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Patient Experiences of Victimization during Mandatory Psychiatric Treatment: A Qualitative Study

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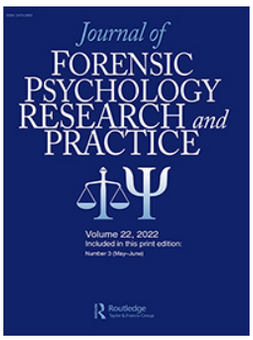

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Patient Experiences of Victimization during Mandatory Psychiatric Treatment: A Qualitative Study

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ABSTRACT

Forensic psychiatric inpatients are frequently exposed to aggression from fellow patients during their treatment, but research on how this impacts patients' well-being and treatment progress is lacking. In this study, we interviewed nine patients on their experiences of victimization during mandatory psychiatric treatment. The interviews were analyzed using a Grounded Theory approach combined with elements from Consensual Qualitative Research and Interpretative Phenomenological Analysis. Three main themes emerged from the data, namely situational descriptives, intrapersonal and interpersonal consequences. Patients were not only exposed to both physical violence and verbal aggression by other patients, but also to a more ubiquitous flow of micro-aggressive comments. Options to escape these situations were limited. This means that victimization processes, which for most patients started much earlier in life, continue during forensic psychiatric treatment. Intrapersonal consequences include fear, hypervigilance, reactive aggression, flashbacks and avoidance and withdrawal. Interpersonal consequences include increased power differences between patients and adverse treatment consequences, such as difficulties with self-esteem. Victimization processes are not always timely noticed in an environment that focuses on risks and treatment of delinquent behavior. A higher level of trauma sensitivity in forensic mental health care is thus required. Recommendations for the implementation of trauma informed care are provided.

KEYWORDS

Victimization; inpatient aggression; forensic psychiatry; justice-involved persons; qualitative study

Inpatient aggression is a common phenomenon in forensic psychiatric hospitals (Bowers et al., 2011). In a meta-analysis of 36 studies in forensic psychiatry, it was calculated that almost one aggressive incident occurs in every 100 occupied patient bed days (Bowers et al., 2011). The proportion of physically violent incidents is 32% (*SD* = 16.6) in studies where four categories of inpatient aggression are reported, that is verbal aggression, aggression toward property, physical violence and self-harm (Bowers et al., 2011). A recent study

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in a Dutch forensic psychiatric hospital found similar results. Verbal aggression was used in the majority (74%) of aggressive incidents whereas physical aggression toward others was reported in around 30% of the incidents (Huitema et al., 2021). Both fellow patients and professionals can be victims of these incidents. A study in an American forensic psychiatric hospital demonstrated that in 62% of all reported incidents (n = 5219) patients were the victims (Bader et al., 2014). The total frequency with which patients are exposed to aggression is higher, however, as patients also witness the victimization of others.

What it means for patients to be exposed to these incidents during mandatory psychiatric treatment remains unclear. Some research has been conducted on the physical consequences of exposure to violence. In a study by Bader et al. (2014), 37% of all reported patient victims needed minor first aid treatment and almost 5% needed treatment by a physician. Research on mental health outcomes is scarcer, particularly when related to witnessing victimization of others, and has primarily been conducted in prison settings. In a qualitative study on previously incarcerated men and women, it was concluded that incarcerated persons were routinely exposed to violence. Violence is described as a core feature of the prison experience. Psychological consequences of the constant exposure to violence include anxiety, depression, hypervigilance and problems with emotion regulation (Novisky & Peralta, 2020). Some of these consequences have also been found in forensic mental health nurses who were confronted with workplace trauma. Psychological distress was the most commonly reported consequence, including anxiety, depression, fear, anger and frustration (Newman et al., 2021).

It is important to examine the effects of patients' exposure to aggression. Forensic psychiatric treatment is aimed at the active rehabilitation of individuals and victimization during treatment is at odds with this objective. Furthermore, a considerable number of forensic psychiatric inpatients already have a history of victimization. Estimates vary and indicate that between 68% (Bohle & de Vogel, 2017) and 75% of all forensic psychiatric patients experienced at least one type of emotional, physical or sexual abuse during childhood (McKenna et al., 2019). Almost 15% of the patients was victim of three types of abuse during childhood (Bohle & de Vogel, 2017). Symptoms of these traumas are important to consider in forensic psychiatric treatment, as they may relate to both the onset of offending and to repeat offending (Fritzon et al., 2021). It is suggested that childhood trauma is related to the development of different risk factors for violence later in life, such as substance abuse, poor achievement in school or at work and symptoms of a personality disorder, including emotion dysregulation (Fritzon et al., 2021) and impulsivity (Alford et al., 2020). There are also indications that exposure to violence during incarceration may lead to an increase in post-traumatic stress disorder (PTSD) symptoms, which, in turn, may increase the risk of reoffending. Research in this area is highly preliminary, however, and has been conducted in populations of

incarcerated persons and not in forensic psychiatric inpatients. In a review of six studies, it was concluded that potentially traumatic events, such as abuse and solitary confinement, in prison were associated with PTSD outcomes (Piper & Berle, 2019). Furthermore, it was found that PTSD symptoms increased the risk of recidivism (Sadeh & McNiel, 2015). Even when controlled for other risk factors, such as age, gender, the presence of substance use disorders and personality disorders, PTSD was associated with a greater likelihood for new felony charges during the year following the index arrest (Sadeh & McNiel, 2015).

In sum, it can be concluded that forensic psychiatric inpatients are regularly exposed to aggression, which has a potentially large negative impact on themselves, others, and their treatment. Few studies have been conducted in this regard, however, and more research into patients' experiences with victimization during forensic psychiatric treatment is necessary.

Aim of the present study

The present study aimed to increase insight into patient experiences with victimization during clinical forensic psychiatric treatment. Given the lack of studies in this area, we conducted an exploratory qualitative study on this subject. More insight in this area is necessary as it may aid in the development and refinement of policies that make the hospital a safer place for everyone involved.

Method

Participants and setting

The present study was conducted in a Dutch forensic psychiatric hospital in which both male and female patients are admitted. In the hospital, approximately 80% of patients are male and around 20% of patients is female. These patients are admitted on gender-mixed wards, which is customary in Dutch forensic mental health care. All patients are admitted with a court order and receive treatment with the aim to reduce the risk of relapse into violent behavior. Around 60% of patients is admitted with a criminal commitment, imposed to reduce the risk of recidivism in violent or sexually violent offenses. The other 40% of the patients is admitted with a civil commitment. These patients receive mandatory psychiatric treatment because they were considered to be a danger to themselves or others and displayed disruptive behavior in regular mental health care. Background characteristics of the interviewed patients are provided in Table 1.

Table 1. Background characteristics of interviewed patients.

Patient number	Age (y)	Gender	Years in current hospital	Ward type
1	28	Male	5	Group ward
2	42	Male	1	Group ward[a]
3	48	Female	8	Group ward, long term treatment
4	48	Male	0.5	Group ward, long term treatment
5	31	Male	0.5	Group ward
6	33	Female	9	Individual ward[b]
7	46	Male	2.5	Group ward
8	53	Male	3	Group ward
9	51	Male	11	Sheltered housing in the community under hospital supervision

[a]Patients who are admitted on group wards have more liberties than patients on individual wards. There is more patient interaction on group wards.
[b]Patients on individual wards remain in their room when they are not in other parts of the hospital for their treatment program. Patients on individual wards generally have a higher risk of inpatient violence and, therefore, more security measures are in place, such as a higher staff-patient ratio.

Procedure

Ethical approval for this study was obtained from the Ethics Committee Social Sciences of the Radboud University in the Netherlands with number ECSW-2019-008. The data for this study were collected between December 2019 and February 2020. First, the study was announced in different multidisciplinary meetings in the hospital and in the patient council. Information brochures were provided with general information about the study. The study population included all patients who were admitted to the hospital at the time of the study, provided that the treatment supervisor considered that the patients would not experience an increase in psychiatric symptoms due to their participation in the study. The sample size is in line with guidelines of both the CQR and IPA methodology, as elements of both methods are incorporated into the analysis plan (see Table 2). In CQR research, saturation is expected to be achieved with a sample size between eight to fifteen participants (Hill et al., 1997). IPA studies mostly have sample sizes of five to ten participants (Smith, 2004).

Table 2. Analysis plan.

What	Who
1. Open coding (Boeije, 2010). Simultaneously, noting any thoughts, observations, and reflections that occurred while reading the transcripts in a separate column (Biggerstaff & Thompson, 2008). This element of IPA was included to create a space for the researchers' subjective reactions to the data, so that the other coding can be performed according to the Grounded Theory principles as described in Boeije (2010), e.g., remain close to the data and as free from biases as possible.	All three researchers individually
2. Axial coding (Boeije, 2010) to determine which elements in the research are the dominant ones and which are the less important ones.	All three researchers individually
3. Consensus meeting within primary team (see, also Hill et al., 1997) to discuss the coding and reach agreement on the division of main categories and subcategories and the meaning of these categories. Determining which interviews are selected in the next round of analysis.	Meeting between three researchers
4. Processing the results of the consensus meeting and finishing the axial coding in ATLAS.ti version 8.	First author

A purposive cell sampling strategy was used (Robinson, 2014), aiming to include both male and female patients, patients with different types of primary diagnoses, such as schizophrenia spectrum disorders and cluster B personality disorders, patients from diverse ward types and, finally, patients both in long-term and in regular forensic mental health care (see also Table 1) in order to explore the topic from different angles. Based on these criteria, nine patients were asked to participate in the study. The researcher had individual introductory meetings with all nine patients. During these meetings, the patients were briefed about the goal of the interview and the procedure, for instance, that their participation would be completely voluntary and that they could always, without explanation, withdraw their participation. Patients were given a minimum of three days to consider whether or not they wanted to participate. All nine patients who were approached for the study consented and participated in an interview.

The interviews had a semi-structured character and were conducted with a topic list, which was developed based on the literature on inpatient violence and discussed in the primary research team consisting of three authors (NV, NPS, VdV). Topics included, but were not limited to, patients' primary appraisal of aggressive situations, their coping, and the influence on their well-being and the relation with treatment. The same topic list was used in all nine interviews in line with the CQR methodology (Hill et al., 1997).

At the start of the study, definitions of aggression were adopted from the four scales of the Modified Overt Aggression Scale+ (Crocker et al., 2006), that is the scales verbal aggression, physical aggression toward others, aggression toward property and sexual aggression. Each type of aggression is defined in four severity levels. For instance, the scale verbal aggression stretches from angrily shouting and insults others toward repeatedly or deliberately threatening others with violence. Given the exploratory nature of this study, an open and flexible approach was used, and participants were also asked what they considered to be aggressive behavior and their perspectives on this were also included in the study. This led to an expansion of the definition of aggression and the inclusion of micro-aggression. The concept of micro-aggression originally stems from research on racism and refers to "brief and commonplace daily verbal, behavioral, and environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults to the target person or group" (Sue et al., 2007, p. 273). It is also applied to other minority groups, such as psychiatric patients (Gonzales et al., 2015) and in this case forensic psychiatric inpatients.

Eight patients agreed to audio-tape the interview and verbatim transcripts were made. One interview was transcribed based on notes that were made during the interview as the patient did not consent to audio-taping it. Most interviews lasted 40 to 50 minutes and were held in one session. Two interviews were shorter and lasted 20 minutes. One interview was held in two 20-

minute sessions. Interviews were held on the ward, in general meeting rooms in the hospital or in the bedroom of the patient. One interview was conducted together with a sociotherapist, a social worker that works on the patient's ward. In line with the advices that Hollomotz (2018) provided on successfully interviewing persons with a mild intellectual disability, the sociotherapist was present during the interview to provide contextual information about the experiences that the patient disclosed, where the patient himself was not fully able to due to his intellectual disability. Only examples that the patient himself provided were included in the analyses. Information that the sociotherapist provided was not included in the analyses. During the interviews, patient's answers were paraphrased by the researcher in order to check if the answers were understood correctly.

Analyses

The data in this study were analyzed with a Grounded Theory approach (Boeije, 2010), combined with elements from Consensual Qualitative Research (CQR; Hill et al., 1997) and Interpretative Phenomenological Analysis (IPA; Smith, 2004). All three analytic approaches are concerned with the detailed exploration of personal meaning and lived experience. In grounded theory, data are systematically generated and analyzed step-by-step in order to describe, understand, and, ultimately, explain social phenomena. The three main steps are the open coding or the segmenting of the data, followed by axial coding in which the categories are described, and, finally, the selective coding or the reassembling of the data (Boeije, 2010). Whereas in grounded theory, no assertions are made about inter-coder agreement, CQR methodology prescribes how all judgments in the analysis process are made in a primary team of at least three researchers so that the best possible construction of the data is developed (Hill et al., 1997). The current study included this focus on consensus and performed the analysis in a primary team of three researchers (see above). Second, in the current study, as is prescribed in CQR, all data were collected using the same topic list to ensure consistency of responses rather than alternating between data gathering and data collecting as is customary in grounded theory (Hill et al., 1997). Finally, an element from IPA was included in the study. One of the characteristics of IPA is that it operates at different levels, one that is clearly grounded in the text and one that is more interpretative and leaves more space for the observations and reflections of the researcher (Smith, 2004). This is particularly useful in studies where participants' reflective abilities are limited, for instance, due to an intellectual disability (Corby et al., 2015) and/or other complex problems in the context of mandatory psychiatric treatment (Neimeijer et al., 2021). In these cases, contextual information may

be required to adequately convey the participants' experiences. It was expected that the patients in the current study also had limited reflective abilities due to psychopathology. Furthermore, as the interviews with patients were the only source of information in this study, this element of IPA was incorporated into the present study.

Four of the nine interviews were randomly selected to be analyzed in the first round. All three researchers started with open coding according to the principles described in Boeije (2010). Simultaneously, any thoughts, observations and reflections that occurred while reading the transcripts were coded in a separate column (Biggerstaff & Thompson, 2008). In Figure 1, an example is provided on the open coding and IPA coding. The open coding remained as close to the data as possible, and the IPA coding left space for questions and thoughts of the researchers. Another example can be found in the interview with a female patient who described how female patients find support with each other and take care of each another. One of the researchers noted that this will most likely not always be the case. This provided relevant contextual information about the level of support that female patients realistically give each other. After the open coding and IPA coding, all three researchers continued with axial coding (Boeije, 2010) to determine which elements in the research were the dominant ones and which were the less important ones. Then, a consensus meeting was held with all three researchers to discuss the coding and reach agreement on the division of main categories and subcategories and the meaning of these categories. Based on these first four interviews, the division in main themes and subthemes was

Open coding grounded theory	**Interview fragment**	**IPA coding**
Verbal aggression *Racism* *Anger* *Patient reacting to provocation* *Staff response after incident* *Worry when family hears verbal aggression*	*Patient:* Yes there is one patient, she is locked in her room, but she keeps staring through the window in her door and when you walk by her, she calls you 'black', racist stuff. I get angry, you know. But then there is the staff. Sometimes, I respond, you know: 'Come outside with your big mouth'. And then immediately, staff comes and talks to me and says: 'Let it go, she doesn't know better', you know. Because it goes on and on. And… *Sociotherapist:* And this gets to you, doesn't it? *Patient:* It gets to me, because sometimes, the same staff says, maybe my family comes in. They visit and then she starts screaming. That's not polite, you know. It's not polite.	*Does the patient feel not being taken seriously by staff when they tell him to let it go? Does he feel offended?*

Figure 1. Example of IPA coding.

Table 3. Overview of main- and subthemes that emerged from the analysis.

Situation	Intrapersonal	Interpersonal
Physical violence	Fear	Power differences
Verbal aggression	Altered reactivity	Treatment consequences
Microaggression	Hypervigilance	
Inevitability	Reactive aggression	
	Flashbacks	
	Avoidance and withdrawal	

developed (see Table 3). Finally, the first author processed the results of the consensus meeting and finished the axial coding in ATLAS.ti version 8. These four steps (open coding, interpretative IPA coding, axial coding, consensus meeting and processing the results in ATLAS.ti) were repeated two more times.

The interviews in the first round mainly described experiences with inpatient aggression from the perspective of witness or bystander. Therefore, in the second round, a different perspective was sought. Out of the five remaining interview transcripts, two were included in the second round of analysis because they also described patients' experiences with inpatient aggression as perpetrator. This was used to check if their perspective on victimization was different. The same themes emerged from the analysis in this second round. This second round did result, however, in a more nuanced understanding of some of the themes. For instance, after the first round, the theme "power differences" described how power differences between staff and patients were enlarged in the aftermath of violence. In the second round of analysis, this was expanded to power differences between patients and how relations between patients become more complicated in the aftermath of inpatient aggression. In the third round, the last three interviews were analyzed. No new findings emerged in this round. Therefore, it was concluded that the saturation level was achieved and that it was not necessary to conduct more interviews.

After completion of the analyses, a member check was conducted to confirm the credibility of the findings. The synthesized research findings were presented to six of the nine interviewed patients. Due to COVID-19 restrictions, this was done by telephone. The first author explained the main themes and subthemes that emerged from the analysis as depicted in Table 3, and briefly illustrated each theme with examples. Patient number 4 was excluded from the member check as it was estimated that participating in the member check would lead to a destabilization of his current mental health. Patients 1 and 5 were not interested in participating in the member check. The other six participants were asked whether the synthesized research findings represented their experiences and whether or not they wanted to add or change anything (Birt et al., 2016). The patients confirmed the findings and stated that they are in line with their experiences.

Results

Three main themes emerged from the data, namely 1) situational descriptives, 2) intrapersonal consequences, and 3) interpersonal consequences. The main themes and sub themes are listed in Table 3.

Situational descriptives

The interviews made clear that aggression is part of the living environment of patients. Patients were frequently exposed to different forms of aggression, and it was hard for them to avoid these situations given the mandatory character of their admission.

Exposure to physical and verbal aggression

All interviewed patients described experiences of victimization during their stay in the hospital. This includes exposure to both physical violence and verbal aggression. Incidents of physical violence included attacks on patients and staff members, sometimes with the use of dangerous objects, such as boiling water or kitchen knives, either as a direct victim or as a witness. The experiences of physical violence were less frequent in comparison to the more ubiquitous incidents of verbal aggression in the hospital. According to the interviewed patients, not all patient groups have equal chances of being targeted. Patients who have committed a sexually violent offense toward children, patients from an ethnic minority groups, homosexual patients and female patients were pointed as groups that were more often subjected to inpatient aggression. Aggressive comments are not always made directly to the person, as patient 2 explained: "It frequently happens that there are groups of patients here in the common room and then it is, yes, they talk about pedophiles this and pedophiles that and blah you know: 'If I see one, then I will stab him.' That kind of things is what you hear."

Patients can have different roles in aggressive situations in the hospital and be a victim or bystander in one situation and an aggressor in another situation. For instance, female patients reported sexually transgressive behavior from male patients, but incidents caused by female patients were also reported. Patient 9 described how a female patient extorted him into giving her money or she would accuse him of sexually harassing him. As he would not give her the money, she followed up on her threat and the hospital staff revoked his right to undertake leave outside the hospital to investigate what had happened and conduct a risk assessment. After four weeks, he was granted leave outside the hospital again.

Furthermore, patients on some wards are frequently exposed to aggression toward property, which was also experienced by the researcher during the interview with patient 4. During the interview, a patient in the adjacent room was screaming and kicking against the walls. The sociotherapist, who was present during the interview to support patient 4, remained silent but very alert on what was going on and whether or not she needed to leave the interview in order to intervene. The patient continued making tea for the interviewers and showed no reaction to the sounds in the room next to him. When the researcher asked him if he heard these sounds more often, he responded: "Yes, sometimes they kick against the door or they bang against the door."

Micro-aggression

Not all aggressive incidents in the hospital are explicit in nature. Patients reported that a more subtle form of verbal aggression occurs in daily interactions. Patient 3 described this as a constant flow of critical comments on the ward:

> That you can actually never do it right. When it was my task to make dinner for the group, that it [the dinner] was never okay, you know. That you never do it right. . . . Comments on everything you do. Yes, that is difficult here.

Patient 1 described it as jokes that are made that are almost aggressive. When asked when he was verbally abused for the last time, he replied: "Really verbally abused or just in a 'joking' way? Really abused is quite a long time ago. Verbally abused as a joke was just this morning." When asked what kind of jokes he referred to, he answered: "Well, just that someone looks terrible or that something he made, that it did not go well, that kind of jokes. Just jokes that are actually just about acceptable, but that some people will find offensive."

Inevitability

Aggression is part of the living environment of patients, both in the hospital and in their past. Patients described how they were exposed to violence in their youth and in previous detention. In the hospital, it is also inevitable that patients are exposed to violence. Given the mandatory nature of treatment, patients were not able to escape this. Patient 9 described it as follows:

> It is not pleasant, that in the evening, you have to sit at the table with them [aggressive patients]. And in the ward meeting, we have to talk about it again. And they repeat it endlessly. And at some point, you think, phew, it has been enough . . . And then you can keep them [the violent patients] behind a locked door for a few days, but not for months. So, at a certain point, it gets stuck. . . . And then they come back to the ward. 'O you are back, well that is great!' And that is it. Then it is no longer talked about.

As patients were confronted with their aggressors and repeatedly had to talk about the incidents, these aggressive incidents continued to influence the atmosphere on the ward, even if the acute situation was resolved. This means that patients were confronted with the consequences for a long time and were not able to escape it.

Sometimes, violence occurred unexpectedly. In these situations, patients felt pressured by hospital staff to intervene by, for instance, calling for help or trying to verbally de-escalate the situation. Patients generally described that they do this automatically. Patient 6 phrased it as follows.

> Yes, I believe that if you see someone getting attacked, I think, even if you are a patient and you yourself have caused incidents. I would do it any second. Yes, I mean that. . . . I think everyone should help if something is going on. It would be very weird if you would just stand there and watch.

Most patients described that they automatically lend assistance and protected staff and other patients, for instance, by standing between two patients who were threatening each other: "that is just who I am," "it doesn't bother me at that moment." However, the realization that they had put themselves in danger follows later. One patient described that she actually received a few "hard blows" because of this.

Intrapersonal consequences

Consequences of experiencing aggression were both interpersonal and intrapersonal. Intrapersonal consequences consisted of fear, altered reactivity, cued recalls, and, finally, avoidance and withdrawal.

Fear

Fear was a common response to aggression. Patients, for instance, reported that they feared that previously violent patients will reengage in violent behavior, that tense situations between patients escalate into violence or that patients would use equipment that is available in the hospital as a weapon. In all these situations, patients feared that they, or staff members or other patients that they care about, would get hurt. Patient 3 described how another patient threatened to assault her in an empty room on the ward. Afterward, she was very afraid to be alone.

Altered reactivity

Hypervigilance, described as a state of being highly alert to threats, is another commonly reported consequence of being exposed to aggression. Patients described how they are constantly aware that an aggressive incident may occur. For instance, patients reported that they noticed all the sounds they hear just outside their room. One patient described how he is always looking

out if other patients do not steal supplies from the workplace to later use it as a weapon. Furthermore, patients noticed how other patients when in the hospital garden make sure they are standing close to the doors so that they can quickly escape if necessary. Patient 2 added that he feels it is necessary to stay alert, because the younger, female staff members are not able to control some of the patients if they become violent. Finally, patients described that this habit of being constantly highly alert of their surroundings was not formed in the current hospital. Patients described that in prison, remaining vigilant is even more important than in the hospital. In their experience, more violent situations occurred during incarceration in prison.

In some cases, experiences of victimization trigger aggression in patients. Patients described how they utter threats after they feel they have been treated in a demeaning way or how they swear back after they have been called names. To not become violent in these cases requires a high level of self-control. Patient 5 explained:

> I become indifferent. If the pressure gets too high, then bring it on. Then it has to happen. Then you are no longer thinking rationally. An automatism comes in place that I have learned in my youth. . . . Then immediately something changes in me. Now that I am older, I am more susceptible to reason. But in the moment, I have to dig really deep to find that. . . . If I have the feeling that I have to [be violent in order to defend his position], then it is going to be really difficult to bring me back. . . . And the anger stays for a long time. I need to talk about it a lot to lose that feeling. To be able to let it go. It keeps me busy for days. Days. Yes. Then, at night, in my bed, I am still fighting so to speak. Super annoying. Brings no good into my life. I am trying to work on that.

Cued recalls

As experiencing violence within the hospital was almost inevitable for patients, so were later confrontations with the violent patient or the location where the violence occurred. For instance, patient 6 was admitted on a crisis ward, where she frequently heard the sound of the sociotherapists' alarm going off, indicating that there is a crisis on the ward. When she heard a ring that is similar to the sound of the alarm, she would think back of the violent incidents that occurred on the ward. Furthermore, every time she heard how a patient was placed into an isolation room, it brought back bad memories of the violent incidents that she herself had caused and memories of when she was put in isolation. Patients not only reported recalling earlier experiences of violence within the hospital. Witnessing violent incidents confronted them with violence they encountered when they were a child or with their own violent behavior within the hospital.

Avoidance and withdrawal

Avoidance and withdrawal were important mechanisms to cope with aggression inside the hospital. This could mean a reluctance to share information with the staff, described by patient 5 as follows:

> And now, for instance, they want me to be open about who is dealing drugs inside the hospital and these sorts of things. And I know some things about that, but I am not going to interfere. I am not going to risk it. . . . I am in a very small community here. Life can be made very difficult for you.

For most patients, this meant withdrawing themselves in their own room, where they can lock the door: "Sometimes, I don't feel safe. Then they talk about sex or violent things. Then I really need to be able to leave." Whereas most patients retreated in their room out of concern for the aggression of others, patient 4 described how he fears his own reaction to aggressive patients and, therefore, withdrew himself in his room:

> Sometimes I say, what an asshole, you know, to do that and not continue with your life, you know. Because when you hit someone . . . I used to get very angry with staff members. So angry that I wanted to punch them. But afterwards, I think, if I punched them, what does it matter? I will be put in isolation and then what? To play tough? So that other patients know, he punched a staff member? Yes, so, I don't do that, you know. You know, sometimes when they keep on going, then I am not able to talk anymore. I prefer to walk away, go to my room, you know. To cool off. These days, I am not even answering them. I go straight to my room and go to sleep.

Although the bedroom was considered a safe place, the safety concerns began at the doorstep:

> I never open the door when someone knocks. I always think, my sociotherapists have a key, and now, of course I knew you came for the interview, so that is different. But if someone knocks unexpectedly, I never open. Or it is [name another patient who she trusts], but she always calls 'It is me!' But otherwise, I never open the door. Not even when they say they have a question. I don't trust that. No. Because than you are gone, you know. Because if I open that door, then I am going to lose [Patient 3].

All patients described some form of avoidance and withdrawal. In some cases, patients described how they received the advice to ignore verbal aggression: "I said that someone is regularly saying ugly things and they [staff] said: 'Yes we can say something about it, but that also has a downside.' . . . They say that it is best to just walk straight ahead and keep going. And think something like, well it is okay."

Interpersonal consequences

Power differences

Power differences are inevitable between patients in mandatory treatment and their treatment providers (i.e., sociotherapists). These differences were enlarged, however, in the aftermath of violent behavior. First, in the experience of patients, staff mainly addressed them in their identity as an offender. For instance, patient 3 described how staff reacts differently if patients are victims of aggression compared to when a staff member becomes the victim of aggression:

> Well, then they often say, it must be your own fault, you know. You must have provoked the situation. And they would never say that to the sociotherapists, you know. Then, they [the violent patient] immediately get thrown into an isolation room or an empty room. And if it is two patients, then the victim often gets questioned if he or she did not provoke the situation. And I don't think that is completely fair. Of course, if two are fighting, they both hold blame. I know that. But sometimes, that is just not the case. Sometimes you just get hit for no reason.

Second, power differences were also enlarged in the provision of aftercare:

> Sometimes, when there has been an incident of aggression on the ward, the sociotherapists are going to comfort each other in their office and we are just sitting there. And, well, I kind of do not like that, actually. As if we are less [Patient 3].

This patient feels like a lesser human being because of the way the aftercare is organized.

Patient 2 described how he feels interrogated by staff about a violent situation that occurred on the ward with the purpose of making a reconstruction of that event. In his experience, no aftercare was provided to victims and witnesses. These experiences, where proper aftercare was experienced as lacking, were described in multiple interviews although positive experiences with aftercare were also described. Patient 6 described that when a crisis occurs on her ward, staff always comes to her door to briefly explain what is going on and when the crisis is averted, they will come back for a more extensive explanation:

> And sometimes, when something really intense happened, we come together, and everyone can say how they feel. For instance, we had someone who started a fire in the middle of the night. The next day, we came together, because some patients were angry, because they feel that that patient jeopardizes their safety by setting that fire. But others said that they didn't blame the patient, because she might have been confused. That sort of things [Patient 6].

Third, the process of pressing charges was experienced as more difficult for patients than for staff members and this raised concern among patients. Hospital staff not always promoted the patients' rights to press charges. For instance, a patient was advised to shift his attention from the wrongdoing of others to his own treatment and thereby, not press charges. Furthermore, relations between patients become more complicated after pressing charges

and patients are condemned to each other. For instance, patient 1 was warned that he could report the situation to the police, but then the other patient will, most likely, also press charges against him and due to national regulations, the liberty of the patient to leave the hospital will be suspended for one year if charges are brought against someone. This means that the patient would risk losing his liberties if he pressed charges against the patient that harmed him.

Treatment consequences

Involvement into conflicts or aggressive incidents with other patients can have consequences for treatment. In some cases, this may have positive side effects as it provides learning opportunities. For instance, exposure to sexist comments compelled patients to become more resilient and learn to recognize and impose their personal boundaries. It could also mean a prolongation of treatment, or in the words of patient 5: "You know the kind of persons you are in here with. . . . Someone else can make your treatment last very long." Patient 3 described how frequent exposure to critical comments made it more difficult to book progress on the treatment goal improving one's self-esteem, as she internalized these comments. When this patient was transferred from a group ward to an independent studio within the hospital, she noticed how the constant comments she received from other patients had affected her self-esteem.

Discussion

The present study aimed to increase insight into patient experiences of victimization during mandatory psychiatric treatment. The results demonstrated how violence is inevitably a part of life for the interviewed forensic psychiatric inpatients. Patients may exhibit violent behavior themselves, but are also frequently exposed to aggression of others, both in the hospital and in their past.

Exposure to aggression during admission entailed less frequent episodes of physical violence, a more constant flow of critical comments and verbal aggression and the feeling of being at risk to become the target of aggressive incidents. Previous studies demonstrated that consequences for staff include emotional reactions such as anger, fear, anxiety and PTSD symptoms (Lanctot & Guay, 2014; Needham et al., 2005). The findings of the current study indicate that consequences for patients may be largely similar. Intrapersonal consequences for patients also included emotional reactions, such as fear and frustration, and PTSD symptoms, such as recurrent memories of the traumatic event, avoidance of external reminders, hypervigilance and angry outbursts. Not only the exposure to physical violence triggered these reactions, also the more frequent critical comments or aggressive "jokes" can have adverse consequences and may hinder treatment progress, for instance, with regard to the improvement of patients' self-esteem. This constant flow of subtle aggression can also be labeled as micro-

aggression. This refers to intentional or unintentional hostile, derogatory or negative slights and insults that are such a pervasive part of daily conversations and interactions that the potential impact of these micro-aggressions is often not recognized anymore (Sue et al., 2007). Whereas micro-aggression is not included in general definitions of aggression in (forensic) psychiatric hospitals, the present study demonstrated that, in the experience of patients, it is part of the same continuum, and it may also negatively impact their well-being. Previous studies are in line with this. A review of 72 study samples on micro-aggression in diverse populations points at adverse effects on mental health, such as higher levels of stress and negative emotionality (Lui & Quezada, 2019).

The impact of being exposed to inpatient aggression may in some regards be comparable for staff and patients, for instance, in the emotional reactions that follow. There are also important differences. Patients are continually exposed to an environment in which aggression occurs, whereas staff members go home at the end of their shift to a generally safe environment. This victim-offender cycle existed in the lives of most patients before the current hospitalization and it continues during the treatment that is aimed at breaking this circle through preventing further violent behavior. This is troublesome, as it is at odds with the assumption that medical treatment, including psychiatric hospitalization, should cause no harm. There is increasing attention on continuous traumatic stress and responses to ongoing traumatic stressors (Eagle & Kaminer, 2013; Goral et al., 2021) in addition to the literature on impact of past traumatic events. The experiences of the interviewed patients can be viewed in this light, also in terms of the consequences. It has been suggested that ongoing exposure to traumatic events leads to symptoms of arousal and avoidance rather than intrusion (Eagle & Kaminer, 2013). Whereas some examples of cued recalls were found in this study, arousal and avoidance were more dominantly present.

Implications for clinical practice

Based on the results of the present study, it is advised to incorporate principles of trauma informed care in forensic psychiatry, such as the ones formulated by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA, 2014) and further described by Levenson and Willis (2019) for correctional settings. Several of the findings of the current study can be related to these principles of trauma informed care. Particularly, the results demonstrate how more attention for these principles is required in clinical practice.

Being aware of the prevalence and impact of trauma is the first of these four assumptions. The possible damaging effects of micro-aggression should also be considered in this regard and receive more attention in forensic mental health care. This is advised, not only because these comments may cause harm in itself, but also because it may create an unsafe atmosphere in which more severe aggressive events can emerge (Phillips, 2016).

The second assumption is that signs and symptoms of trauma should be adequately recognized. Levenson and Willis (2019) noted that, in correctional settings, interpersonal and self-regulation deficits may not be recognized as signs of early trauma, but are solely seen as risk factors for reoffending. In the current study, patients reported angry outbursts after experiences of victimization and a staff focus on the outburst, thereby neglecting the victimization that provoked this. These patient experiences suggest that staff is focused on the patients' identity as an offender, that the behavior of patients is evaluated accordingly and explained as part of the treatment that they receive. Patients also described avoidant coping strategies and high levels of hypervigilance as a reaction to the frequent occurrence of (micro-)aggressions in the hospital. It is important to realize how circumstances during treatment may lead to an aggravation of these behaviors that may have been present already. Disentangling the relationship between victimization and offending and, thereby, distinguishing between the two in clinical practice appears to be difficult, also given the underdiagnoses of PTSD that has been found in different (forensic) psychiatric samples (Alexander et al., 2016; Nieuwenhuis et al., 2019; Zimmerman & Mattia, 1999). PTSD-symptoms appear to be frequently overlooked when they are not the presenting complaints (Zimmerman & Mattia, 1999).

The other two assumptions of trauma informed care include the integration of knowledge about trauma into policies, procedures, and practices and the active avoidance of re-traumatization in the service delivery setting. Everyone in the organization should take patients' experiences of trauma into consideration (SAMHSA, 2014) and employ safe, collaborative, and empathetic interactions with patients, instead of resorting to rigid limit setting and punitive consequences (Levenson & Willis, 2019). Power balances between patients and staff should also be considered in this light. In most health care settings, treatment providers have specialized knowledge and the patients generally have a dependent position (Reeves, 2015). In forensic mental health care, these differences are even bigger due to the mandatory nature of treatment. The present study describes how circumstances in the aftermath of aggressive behavior, such as difficulties for patients when pressing charges, can lead to increased power differences and to diminished trust in staff. In line with this, it is important to acknowledge the damaging influence micro-aggression can have. It is questionable whether micro-aggression is always noticed and acted upon given its subtle and ubiquitous character. It can be assumed that patients do not always experience support from their therapists in these situations. This is troublesome, because a good therapeutic alliance is considered to be one of the strongest and most robust predictors of treatment success (Horvath et al., 2011). Furthermore, the level of support from nurses was negatively associated with the number of violent incidents (Ros et al., 2013). This way, a vicious circle may arise in which incidents lead to more incidents. It is advised to develop

specific policies on the provision of aftercare and pressing charges for patients, so that these circumstances in the aftermath of aggressive behavior do not lead to deterioration of treatment relations.

Limitations

Several limitations can be noted for the present study. First, the present study aimed to grasp the experiences of patients and, therefore, relied solely on interviews. No methodological triangulation was used, that is no different research methods were employed to investigate the topic from different angles (Boeije, 2010), such as observations or study of hospital records on aggressive events, although this is advised in qualitative research to check the validity of the data (Patton, 1999). To compensate for this, a member check has been conducted and researcher triangulation was used by performing the analysis in consensus with three researchers in line with CQR research. Second, due to the exploratory nature, a broad approach was used in the interviews, aiming to collect information on a variety of patient experiences related to victimization during forensic psychiatric treatment. This broad approach was used because of the dearth of knowledge in this area. Certain topics emerged from the data but could be further explored. For instance, more insights could be developed on the impact of patient victimization on treatment progress.

Implications for further research

Future studies on patient victimization during forensic psychiatric treatment are strongly advised. As common for this type of research, the present study is based on a relatively small number of interviews although the saturation level was achieved. Future studies should include broader samples from different settings, including prison, as traumatic experiences in prison were often reported by patients. With broader samples, it is possible to compare experiences of different patient groups, such as male and female patients, patients with different commitment types and patients in long term and regular forensic mental health care. Future studies could include standardized measures to examine the effect of inpatient aggression on the physical and mental health and treatment progress of patients and assess the level of PTSD symptoms, preferably in longitudinal designs. Including staff perspectives is also advised in order to gain insight into the level of trauma-sensitivity of forensic psychiatric institutions. Second, it is advised to conduct further research on the impact of inpatient aggression on treatment relations between patients and staff. The present study provides indications for a deterioration of the quality of the treatment relationships in the aftermath of aggressive incidents. More research is necessary to follow up on this finding and to shed more light on the way that staff and patients interact

with each other after aggressive incidents have occurred. Third, it is advised to conduct studies that specifically examine the prevalence and impact of micro-aggression in forensic psychiatry and in detention. The current study provides indications that this subtle form of aggression is omnipresent and negatively affects patients' well-being. It can be assumed that micro-aggressions are difficult to grasp due to its subtle nature. More insight into the ways in which micro-aggression affects the safety on wards is necessary.

Conclusion

The present study explored how patients experience their exposure to different sorts of potentially traumatic experiences during treatment. Due to the mandatory nature of treatment, their options to escape these situations are limited. Exposure to aggression can lead to a decrease in patients' mental health and treatment relationships with staff and in some cases may negatively affect treatment progress. Although exposure to aggression is, at least to some extent, inevitable in closed psychiatric settings, preventing patient victimization is pivotal and minimizing its consequences should be prioritized in forensic psychiatry. Principles of trauma informed care should, therefore, be a vital part of forensic psychiatric treatment.

Disclosure statement

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