cardiff Metropolitan University are required to submit a Research degree proposal. This proposal is reviewed by their Supervisors, their School and the University Research Degree Committee. This was approved on 17.01.17.

*For all studies except non-doctoral student research, please enclose a copy of any available scientific critique reports, together with any related correspondence.*

*For non-doctoral student research, please enclose a copy of the assessment from your educational supervisor/ institution.*

**A59. What is the sample size for the research?** *How many participants/samples/data records do you plan to study in total? If there is more than one group, please give further details below.*

| | |
|---|---|
| Total UK sample size: | 12 |
| Total international sample size (including UK): | 12 |
| Total in European Economic Area: | 0 |

*Further details:*

**A60. How was the sample size decided upon?** *If a formal sample size calculation was used, indicate how this was done, giving sufficient information to justify and reproduce the calculation.*

The sample will include the last 12 suitable service users to have completed EMDR therapy.

This is the number of participants suggested by (Braun & Clarke, 2013) for a doctoral level piece of reserach using qualitative analysis (12 participants). This size is large enough to demonstrate patterns across a data set, but small enough to retain a focus on the experiences of the individual participants.

**A62. Please describe the methods of analysis (statistical or other appropriate methods, e.g. for qualitative research) by which the data will be evaluated to meet the study objectives.**

The aim of the research is to develop an understanding of personal experiences of EMDR therapy within secure services.

The research objectives are based around exploring people's experiences and how the world is seen and understood from their perspective. As such this lends itself to more qualitative, and in particular, experiential research. Suitable analytical methods include Interpretative Phenomenological Analysis (IPA) (Smith, Flowers, & Larkin, 2009) and experiential Thematic Analysis (Braun & Clarke, 2013). Both of these approaches focus on the individual and their framing. However, TA explores the data as a whole and explore overall patterns. It is argued that such this approach may offer greater flexibility. That is, being able to explore lived experiences (e.g., "What EMDR feels like") but also allowing the option to evaluate and compare EMDR with other therapies. It is for this reason that TA will be used to explore personal experiences of the EMDR process within a secure service.

When considering the research question around people's experiences, interviews are arguably a suitable data source. Other forms e.g., focus groups, personal blogs, maybe not be accessible for this group and surveys may not provide the richness of data sought. As the interventions will already have been completed researcher directed diaries would not be suitable. Semi-structured interviews also allows for participants to be able to raise issues not previously anticipated.

## 6. MANAGEMENT OF THE RESEARCH

**A63. Other key investigators/collaborators.** *Please include all grant co-applicants, protocol co-authors and other key members of the Chief Investigator's team, including non-doctoral student researchers.*

## A64. Details of research sponsor(s)

**A64-1. Sponsor**

**Lead Sponsor**

Status:
- ○ NHS or HSC care organisation
- ◉ Academic
- ○ Pharmaceutical industry
- ○ Medical device industry
- ○ Local Authority
- ○ Other social care provider (including voluntary sector or private organisation)
- ○ Other

Commercial status:

*If Other, please specify:*

**Contact person**

Name of organisation: Cardiff Metropolitan University
Given name: Ian
Family name: IMathieson
Address:

Town/city
Post code
Country UNITED KINGDOM
Telephone
Fax
E-mail IMathieson@cardiffmet.ac.uk

**A65. Has external funding for the research been secured?**

☐ Funding secured from one or more funders
☐ External funding application to one or more funders in progress
☑ No application for external funding will be made

What type of research project is this?

◉ Standalone project
○ Project that is part of a programme grant
○ Project that is part of a Centre grant
○ Project that is part of a fellowship/ personal award/ research training award
○ Other

Other – please state:

**A66. Has responsibility for any specific research activities or procedures been delegated to a subcontractor (other than a co-sponsor listed in A64-1) ?** *Please give details of subcontractors if applicable.*

○ Yes ◉ No

**A67. Has this or a similar application been previously rejected by a Research Ethics Committee in the UK or another country?**

○ Yes ◉ No

*Please provide a copy of the unfavourable opinion letter(s). You should explain in your answer to question A6-2 how the reasons for the unfavourable opinion have been addressed in this application.*

**A68-1. Give details of the lead NHS R&D contact for this research:**

Title Forename/Initials Surname [redacted]
Organisation
Address
Post Code
Work Email
Telephone

Fax
Mobile

*Details can be obtained from the NHS R&D Forum website: http://www.rdforum.nhs.uk*

**A69-1. How long do you expect the study to last in the UK?**

Planned start date: 01/02/2018
Planned end date: 04/01/2019
Total duration:
Years: 0 Months: 11 Days: 4

**A71-1. Is this study?**

○ Single centre
◉ Multicentre

**A71-2. Where will the research take place?** *(Tick as appropriate)*

☑ England
☐ Scotland
☐ Wales
☐ Northern Ireland
☐ Other countries in European Economic Area

Total UK sites in study 3

**Does this trial involve countries outside the EU?**
○ Yes ◉ No

**A72. Which organisations in the UK will host the research?** *Please indicate the type of organisation by ticking the box and give approximate numbers if known:*

☑ NHS organisations in England 3
☐ NHS organisations in Wales
☐ NHS organisations in Scotland
☐ HSC organisations in Northern Ireland
☐ GP practices in England
☐ GP practices in Wales
☐ GP practices in Scotland
☐ GP practices in Northern Ireland
☐ Joint health and social care agencies (eg community mental health teams)
☐ Local authorities
☐ Phase 1 trial units
☐ Prison establishments
☐ Probation areas

☐ Independent (private or voluntary sector) organisations
☐ Educational establishments
☐ Independent research units
☐ Other (give details)

Total UK sites in study: 3

**A73-1. Will potential participants be identified through any organisations other than the research sites listed above?**

○ Yes ◉ No

**A74. What arrangements are in place for monitoring and auditing the conduct of the research?**

This project will be monitored and audited in accordance with sponsors policies and procedures. In addition, the documentation and study data will be made available to REC committees and NHS Organisations should this be required.

**A76. Insurance/ indemnity to meet potential legal liabilities**

*Note: in this question to NHS indemnity schemes include equivalent schemes provided by Health and Social Care (HSC) in Northern Ireland*

**A76-1. What arrangements will be made for insurance and/or indemnity to meet the potential legal liability of the sponsor(s) for harm to participants arising from the management of the research?** *Please tick box(es) as applicable.*

*Note: Where a NHS organisation has agreed to act as sponsor or co-sponsor, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For all other sponsors, please describe the arrangements and provide evidence.*

☐ NHS indemnity scheme will apply (NHS sponsors only)
☑ Other insurance or indemnity arrangements will apply (give details below)

Cardiff Metropolitan University Insurance. As attached.

*Please enclose a copy of relevant documents.*

**A76-2. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of the sponsor(s) or employer(s) for harm to participants arising from the design of the research?** *Please tick box(es) as applicable.*

*Note: Where researchers with substantive NHS employment contracts have designed the research, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For other protocol authors (e.g. company employees, university members), please describe the arrangements and provide evidence.*

☐ NHS indemnity scheme will apply (protocol authors with NHS contracts only)
☑ Other insurance or indemnity arrangements will apply (give details below)

Cardiff Metropolitan University Insurance. As attached.

*Please enclose a copy of relevant documents.*

**A76-3. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of investigators/collaborators arising from harm to participants in the conduct of the research?**

*Note: Where the participants are NHS patients, indemnity is provided through the NHS schemes or through professional indemnity. Indicate if this applies to the whole study (there is no need to provide documentary evidence). Where non-NHS sites are to be included in the research, including private practices, please describe the arrangements which will be made at these sites and provide evidence.*

- [x] NHS indemnity scheme or professional indemnity will apply (participants recruited at NHS sites only)
- [ ] Research includes non-NHS sites (give details of insurance/ indemnity arrangements for these sites below)

*Please enclose a copy of relevant documents.*

**A78. Could the research lead to the development of a new product/process or the generation of intellectual property?**

○ Yes ◉ No ○ Not sure

## PART C: Overview of research sites

**Please enter details of the host organisations (Local Authority, NHS or other) in the UK that will be responsible for the research sites.** *For further information please refer to guidance.*

| Investigator identifier | Research site | Investigator Name |
|---|---|---|
| IN1 | ◉ NHS/HSC Site<br>○ Non-NHS/HSC<br>Organisation name<br>Address<br>Post Code<br>Country | [redacted] |
| IN2 | ◉ NHS/HSC Site<br>[redacted] | |
| IN3 | ◉ NHS/HSC Site<br>○ Non-NHS/HS<br>Organisation name<br>Address | [redacted] |


Post Code
Country

# Appendix 10: Berkshire REC – Favourable Approval (06.03.18)

NHS
Health Research Authority
South Central - Berkshire Research Ethics Committee
Bristol REC Centre
Whitefriars
Level 3, Block B
Lewins Mead
Bristol
BS1 2NT

Telephone: 020 7104 8057

**Please note: This is the favourable opinion of the REC only and does not allow you to start your study at NHS sites in England until you receive HRA Approval**

06 March 2018

Ms Marnie E Allen
Forensic Psychologist
Cardiff Metropolitan University
Llandaff Campus
Western Avenue
Cardiff
CF5 2YB

Dear Ms Allen

| | |
|---|---|
| **Study title:** | **Exploring personal experiences of EMDR therapy within secure services.** |
| **REC reference:** | **18/SC/0034** |
| **Protocol number:** | **NA** |
| **IRAS project ID:** | **217066** |

The Research Ethics Committee reviewed the above application at the meeting held on 20 February 2018. Thank you for attending to discuss the application.

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 favourable opinion letter. The expectation is that this information will be published for all studies that receive an ethical opinion but should you wish to provide a substitute contact point, wish to make a request to defer, or require further information, please contact hra.studyregistration@nhs.net outlining the reasons for your request. Under very limited circumstances (e.g. for student research which has received an unfavourable opinion), it may be possible to grant an exemption to the publication of the study.

**Ethical opinion**

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, 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.

1. Please review the interview questions to see if any of them could be changed so that there were less closed questions.

2. Please add to the PIS and consent form that there were certain limitations to confidentiality, for example explain that although the interview is confidential any information divulged about crimes committed which no one knows about and any safeguarding concerns will remove the confidentiality obligation.

3. Please amend the *'you may choose a date and time'* statement on the invitation letter.

4. Please make the following changes to the PIS:

a) Include a statement about whom a participant could approach if they had any complaints about the research.

**You should notify the REC once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. Revised documents should be submitted to the REC electronically from IRAS. The REC will acknowledge receipt and provide a final list of the approved documentation for the study, which you can make available to host organisations to facilitate their permission for the study. Failure to provide the final versions to the REC may cause delay in obtaining permissions.**

Management permission 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 HRA Approval (England)/ NHS permission for research is available in the Integrated Research Application System, at 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. This should be before the first participant is recruited but no later than 6 weeks after recruitment of the first participant.

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. 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 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).

**Summary of discussion at the meeting**

The Chair welcomed the researchers to the meeting and told them that there were observers present and they could have them removed if they wished. They were happy for the observers to stay.

- **Social or scientific value; scientific design and conduct of the study**

The Committee summarised that this was a qualitative study, undertaken as part of a Doctorate in Forensic Psychology. The CI was a forensic psychologist, working within a secure unit, but the research would be undertaken in 3 other secure units. No adults lacking capacity would be recruited.

EMDR – an eye movement desensitisation and reprocessing therapy - was a standard treatment of trauma outside secure units, and was applied to an increasing number of mental health problems. It was recognised that trauma and offending behaviour were interlinked, and EMDR has started to be used within secure services. EMDR was also being used within secure services for a wider range of conditions than trauma but little was known about its use. Interviews lasting approximately an hour would be undertaken with a total of 10 to 12 participants currently detained in secure units and who had completed EMDR; the aim was to understand their experiences of receiving EMDR within secure services.

The setting clearly adds additional complexity to the research. However, the HRA definition of prison research did not include patients detained under the Mental Health Act either at special hospitals or other secure psychiatric units. So this study was not classed as prison research. Fundamentally this was a straightforward qualitative evaluation of an intervention, comparatively low risk and low burden. Any risk largely arose from the context - the setting in a secure unit - rather than the research per se. The researcher was in a good position to undertake the research and minimise any risks.

The Committee noted that the researcher was well aware of limitations to confidentiality and safeguarding requirements in the case of disclosure of a risk of serious harm, or of criminal behaviour, and it was likely that participants would also be aware of this. Nevertheless, limitations to confidentiality should be stated in the PIS and on the consent form, and the Committee asked for this to be added. Ensuring anonymity and confidentiality of these small group of participants was going to be difficult in relation to their clinical team and the Committee asked if the researcher considered how this might be managed.

*Ms Allen said that she was asking questions to do with if the participants had taken part in any EDMR therapy and the questions would more be around referrals and what the therapy was like for them. Ms Allen clarified that from these types of questions it was unlikely that any background of convictions or how they ended up in the hospital would arise.*

The Committee said that it was more concerned regarding a participant disclosing that they saw a certain therapist and said that their method was not good. They could say specific things about the people they saw and it would be useful to add to the PIS that confidentiality would be broken in some cases.

- **Recruitment arrangements and access to health information, and fair participant selection**

The Committee said that the way participants were recruited was likely to lead to a biased sample. This may be inevitable, given ethical concerns and the constraints of the setting but it asked if the researcher had considered also including participants who started but did not complete an EMDR course.

*Ms Allen said that she did wonder about this but thought that this could be incorporated into the next stage of the research. Because the participant group was so small as a therapist doing this in a secure hospital Ms Allen couldn't do the research just with the people she worked with. She had to place the participants and go over the country to find the people who did this therapy.*

- **Care and protection of research participants; respect for potential and enrolled participants' welfare and dignity**

The Committee noted that there was a contradiction in the documents regarding the sites and whether they were low, medium or high secure services.

*Ms Allen clarified that there were two high secure services and she would be attending both of these. She had worked at high security hospitals before so knew the issues and restrictions that she would face. The participant group were being detained under the mental health act and she would be looking to consent only those who had capacity.*

- **Informed consent process and the adequacy and completeness of participant information**

The Committee noted the PIS and letter both used the acronym EMDR, without spelling out the term and it asked whether potential participants would recognise the acronym rather than the full title of the therapy.

*Ms Allen confirmed that the participants would know what this was and in fact it was actually known more for the acronym than the full title.*

The Committee noted that the PIS did not include any information about who a participant could approach if they had any complaints about the research, and asked for this to be added.

The Committee asked for further minor changes to be made to the PIS and consent forms, noted in the Committee's decision letter.

- **Independent review**

The Committee noted that the IRAS form and Protocol stated that there had been Public and Patient involvement but no evidence was offered.

*Ms Allen said that this was completed very much on an informal level, speaking to people in terms of language used. People that Ms Allen worked with had cognitive difficulties and she was very much aware to make the information as readable and understandable as possible. She wanted to gain a general idea of what this group would like to talk about and she received some good feedback regarding what questions to ask.*

The Committee noted that many of the questions in the interview guides were closed questions, and it suggested that this seemed very structured. It queried whether this was what Ms Allen wanted.

*Ms Allen said she would have another look at this as she did not want too many closed questions.*

- **Suitability of supporting information**

The Committee commented that the invitation letter said *'you can choose a date and time for your interview'*, which made room for participants to suggest any time day or night. The Committee suggested that Ms Allen safeguarded herself against this.

*Ms Allen said that she agreed this could be changed but she had decided that she would be travelling to places like Nottingham and during these visits she would stay for a few days, just in case something arose where the interviews couldn't take place, yet could happen the day after. This would depend on how many people Ms Allen would see.*

- **Other general comments**

The Committee noted that the EMDR therapy suffered from a poor evidence base.

*Ms Allen told the Committee that the therapy was very new to secure services and as it was so odd nobody knew how it worked. There were a lot of bad reports about it but after some research it appeared that it worked well, was well received and was now included in NICE guidelines and generally accepted. Ms Allen said in secure hospitals it could be used in different ways and she wanted to know exactly how this happened.*

**Other ethical issues were raised and resolved in preliminary discussion before your attendance at the meeting.**

Please contact the REC Manager if you feel that the above summary is not an accurate reflection of the discussion at the meeting.

**Approved documents**

The documents reviewed and approved at the meeting were:

| *Document* | *Version* | *Date* |
|---|---|---|
| Covering letter on headed paper [Covering Letter] | V1 | 20 November 2017 |
| Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Indemnity] | V1 | 18 July 2017 |
| GP/consultant information sheets or letters [Letter to Consultant] | V1 | 20 November 2017 |
| Interview schedules or topic guides for participants [Interview Schedule] | V1 | 20 November 2017 |
| IRAS Application Form [IRAS_Form_02012018] | | 02 January 2018 |
| IRAS Application Form XML file [IRAS_Form_02012018] | | 02 January 2018 |
| IRAS Checklist XML [Checklist_02012018] | | 02 January 2018 |
| IRAS Checklist XML [Checklist_06022018] | | 06 February 2018 |
| IRAS Checklist XML [Checklist_10022018] | | 10 February 2018 |
| Letters of invitation to participant [Letter to Participant] | V1 | 20 November 2017 |
| Participant consent form [Participant Consent Form] | V1 | 07 April 2017 |
| Participant information sheet (PIS) [Participant Information Sheet] | V1 | 07 April 2017 |
| Research protocol or project proposal [Research Protocol 10.08.18] | 1 | 08 February 2018 |
| Summary CV for Chief Investigator (CI) [CI 2 page CV] | V.1 | 20 November 2017 |
| Summary CV for supervisor (student research) [Dr Hegg CV] | V1 | 20 November 2017 |
| Summary CV for supervisor (student research) [Dr De Claire CV] | V1 | 31 August 2016 |
| Summary CV for supervisor (student research) [Dr Etheridge CV] | V1 | 20 November 2017 |

**Membership of the Committee**

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

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/

| 18/SC/0034 | Please quote this number on all correspondence |
|---|---|

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

Yours sincerely

pp

**Dr Mike Proven**
**Vice-Chair**

E-mail: nrescommittee.southcentral-berkshire@nhs.net

*Enclosures:* *List of names and professions of members who were present at the meeting and those who submitted written comments*

*"After ethical review – guidance for researchers" [SL-AR2 for other studies]*

*Copy to:* [redacted]

**South Central - Berkshire Research Ethics Committee**

**Attendance at Committee meeting on 20 February 2018**

**Committee Members:**

| *Name* | *Profession* | *Present* | *Notes* |
|---|---|---|---|
| [redacted] | Social Scientist | No | |
| | Pharmaceutical Consultant | No | |
| | Director of risk management services | Yes | |
| | Retired Midwife and Clinical Governance Manager | Yes | |
| | R&D Research Co-ordinator | No | |
| | Retired Corporate Lawyer | Yes | |
| | Director | Yes | |
| | Aviation Safety Consultant | Yes | |
| | Consultant Paediatrician | Yes | |
| | Coordinator for QA in Research | Yes | |
| | Social Worker | Yes | |
| | Regulatory Affairs Consultant | No | |
| | Lead Pharmacist for Elderly Care, Neuro-rehabilitation, Dermatology and Clinical Governance | No | |
| | Medical Director | Yes | |
| | Senior Research Support Associate | Yes | |
| | Clinical Study Manager | Yes | |

**Also in attendance:**

| *Name* | *Position (or reason for attending)* |
|---|---|
| Mr Alex Martin | REC Manager |

# Appendix 11: Berkshire REC – Conditions met for Approval based on further documents (24.05.18)

NHS
Health Research Authority
South Central - Berkshire Research Ethics Committee
Bristol REC Centre
Whitefriars
Level 3, Block B
Lewins Mead
Bristol
BS1 2NT

Telephone: 020 7104 8057

**Please note: This is an acknowledgement letter from the REC only and does not allow you to start your study at NHS sites in England until you receive HRA Approval**

24 May 2018

Ms Mamie E Allen
Llandaff Campus
Western Avenue
Cardiff
CF5 2YB

Dear Ms Allen

| | |
|---|---|
| **Study title:** | **Exploring personal experiences of EMDR therapy within secure services.** |
| **REC reference:** | **18/SC/0034** |
| **Protocol number:** | **NA** |
| **IRAS project ID:** | **217066** |

Thank you for your letter of 21 May 2018. I can confirm the REC has received the documents listed below and that these comply with the approval conditions detailed in our letter dated 06 March 2018

**Documents received**

The documents received were as follows:

| *Document* | *Version* | *Date* |
|---|---|---|
| Covering letter on headed paper [Resubmission Letter.V1.12.5.18] | | 12 May 2018 |
| Letters of invitation to participant [Letter to MDT.V2.03.04.18] | 3 | 03 April 2018 |
| Letters of invitation to participant [Letter to participant.V2.03.04.18] | 2 | 03 April 2018 |

| | | |
|---|---|---|
| Non-validated questionnaire [Semi structured interview guidance V2 - 28.3.18] | 2 | 23 March 2018 |
| Participant consent form [Consent Form V2.03.04.18] | 2 | 03 April 2018 |
| Participant information sheet (PIS) [Participant Information Sheet.V2.03.04.18docx] | 2 | 03 April 2018 |

**Approved documents**

The final list of approved documentation for the study is therefore as follows:

| *Document* | *Version* | *Date* |
|---|---|---|
| Covering letter on headed paper [Covering Letter] | V1 | 20 November 2017 |
| Covering letter on headed paper [Resubmission Letter.V1.12.5.18] | | 12 May 2018 |
| Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Indemnity] | V1 | 18 July 2017 |
| GP/consultant information sheets or letters [Letter to Consultant] | V1 | 20 November 2017 |
| IRAS Application Form [IRAS_Form_02012018] | | 02 January 2018 |
| IRAS Application Form XML file [IRAS_Form_02012018] | | 02 January 2018 |
| Letters of invitation to participant [Letter to MDT.V2.03.04.18] | 3 | 03 April 2018 |
| Letters of invitation to participant [Letter to participant.V2.03.04.18] | 2 | 03 April 2018 |
| Non-validated questionnaire [Semi structured interview guidance V2 - 28.3.18] | 2 | 23 March 2018 |
| Participant consent form [Consent Form V2.03.04.18] | 2 | 03 April 2018 |
| Participant information sheet (PIS) [Participant Information Sheet.V2.03.04.18docx] | 2 | 03 April 2018 |
| Research protocol or project proposal [Research Protocol 10.08.18] | 1 | 08 February 2018 |
| Summary CV for Chief Investigator (CI) [CI 2 page CV] | V.1 | 20 November 2017 |
| Summary CV for supervisor (student research) [Dr Hegg CV] | V1 | 20 November 2017 |
| Summary CV for supervisor (student research) [Dr De Claire CV] | V1 | 31 August 2016 |
| Summary CV for supervisor (student research) [Dr Etheridge CV] | V1 | 20 November 2017 |

You should ensure that the sponsor has a copy of the final documentation for the study. It is the sponsor's responsibility to ensure that the documentation is made available to R&D offices at all participating sites.

| **18/SC/0034** | **Please quote this number on all correspondence** |
|---|---|

Yours sincerely

**Alex Martin**
**REC Manager**

# Appendix 12: HRA Ethics – Approval (11.06.18)

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Email: hra.approval@nhs.net
Research-permissions@wales.nhs.uk

Ms Marnie E Allen
Forensic Psychologist
Cardiff Metropolitan University
Llandaff Campus
Western Avenue
Cardiff
CF5 2YB

11 June 2018

Dear Ms Allen

**HRA and Health and Care Research Wales (HCRW) Approval Letter**

| | |
|---|---|
| **Study title:** | **Exploring personal experiences of EMDR therapy within secure services.** |
| **IRAS project ID:** | **217066** |
| **Protocol number:** | **NA** |
| **REC reference:** | **18/SC/0034** |
| **Sponsor** | **Cardiff Metropolitan University** |

I am pleased to confirm that HRA and Health and Care Research Wales (HCRW) Approval has been given for the above referenced study, on the basis described in the application form, protocol supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

**How should I continue to work with participating NHS organisations in England and Wales?**
You should now provide a copy of this letter to all participating NHS organisations in England and Wales*, as well as any documentation that has been updated as a result of the assessment.

*In flight studies which have already started an SSI (Site Specific Information) application for NHS organisations in Wales will continue to use this route. Until 10 June 2018, applications on either documentation will be accepted in Wales, but after this date all local information packs should be shared with NHS organisations in Wales using the Statement of Activities/Schedule of Events for non-commercial studies and template agreement/ Industry costing template for commercial studies.

Following the arranging of capacity and capability, participating NHS organisations should **formally confirm** their capacity and capability to undertake the study. How this will be confirmed is detailed in the "*summary of assessment*" section towards the end of this letter.

You should provide, if you have not already done so, detailed instructions to each organisation as to how you will notify them that research activities may commence at site following their confirmation of capacity and capability (e.g. provision by you of a 'green light' email, formal notification following a site initiation visit, activities may commence immediately following confirmation by participating organisation, etc.).

It is important that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details of the research management function for each organisation can be accessed here.

**How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?**
HRA and HCRW Approval does not apply to NHS/HSC organisations within the devolved administrations of Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) has been sent to the coordinating centre of each participating nation. You should work with the relevant national coordinating functions to ensure any nation specific checks are complete, and with each site so that they are able to give management permission for the study to begin.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

**How should I work with participating non-NHS organisations?**
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

**What are my notification responsibilities during the study?**
The document "*After Ethical Review – guidance for sponsors and investigators*", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

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

**I am a participating NHS organisation in England or Wales. What should I do once I receive this letter?**
You should work with the applicant and sponsor to complete any outstanding arrangements so you are able to confirm capacity and capability in line with the information provided in this letter.

The sponsor contact for this application is as follows:

Name: Ms Marnie Allen
Tel: [redacted]
Email: M.Allen14@outlook.cardiffmet.ac.uk

| IRAS project ID | 217066 |
|---|---|

**Who should I contact for further information?**
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **217066**. Please quote this on all correspondence.

Yours sincerely

Joanna Ho
Assessor

Email: ira.approval@nhs.net

*Copy to:* [redacted]

# Appendix 13: HRA Ethics Committee – 1st Substantial Amendment for the inclusion of another Hospital (21.3.19)

NHS
Health Research Authority

South Central - Berkshire Research Ethics Committee
Bristol REC Centre
Whitefriars
Level 3, Block B
Lewins Mead
Bristol
BS1 2NT

Tel: (020) 71048043

**Please note: This is the favourable opinion of the REC only and does not allow the amendment to be implemented at NHS sites in England until the outcome of the HRA assessment has been confirmed.**

21 March 2019

Ms Mamie E Allen
Llandaff Campus
Western Avenue
Cardiff CF5 2YB

Dear Ms Allen

| | |
|---|---|
| **Study title:** | **Exploring personal experiences of EMDR therapy within secure services.** |
| **REC reference:** | **18/SC/0034** |
| **Protocol number:** | **NA** |
| **Amendment number:** | **Substantial amendment 1 - 1.1.1** |
| **Amendment date:** | **02 January 2019** |
| **IRAS project ID:** | **217066** |

The above amendment was reviewed by the Sub-Committee in correspondence.

**Ethical opinion**

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

**Approved documents**

The documents reviewed and approved at the meeting were:

A Research Ethics Committee established by the Health Research Authority

| Document | Version | Date |
|---|---|---|
| Notice of Substantial Amendment (non-CTIMP) [18 SC 0034 AmendmentForm_ReadyForSubmission] | Substantial amendment 1 - 1.1.1 | 02 January 2019 |

**Membership of the Committee**

The members of the Committee who took part in the review are listed on the attached sheet.

**Working with NHS Care Organisations**

Sponsors should ensure that they notify the R&D office for the relevant NHS care organisation of this amendment in line with the terms detailed in the categorisation email issued by the lead nation for the study.

**Statement of compliance**

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

We are pleased to welcome researchers and R & D staff at our Research Ethics Committee members' training days – see details at http://www.hra.nhs.uk/hra-training/

| 18/SC/0034: | Please quote this number on all correspondence |
|---|---|

Yours sincerely

**PP - Mr David Carpenter**
**Chair**

E-mail: nrescommittee.southcentral-berkshire@nhs.net

*Enclosures:* *List of names and professions of members who took part in the review*

*Copy to:* [redacted]

# Appendix 14: HRA Ethics Committee – 2nd Substantial Amendment regarding transcription (14.5.19)

NHS
Health Research Authority

South Central - Berkshire Research Ethics Committee

Bristol REC Centre
Whitefriars
Level 3, Block B
Lewins Mead
Bristol
BS1 2NT

Tel: 0207 104 8241

**Please note: This is the favourable opinion of the REC only and does not allow the amendment to be implemented at NHS sites in England until the outcome of the HRA assessment has been confirmed.**

14 May 2019

Ms Marnie E Allen
Llandaff Campus
Western Avenue
Cardiff
CF5 2YB

Dear Ms Allen

| | |
|---|---|
| **Study title:** | **Exploring personal experiences of EMDR therapy within secure services.** |
| **REC reference:** | **18/SC/0034** |
| **Protocol number:** | **NA** |
| **Amendment number:** | **2** |
| **Amendment date:** | **04 April 2019** |
| **IRAS project ID:** | **217066** |

Approval was sought for, the interviewer to use a recording device which is the property of the hospital and that a member of the psychology admin team will transcribe the interview in the agreed format, as [redacted] and the security team have recently denied access of an external recording device. The above amendment was reviewed at the meeting of the Sub-Committee held on 10 May 2019.

**Ethical Opinion**

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

**Approved Documents**

The documents reviewed and approved at the meeting were:

| Document | Version | Date |
|---|---|---|
| Notice of Substantial Amendment (non-CTIMP) [2nd Signed Amendment Form] | 2 | 04 April 2019 |

**Membership of the Committee**

The members of the Committee who took part in the review are listed on the attached sheet.

**Working with NHS Care Organisations**

Sponsors should ensure that they notify the R&D office for the relevant NHS care organisation of this amendment in line with the terms detailed in the categorisation email issued by the lead nation for the study.

**Statement of Compliance**

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

**HRA Learning**

We are pleased to welcome researchers and research staff to our HRA Learning Events and online learning opportunities– see details at: https://www.hra.nhs.uk/planning-and-improving-research/learning/

| 18/SC/0034: | Please quote this number on all correspondence |
|---|---|

Yours sincerely

PP
**Mr David Carpenter**
**Chair**

E-mail: nrescommittee.southcentral-berkshire@nhs.net

*Enclosures:* *List of names and professions of members who took part in the review*

*Copy to:* *Ms Mamie E Allen*

# Appendix 15: Trust Feedback (05.04.18)

[redacted]

Ms Marnie E Allen
Llandaff Campus
Western Avenue
Cardiff CF5 2YB

5 April 2018

Dear Ms Allen

**Re: Exploring personal experiences of EMDR therapy within secure services**
**LREC Ref: 18/SC/0034**
**R&D Reference Number: 217066**

Thank you for submitting your protocol to the Clinical Projects Peer Review Group. I would like to feed back the following comments to you for your information:

- The peer reviewers thought this was a reasonable and interesting study. They felt that the subject was important and worth doing. This is an interesting and relevant study. The role of trauma in this population is under-recognised. The impact of treatment for trauma is an important area of consideration, especially given the engagement issues.
- They also would like to know what recruitment rates are likely to be in Forensic Services as they are not aware how wide-spread the use of EMDR is in those services.
- The key to success of the project would seem to be that respondents feel confident their feedback will not go straight to the clinician involved. The reviewers recommended that this fact be emphasised more to participants during the research when possible.
- One omission from the submitted documentation is the interview schedule itself. This has been devised 2 years ago, according to the protocol. Please include a copy of your interview schedule with your protocol.
- The reviewers suggested giving a presentation on the study at [redacted] if this is possible.

[redacted]

Thanks very much.

Best wishes

[redacted]

# Appendix 16: Trust Response to feedback (25.6.18)

Marnie Allen
Llandaff Campus
Western Avenue
Cardiff CF5 2YB

M.allen14@outlook.cardiffmet.ac.uk

[redacted]

25.06.2018

Dear [redacted]

In response to the feedback from the peer review, I have attempted to address some of the queries raised.

The recruitment rates recruitment rates in Forensic Services are likely to be low. Although I understand from clinical contacts that the use of EMDR has increased since commencing my study, cases are often complex, and completion can take years. This is one of the reasons that I have approached a number of trusts and have used qualitative methodology.

I understand the feedback regarding participants feeling confident that their feedback will not go straight to the clinician involved. I will ensure that this is emphasised more to participants during the research when possible. Additionally, the use of additional trusts will aid with this anonymity.

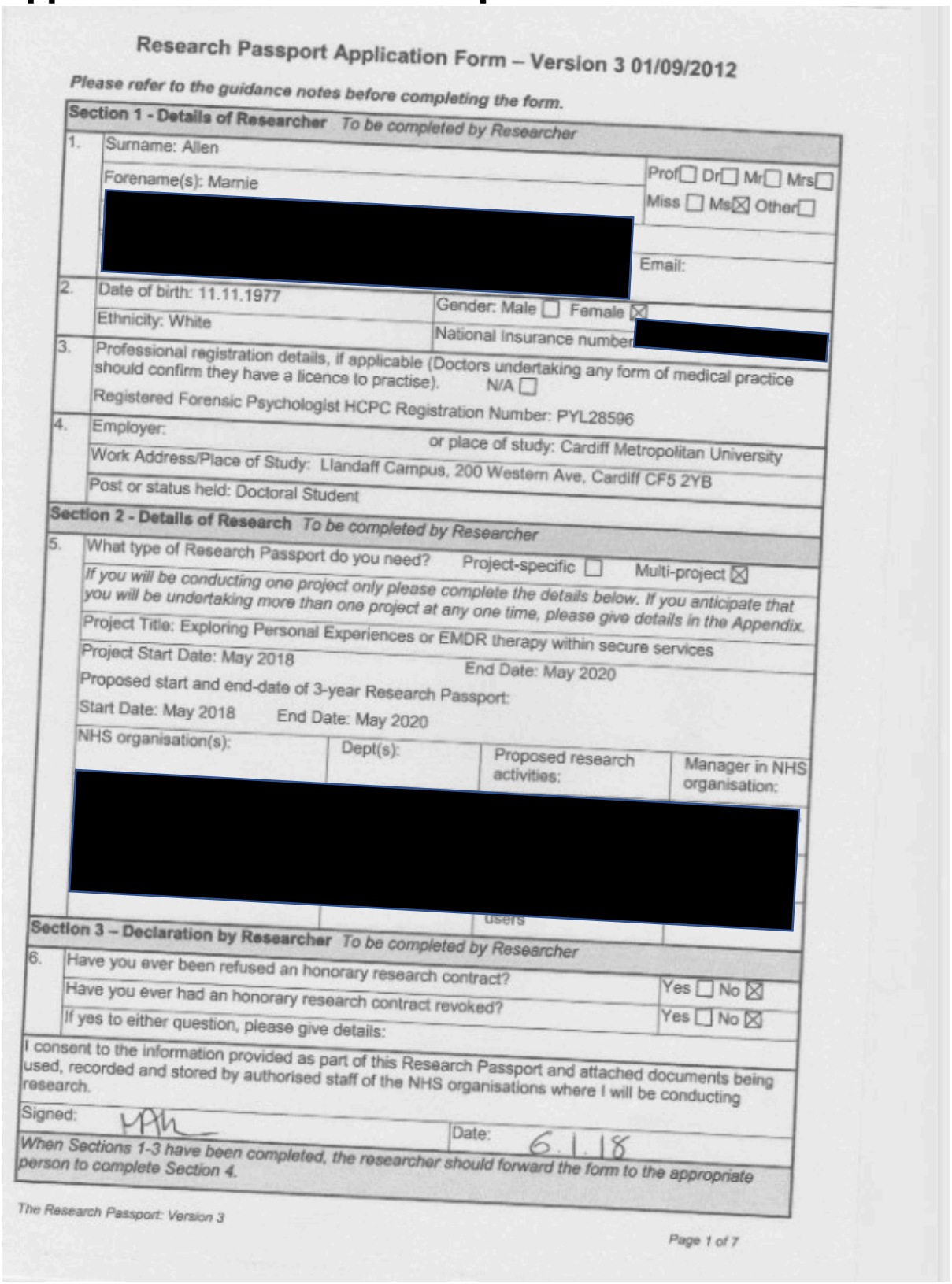
I have recently received HRA approval and I will forward the interview schedule along with the other related documents.

I had previously mentioned in email that I would be happy to do a presentation, but the response was that this was not necessary. I am happy do but I will await your response.

Best Wishes,

Marnie Akers

# Appendix 17: Research Passport



**Research Passport Application Form – Version 3 01/09/2012**

*Please refer to the guidance notes before completing the form.*

**Section 1 - Details of Researcher** *To be completed by Researcher*

1. Surname: Allen
   Forename(s): Marnie [redacted]
   Prof ☐ Dr ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☒ Other ☐
   Email:
2. Date of birth: 11.11.1977 Gender: Male ☐ Female ☒
   Ethnicity: White National Insurance number [redacted]
3. Professional registration details, if applicable (Doctors undertaking any form of medical practice should confirm they have a licence to practise). N/A ☐
   Registered Forensic Psychologist HCPC Registration Number: PYL28596
4. Employer: or place of study: Cardiff Metropolitan University
   Work Address/Place of Study: Llandaff Campus, 200 Western Ave, Cardiff CF5 2YB
   Post or status held: Doctoral Student

**Section 2 - Details of Research** *To be completed by Researcher*

5. What type of Research Passport do you need? Project-specific ☐ Multi-project ☒
   *If you will be conducting one project only please complete the details below. If you anticipate that you will be undertaking more than one project at any one time, please give details in the Appendix.*
   Project Title: Exploring Personal Experiences or EMDR therapy within secure services
   Project Start Date: May 2018 End Date: May 2020
   Proposed start and end-date of 3-year Research Passport:
   Start Date: May 2018 End Date: May 2020

| NHS organisation(s): | Dept(s): | Proposed research activities: | Manager in NHS organisation: |
|---|---|---|---|
| [redacted] | | | |

users

**Section 3 – Declaration by Researcher** *To be completed by Researcher*

6. Have you ever been refused an honorary research contract? Yes ☐ No ☒
   Have you ever had an honorary research contract revoked? Yes ☐ No ☒
   If yes to either question, please give details:

I consent to the information provided as part of this Research Passport and attached documents being used, recorded and stored by authorised staff of the NHS organisations where I will be conducting research.

Signed: MAh Date: 6.1.18

*When Sections 1-3 have been completed, the researcher should forward the form to the appropriate person to complete Section 4.*

*The Research Passport: Version 3*

*Page 1 of 7*

**Section 4 - Suitability of Researcher**
*To be completed by researcher's substantive employer, e.g. line manager, or academic supervisor*

| | | |
|---|---|---|
| 7.a | Will this person's research activity mean that they may be undertaking regulated activity with children and/or adults as defined in the Safeguarding Vulnerable Groups Act 2006, as amended (in particular by the Protection of Freedoms Act 2012)? (please use the Research Passport algorithm to make this judgement) | Yes ☑ No ☐ |
| 7. b | I am satisfied that the above named individual is suitably trained and experienced to undertake the duties associated with the research activities outlined in this Research Passport form | [redacted] |

*When Section 4 has been completed, the researcher should forward the form to the appropriate person to complete Section 5.*

**Section 5 - Pre-engagement checks** *To be completed by the HR department of the researcher's substantive employer or registry at place of study*

| | | |
|---|---|---|
| 8. | Does the above named individual's research involve Regulated Activity with children and/or adults as defined in the Safeguarding Vulnerable Groups Act 2006, as amended (in particular by the Protection of Freedoms Act 2012)? | ☒ Yes ☐ No |
| | If yes to the above, has the above named individual been checked against ISA barred lists for adults and/or children, as appropriate and have you received confirmation via the criminal record disclosure that the person is not barred from working with adults and/or children? (*NB individuals who are barred from working with adults or children must not undertake a regulated activity in the NHS with the vulnerable group from which they are barred, and you must not submit a Research Passport form in such cases).* | Checked against: ISA Adults List? Yes ☐ No ☒ N/A ☐<br>ISA Children's List? Yes ☐ No ☒ N/A ☐ |
| | Can you confirm that a clear criminal record disclosure has been obtained for the above-named individual, with no subsequent reports from the individual of changes to this record? *NB for Regulated Activity this must be an enhanced level criminal record check. For non-regulated activity, ensure the criminal record check is at the mandated level.* | Yes ☒ No ☐ N/A ☐ |
| | *If yes, please provide details of the clear disclosure:* | |
| | Date of disclosure: 04.07.17 | Type of disclosure: Enhanced |
| | Disclosure No.: 001579180137 | [redacted] |

| | | |
|---|---|---|
| 9. | Have the pre-engagement checks described below been carried out with regard to the above-named individual and is confirmation of the necessary checks, including any required satisfactory documentary evidence, available in the employing organisation's/place of study's records? | |
| | ▪ Employment/student screening: | |
| | o ID with photograph | Yes ☒ No ☐ |
| | o two references | Yes ☒ No ☐ |
| | o verification of permission to work/study in the UK | Yes ☒ No ☐ |
| | o exploration of any gaps in employment | Yes ☒ No ☐ |
| | ▪ Evidence of current professional registration | Yes ☒ No ☐ N/A ☐ |
| | ▪ Evidence of qualifications | Yes ☒ No ☐ |
| | ▪ Occupational health screening / clearance | Yes ☒ No ☐ |
| | Is the named individual on a fixed term contract or is the contract end imminent? Yes ☐ No ☒<br>Please indicate current contract end-date Date: | [redacted] |

| **Section 6 - Instructions to applicants**<br>*To be completed by Researcher* | |
|---|---|
| *Please indicate which of the following documents are attached to this Research Passport:* | |
| Current curriculum vitae, including details of qualifications, training and professional registration (please use the template C.V. at http://www.rdforum.nhs.uk/docs/template_cv.doc) | Yes ☒ No ☐ |
| Researcher's copy of criminal record disclosure. NB where research involves regulated activity with children and/or adults as defined in the Safeguarding Vulnerable Groups Act 2006, as amended (in particular by the Protection of Freedoms Act 2012), the disclosure must include confirmation of a check against the appropriate ISA barred list(s). | Yes ☒ No ☐ N/A ☐ |
| Evidence of occupational health screening / clearance | Yes ☒ No ☐ N/A ☐ |
| Appendix – List of projects and amendments | Appendix numbers:<br><br>N/A ☐ |

*Please send the completed form and original documents to the Lead R&D office. The completed form and original documents will be returned to you. This package of documents will be used to validate your completed Research Passport form. You may then, and where relevant, provide the Research Passport to other NHS organisations.*

**You must inform all NHS organisations that have received this Research Passport of any changes to the information supplied above. Failure to do so may result in withdrawal of your honorary research contract or letter of access. As part of the quality control procedures for the Research Passport, random checks on the accuracy of the information held on this Research Passport may be made.**

Please return the form to the researcher.

**Section 7**
**This section should be completed by HR in the Lead NHS organisation, only if additional checks are undertaken**

The following additional checks have been completed:

Having confirmed that the necessary additional pre-engagement checks have been completed, I am satisfied that the above named researcher is suitable to carry out the duties associated with their research activity outlined in this Research Passport.

| | |
|---|---|
| Signed: | Date: |
| Name: | Job Title: |
| Organisation: | Department: |
| Email: | |

**Section 8 - For Office Use Only**

*This section should be completed by the NHS R&D office that received the initial application. The NHS R&D office must countersign and date retained photocopies of the documents. The grey section must be completed before the form is returned to the applicant.*

| | | | |
|---|---|---|---|
| CV reviewed? | Yes ☑ No ☐ | Training? | Yes ☐ No ☑ |
| Evidence of qualifications? | Yes ☐ No ☑ | Appendix pages reviewed? | Numbers: N/A |
| Professional registration details reviewed? | Yes ☐ No ☐ N/A ☑ | Occupational health clearance reviewed? | Yes ☑ No ☐ N/A ☐ |
| Criminal record disclosure reviewed? | Yes ☑ No ☐ N/A ☐ | Date of disclosure: 04 JULY 2017<br>Disclosure No: 001579180137 | |
| For regulated activity as defined in the Safeguarding Vulnerable Groups Act 2006, as amended (in particular by the Protection of Freedoms Act 2012), did the criminal record disclosure confirm a satisfactory check against the appropriate ISA barred list(s) ADULTS | | | Yes ☑ No ☐ N/A ☐ |

Enter Electronic Staff Record Number (if issued):

Confirmation of valid Research Passport:

Project specific ☐ Three-year ☐ Other End date ☑ Date: 31/05/2020

[redacted]

| | |
|---|---|
| Date ~~Honorary Research Contract~~/letter of access issued *(delete as appropriate)* | 18/07/2018 |

# Appendix 18: Example of Letter of Access

[redacted]

Ms Marnie Allen
[redacted]

4 September 2018

Dear Ms Allen

**Letter of Access for Research**

You have a right of access to conduct such research as confirmed in writing in the letter of permission for research from this NHS organisation. Please note that you cannot start the research until the Principal Investigator for the research project has received a letter from us giving permission to conduct the project.

The information supplied about your role in research at [redacted] has been reviewed and you do not require an honorary research contract with this NHS organisation. We are satisfied that such pre-engagement checks as we consider necessary have been carried out.

You are considered to be a legal visitor to [redacted] premises. You are not entitled to any form of payment or access to other benefits provided by this NHS organisation to employees and this letter does not give rise to any other relationship between you and this NHS organisation, in particular that of an employee.

While undertaking research through [redacted], you will remain accountable to your employer but you are required to follow the reasonable instructions of [redacted], in this NHS organisation or those given on her behalf in relation to the terms of this right of access.

Where any third party claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by this NHS organisation in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings.

You must act in accordance to the [redacted] policies and procedures, which are available to you upon request, and the Research Governance Framework.

You are required to co-operate with [redacted] in discharging its duties under the Health and Safety at Work etc Act 1974 and other health and safety legislation and to take reasonable care for the health and safety of yourself and others while on [redacted] premises. You must observe the same standards of care and propriety in dealing with patients, staff, visitors, equipment and premises as is expected of any other contract holder and you must act appropriately, responsibly and professionally at all times.

If you have a physical or mental health condition or disability which may affect your research role and which might require special adjustments to your role, if you have not already done so, you must notify your employer and the Trust.

Yours sincerely

[redacted]

**Research Co-ordinator**

[redacted]

# Appendix 19: Example of Dictaphone Approval

NHS

[redacted]

**EP5**

**ELECTRONIC EQUIPMENT – [redacted]**

This form is to request authorisation to bring electronic equipment inside the [redacted] secure area for All Visitors (including memory sticks)

**Access will be granted under the guidelines of Trust Policy & Procedures.**
**Fields highlighted Yellow are mandatory and must be completed.**

**This form must be completed electronically, saved as a MS Word document and emailed as an attachment to**
[redacted]

| **SECTION 1: DETAILS OF REQUESTOR**<br>**N.B. Authorisation may be a clinical director, consultant or line/departmental manager.** | | | | | |
|---|---|---|---|---|---|
| Requester's Name | [redacted] | Requester's Ward/Dept. | [redacted] | Requester's Key Number | [redacted] |
| Visitor Name | Marnie Allen | Visitor's Contact Number | [redacted] | Visitor's Organisation | Cardiff Metropolitan University |

| **SECTION 2: DETAILS OF EQUIPMENT** | | | |
|---|---|---|---|
| Type of Device (Laptop, memory stick, iPad, etc.): | Dictaphone | | |
| Make of Device: | Olympus | Model of Device: | DS-7000 |
| Serial Number: | N/A | Who owns the equipment? | Visitor - Marnie Allen |
| Date of Visit | 7th and 8th January 2019 | Time of Visit | 9-5am |
| Please give a valid reason for why the visitor will be bringing this equipment onto site? | | | Research - Interviewing patients |
| Will the device require access to the network and/or network resources? | | | Yes ☐ No ☒ |
| If yes, please give details | | | |
| Will the visitor be taking the device into a Patient Area? | | | Yes ☒ No ☐ |
| If yes, please give details of security precautions to prevent patient access | | | Will be kept on persons at all times and secured safely away in bag when not in use. |
| Will the equipment be kept on the visitor's person at all times? | | | Yes ☒ No ☐ |
| If no, please describe the security arrangements | | | |

**SECTION 3: APPROVAL CONFIRMATION (to be completed by the requestor)**
**By completing this section of the form and emailing it, you are confirming that the visitor listed above has read and agreed to the Conditions of Approval listed in Section 4 and that they have agreed to abide by the Trust's Policies and Procedures.**

| | |
|---|---|
| Name: | [redacted] |
| Department/Ward: | |
| I confirm that I have also completed and submitted a Visitor Authority Form as outlined in FO/R/06 Professional Visits. ☒ | |

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NHS

[redacted]

**SECTION 4: CONDITIONS OF APPROVAL**

1. [redacted]
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policies and procedures.

Any queries, regarding this form must be submitted to the IT Security team.
Any incorrect forms will be rejected.

**SECTION 6: AUTHORISATION BY IT SECURITY**

[redacted]

**SECTION 7: AUTHORISATION BY HEAD OF SECURITY**

[redacted]

**SECTION 8: RECEPTION TEAM LEADER PLEASE DATE AND SIGN ONCE PROCESSED AND THEN FILE**

| | |
|---|---|
| Print Name | |
| Signature | |
| Date | |



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# Appendix 20: Poster Presentation at Division of Forensic Psychology (DFP) Conference, Newcastle Upon Tyne (2018)

## EMDR Therapy within Secure Services

Cardiff Metropolitan University

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### Introduction

The fundamental link between childhood trauma, violence and criminal behaviours is widely accepted. (Ardino, 2012) Offenders typically present with a higher prevalence of Post-Traumatic Stress Disorder (PTSD) and associated symptoms when compared with the general population (APA, 1994). Although trauma-informed care has gained momentum in recent years, services primarily offer offence focused interventions using a Cognitive Behavioural Therapy (CBT) modality (Redondo et al., 1999).

Eye Movement Desensitization and Reprocessing (EMDR) therapy has become widely recognised as an effective approach for treating trauma and other mental health difficulties. The element that is unique to EMDR is the use of "bilateral stimulation". Traditionally, this involves sets of lateral eye movements, after which the client is asked to notice and then provide a brief description what they are experiencing. Participants may report experiencing images, thoughts or bodily sensations.

The use of EMDR therapy within secure services is steadily growing. It is neither offence focused nor mandated. Currently, little is known about service user experiences of why they engage in EMDR therapy or how it may be beneficial to them in terms of their recovery and/ or risk reduction.

### Aim

To develop an understanding of personal experiences of EMDR therapy within secure services. This will inform the application of trauma based therapy and resource needs.

### Method

An opportunistic sample of 10-12 service users will be identified via practicing EMDR therapists within several secure services. Participants will include males and females who have:

- Been detained under the Mental Health Act (1983)
- Complex mental health disorders
- A forensic history
- Completed EMDR therapy

Semi-structured interviews will provide participants with the opportunity to communicate their understanding of their current situation and experiences of EMDR therapy process.

Thematic Analysis will be used to analyse the data.

### References

American Psychiatric Association (APA). (1994). *Diagnostic and statistical manual of mental disorders (4th ed.)*. Washington DC: American Psychiatric Association.

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**Supervisors:**
Joselyn Sellen (Senior Lecturer and Joint Programme Director) & Leanne Etheridge (Lecturer).

# Appendix 21: Simple Summary

## PERSONAL EXPERIENCES OF EMDR THERAPY WITHIN SECURE SERVICES

### Introduction

The fundamental link between childhood trauma, violence and criminal behaviours (Ardino, 2012) is widely accepted. Individuals who have offended typically present with a higher prevalence of Post-Traumatic Stress Disorder (PTSD) and associated symptoms when compared with the general population (APA, 1994). Although trauma-informed care has gained momentum in recent years, services primarily offer offence focused interventions using a Cognitive Behavioural Therapy (CBT) modality (Redondo et al., 1999).

Eye Movement Desensitization and Reprocessing (EMDR) therapy has become widely recognised as an effective approach for treating trauma and other mental health difficulties. The element that is unique to EMDR is the use of "bilateral stimulation". Traditionally, this involves sets of lateral eye movements, after which the client is asked to notice and then provide a brief description of what they are experiencing. Participants may report experiencing images, thoughts or bodily sensations.

The use of EMDR therapy within secure services is steadily growing. It is neither offence focused nor mandated. Currently, little is known about service user experiences of why they engage in EMDR therapy or how it may be beneficial to them in terms of their recovery and/ or risk reduction.

**Aim** - To develop an understanding of personal experiences of EMDR therapy within secure services. This will inform the application of trauma-based therapy and resource needs.

### Method

An opportunistic sample of 8 services users were recruited from secure services and invited to engage in a semi-structured interview to explore their experiences. Thematic analysis was used to analyse the data.

# Analysis

Four main themes were revealed as central to participant experiences of engaging in EMDR therapy with a secure service:

1. **Decision to Engage in EMDR Therapy** including 'Accessing Information and the Unknown' along with 'Making a Personal Commitment to Engage' in EMDR therapy.

*There are horror stories you hear of EMDR that it really effects you and things like that that*
**Samuel**

*Very personalised so it was really my issues things that came up for me things that I wanted things that I identified that I still struggle with rather than it being these are the things that the team have noticed and want to work on.*
**Sydney**

*Explain[ing] to people that it's normal to feel that way after EMDR because it's quite scary*
**Aljazeera**

*I knew that it was focused on something that was so much engrained in me something that that dominated my life something that that had been hanging over my head for just so many years I knew that I to release these demons*
**Samuel**

2. **Essential Support Structures** that was in place including the 'Challenges of a Secure Environment' and the 'Necessity of the Therapeutic Relationship'.

*It can be slowed down by what's going on outside of the room because you can be literally in a memory and there's banging there's shouting outside the door and it can pull you out or just make that a bit heavier because it might relate to some of the things that have been going on.*
**Aljazeera**

*Well I'll be honest with you now that I don't think for one minute if I didn't have the therapist relationship with my EMDR therapist I wouldn't be the person I am now I know because it wouldn't have worked*
**John**

3. **EMDR Therapy Process** including the 'Functional Aspects of Bilateral Stimulation' and the 'Visceral Impact of Engagement'.

*You're bearing your soul to somebody*
**Samuel**

*It makes you go a little bit deeper than on a superficial level a little bit deeper and different feelings thoughts emotions will come out*
**Percy**

*The first time was the scariest because you started to feel but not quite ready to go there*
**Aljazeera**

4. **Identifying Personal Change** that participants observed in relation to 'Changes in Mental Health and Diagnosis', 'Insight and Reflections on Offending Behaviour' and 'Ability to Cope and Experience Hope for the Future'.

*I've stopped having flashbacks I [was] having these flashbacks or hearing screams from the past that's none existent now*
**Samuel**

*I don't automatically begin that process of disengaging and building weapons and thinking about defending myself and the environment and taking drugs*
**Sydney**

*I never knew about how I could handle things*
**Joseph**

*I address things like much easier now I still get upset sometimes when I think about stuff but I process things completely different now*
**Sky**

## Discussion

EMDR therapy was reportedly life changing for all of the participants. However, this was not an easy therapy for participants to engage in and showed considerable personal commitment on their behalf. A number of relevant factors were identified that require further consideration when offering a trauma intervention within a secure service.

Secure services will benefit from continuing to raise awareness of trauma informed services for both staff and service users. Information about EMDR therapy needs to clearly outlined alongside the costs and benefits of engaging. This information could also provide personal accounts and success stories, which normalises the experiential impact of the therapy and introduces ways to manage cope with this.

The therapeutic relationship is essential in EMDR therapy. Efforts should be made to develop this as early as possible; ensuring good levels of trust has been developed prior to attempting processing. Additionally, clinicians should be mindful of the ability to offer a safe, private therapy space and be aware of the negative impact of an unsupportive environment.

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